ONTARIO NURSES' ASSOCIATION

SUBMISSION

ON

Long-Term Care Staffing Study

TO

LONG-TERM CARE ADVISORY GROUP

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Summary of ONA Recommendations for Long-Term Care Staffing

1. Kick start systemic change in Ontario's long-term care sector by immediately increasing the funding per home and enforcement of a regulated minimum staffing standard in long-term care homes set at an average level of four worked hours of nursing and personal care per resident per day. The four hours of daily care per resident must be funded on the basis of worked hours where care is actually provided to residents and must include the following skill mix to meet resident need: 20 per cent registered nurse (RN) care, 25 per cent registered practical nurse (RPN) care, 55 per cent care from personal support workers (PSWs) and one (1) nurse practitioner (NP) for every 120 residents. At least four hours of worked direct nursing and personal care per resident per day is essential until a full study is done in Ontario regarding optimal staffing to meet resident need and advanced levels of acuity.
2. Phase out "for-profit" long-term care homes within five (5) years to ensure public funding is directed to improve staffing and the quality care to meet resident needs.
3. Implement paid professional development education and replacement (backfilling) for registered staff to attend enhanced training in gerontological care.
4. Implement strategies to enhance clinical placement and education on gerontology in the nursing curriculum.
5. Implement urgent dedicated staffing, training and orientation in infection control practices and the effective use of personal protective equipment (PPE) during outbreaks.
6. Effective recruitment and retention of nursing and personal care staffing is contingent on competitive compensation. Urgent action is recommended to equalize rates of compensation with the hospital and not-for-profit long-term care sectors.
7. Eliminate on-line surge/e-learning to ensure effective training and learning on paid time with appropriate staff coverage for resident care.

I. Introduction

The Ontario Nurses' Association represents 68,000 registered nurses (RNs) and health-care professionals in all health-care sectors, including thousands of RNs in long-term care.

ONA welcomes the opportunity to provide the Long-Term Care Advisory Group (the Advisory Group) with recommendations from the perspective of front-line registered nurses and health-care professionals with respect to our priorities for staffing in the long-term care sector.

I want to start by letting the Advisory Group know that ONA was a major participant in the Long-Term Care Public Inquiry and provided an extensive submission[1] with recommendations. I also want to remind you that Recommendation 85 from the Public Inquiry focuses specifically on registered staff:

> The Ministry of Health and Long-Term Care should conduct a study to determine adequate levels of *registered staff* in long-term care (LTC) homes on each of the day, evening, and night shifts. The Minister of Health and Long-Term Care should table the study in the legislature by July 31, 2020. If the study shows that additional staffing is required for resident safety, LTC homes should receive a higher level of funding overall, with the additional funds to be placed in the nursing and personal care envelope.

All evidence and testimony, including from all participants in the Public Inquiry, agreed about the need for more registered staff in long-term care.

There is also extensive evidence in the research literature on the strong relationship between higher RN staffing levels in long-term care homes and improved quality of care outcomes for residents. Conversely, decreasing RN staffing in long-term care homes has a negative impact on resident health outcomes.

We expect the Advisory Group conducted a thorough review of the available literature and any recommendations on staffing in long-term care will be based on the evidence. We ask that any studies that the Advisory Group has commissioned or undertaken be made public so that the basis for the recommendations is transparent.

II. More RNs, more RPNs and Improved funding for Long-Term Care

ONA believes systemic change is required in the long-term care sector to address the overarching issues of understaffing and underfunding.

Long-term care homes are staffed far too lean in Ontario and the ratio of registered nurses to residents in nursing homes is far too low to allow adequate and safe care. This became abundantly apparent during the pandemic.

Compounding this problem of understaffing is the widespread recruitment and retention issues for the RNs in this sector, and the unsafe use of staffing agencies that send in temporary staff who are not familiar with the homes or residents. This is contradictory to the best practice of continuity of care that results from full-time permanent staff who know the residents and develop long-lasting relationships that are essential for improved care.

Residents in today's long-term care homes are typically older and frailer, with higher acuity and more comorbidities, than the residents of the past. The data collected by the Ministry of Health and Long-Term Care from 2014, and presented to the Public Inquiry, confirms that the average age of residents in long-term care was 85 years. Of these residents:

- 78 per cent required assistance (total or extensive) with the activities of daily living;
- 65 per cent suffered from depression; almost half had aggressive behaviors for medical reasons;
- more than half were medically "unstable";
- 69 per cent had dementia/Alzheimer's disease;
- 50 per cent had heart disease; and
- 26 per cent had diabetes.

In addition, of the 71,000 residents in 2014, almost 23,000 were transferred to acute care hospitals. As you can infer from this data, these residents are not a medically-stable patient population.

Since as early as the Price Waterhouse Cooper study in 1999, successive provincial governments have been provided with multiple expert reports, inquests, and other reviews in long-term care that each provide clear, strongly worded recommendations regarding an urgent need to increase staffing and improve funding in long-term care.

Despite this series of reports – each containing an express finding that long-term care homes are insufficiently staffed to provide care and prevent harm to residents – the Ministry of Long-Term Care has yet to implement a satisfactory registered nurse-to-resident ratio or mandate a set number of hours of care, per resident, each day.

There remains insufficient funding and regulation to ensure adequate nursing and personal care staffing that is capable of meeting the needs of residents in long-term care facilities. Staffing and funding go hand in hand. As does enforcement of stronger regulations on staffing.

The 2005 recommendations in the Casa Verde Inquest speak to funding to set standards to increase staffing levels and ensure wage parity. The 2008 Sharkey Report recommends that guidelines be established to support funding to provide up to four hours of care per resident per day.

The 2012 Donner Report strongly recommends that the Sharkey Report be implemented, again drawing the connection between funding and staffing. Further, the evidence from the Public Inquiry specifically pressed home the issue of improved levels of ***registered*** staffing to keep residents healthy and safe. The key is to ensure full clinical assessments by professional staff to monitor and set in place a plan of care to return residents to health on an ongoing basis. Early recognition and treatment is the path to healthy residents as they age.

It is virtually impossible to address staffing issues in long-term care without also properly funding long-term care. Staffing in long-term care has been a chronic problem for decades. It is now reaching an untenable level that will only worsen with Ontario's aging population. Again, the pandemic has accentuated the glaring need for professional staffing assistance with infection control practices and measures, and the care of residents with ongoing chronic conditions. Systemic change and sufficient funding must be implemented, as these changes require additional staff, particularly RNs, due to resident acuity and the requisite knowledge and skill base to properly care for residents.

ONA is calling for funding and enforcement of a regulated minimum staffing standard in long-term care homes set at an average level of four worked hours of nursing and personal care per resident per day.

Our call for funding and enforcement of a daily four-hour nursing and personal care staffing standard is designed to meet the increased care requirements of residents in long-term care homes.

The four hours of daily care per resident[2] must be funded on the basis of worked hours where care is actually provided to residents and must include the following skill mix to meet resident need: 20 per cent RN care, 25 per cent registered practical nurse (RPN) care, 55 per cent care from personal support workers (PSWs) and 1 nurse practitioner (NP) for every 120 residents.

At least four hours of worked direct nursing and personal care per resident per day is essential until a full study is done in Ontario regarding optimal staffing to meet resident need and advanced levels of acuity.

This is the minimum staffing required to meet resident need as provided for in the literature.

More registered staff would also assist with job satisfaction, as there would be an ability to provide variety for the professional staff as well as contribute to overall better assessments and interactions with the residents.

III. Staffing Flexibility

The Advisory Group suggests that they heard at the stakeholder listening day that there could be "better utilization of different types of staff to reduce staff workloads, maximize staff's ability to use their full scope of practice and more effectively meet resident needs."

The Advisory Group asked ONA the following questions.

1. What other roles should be considered (e.g., personal care aide, co-op program for students, different classifications within the PSW role, increased use of OT/PT roles)?

Given that resident acuity continues to increase, ONA asked the Advisory Council where is the enhanced role of the RN and Nurse Practitioner (NP), especially given the evidence and testimony at the Public Inquiry and the experience during the pandemic? RNs and NPs are not working to full scope with a focus on improving resident outcomes.

The RN role has become mostly administrative versus patient facing; this needs to change. RNs can improve resident outcomes when given sufficient staffing and daily time to conduct full assessments to implement care plans to meet resident need. Homes that had well-developed Infection Control positions with RNs in the roles have fared better during COVID.

With respect to Personal Support Workers (PSWs), ONA does not support fewer full trained PSWs. Nor does ONA support the introduction of lesser-trained workers such as aides.

What we question is that the focus on uniform education standards set by Health Force Ontario seems to have shifted to simply staffing with insufficiently trained PSWs. In addition, it is difficult to retain fully trained, experienced PSWs in homes because of the untenable workload and low rates of pay compared to other sectors.

ONA also questions where is the role of competent trained and experience Administrators and Directors of Resident Care? The gaps in relevant training and experience of senior management in homes is discussed in the Public Inquiry and have not been rectified. This has been obvious during the pandemic. Gail Donner's report also raised this issue.

a) What are the barriers and/or enablers to better use of these roles?

As we discussed, the long-term care sector is chronically underfunded and understaffed.

There are insufficient hours of care from RNs, RPNs, NPs and PSWs to appropriately meet the needs of residents. As well, there are far too many part-time positions and not enough full-time positions to provide continuity of care.

b) What models allow for more direct care?

Professor Pat Armstrong and associates[3] have completed an eight-year international study on reimagining long-term care. Professor Armstrong's work shows a way forward compared to optimal practices in other jurisdiction and shows that the conditions of work for staff are the conditions of care for residents. This is critical to understanding how staffing levels must be improved to meet resident care needs.

As a start, additional funding to enable staff levels of four worked hours of daily nursing and personal care per resident is a first step.

This would mean that funding levels would be appropriate to meet the minimum staffing required to meet actual resident needs.

Currently, the CMI process for funding can result in less funding given the results of resident evaluation at a specific point in time. CMI does not measure resident care needs in real time and can result in reduced funding if needs are not identified at the point in time CMI is measured. The process also negatively rewards homes who improve resident outcomes with decreased funding through a reduced CMI.

As we have indicated, minimum staffing levels must be set at to reflect 20 per cent of care from RNs, 25 per cent from RPNs, 55 per cent from PSWs plus one NP for every 120 residents.

Staffing hours of 4 hours of Nursing care per resident per day have been impacted by changes in how that formula is applied by homes that include all staff into the formula – not just Nursing. There is no meaningful measure of care needs currently and no tool exists in LTC to address acuity. RAI and MDS are not used in real time.

The Inquiry evidence from DORC, Administrators, Nurses and PSW's identified Nursing needs as 1 to 10.

2. Based on the 24 hour a day, 7 day a week operation of long-term care homes, we have heard about scheduling challenges associated with moving into greater use of full-time roles.

a) Are 12-hour shifts appropriate for long-term care home staff, if so, for what roles?

RNs are currently working twelve-hour shifts in about 30-4o per cent of homes. There could also be hybrid schedules (a mix of 8 and 12-hour tours). This would require more full-time staff.

Some other employees could also work the same schedules provided workload is manageable.

(b) Are you aware of other best practices to facilitate greater use of full-time roles?

Some homes have not staffed with full-time RNs. The workforce of RNs, RPNs, PSWs is very casualized; they work in two to three homes to piece together full-time hours. This has proven very problematic during COVID, requiring a mandatory order from public health to work in only one home, and at other times when part-time are not available because they are working at multiple employers.

The biggest issue for retention and recruitment of RNs and other staff is that wages and benefits are not competitive with the hospital sector or not-for profit homes sector.

(c) Are there opportunities to leverage online scheduling tools, or self-scheduling programs to support part-time and casual staff?

Online scheduling tools do not work in hospitals and will not work in long-term care homes. This would be a mistake. As well, they are very costly, and many homes do not have the computer system and infrastructure to support the needs of the programs.

What is key is increased full-time staffing to meet resident care needs.

Self-scheduling programs to support part-time and casual staff could work, but they require a dedicated lead. It will never work (ONA has lots of experience with these models in other sectors) with too few full-time employees. Full-time staffing is the key.

IV. Working Conditions

3. The Advisory Council heard at the stakeholder listening day that compensation, benefits, and fulltime opportunities are important factors in improving working conditions within the long-term care sector.

b) What other elements should be considered to improve working conditions for employees such as professional development or engagement opportunities?

Employers in the long-term sector should support advanced gerontology education for RNs, RPNs and other staff. These were recommendations in Dr. Sinha's report that ONA supported then and continues to support now.[4]

Employers could fund continuing gerontology education and release time for staff to participate.

In Shirlee Sharkey's report,[5] she discussed in-home education with staff backfilled to attend and participate. ONA supported this recommendation but not all her report.

Online surge learning does not work. A five-minute video on PPE and infection control clearly does not work as evidenced by COVID. Online learning in the context of COVID and closure of schools has shown several issues with that learning model.

c) What are the barriers to implementing these elements?

Homes are not willing to fund education and/or backfill related to cost, especially in the for-profit homes. There is also a shortage of staff to backfill. Registered Staff are often required to backfill for other home staff in order for them to receive training, but are left on their own to complete surge, e-learning and other education or are expected to already have current skills by virtue of their license to practice. Registered staff require ongoing education to ensure they can assess and adapt to the changing acuity of residents, treatments, and needs of residents.

Staff should not be required to complete e-learning at home on their own time. If e-learning continues, computer systems within homes must be updated to ensure compatibility with e-learning and in a sufficient supply to meet in-house training needs.

4. The Advisory Council heard at the stakeholder listening day that appropriate onboarding and professional development opportunities are important factors to enhance recruitment and retention of staff within long-term care homes.

a) What training models should be implemented within long-term care homes?

Three to five days of education/onboarding RNs into long-term care is insufficient to work independently and be alone in the home.

As well, there is very little clinical laddering in long-term care homes.

There are no additional in-person learning opportunities in homes.

External education is costly and nursing home staff are underpaid. Payment for any training and replacement (backfilling) of staff is essential to create ongoing learning opportunities and professional development.

b) How could training options vary depending on the staff role?

ONA has raised these issues many times with government representatives; there is no gerontology focus in long-term care in the BScN program. Long-term care is not promoted in the nursing education programming nor is there a focus on promoting long-term care as a nursing career.

New graduate nurses should not work in environments where there is no other RN support for learning, teaching, coaching or support. Academics such as Heather Laschinger and others have supported this.

RNs describe the experiences of new employees who enter long-term care homes, see the environment, the lack of supports, understaffing and the compensation, and leave immediately to work in other sectors like hospitals. Many RNs redeployed from hospitals to long-term care homes during the pandemic had similar reactions.

For-profit homes that pay less than not-for-profit homes describe just getting new nurses established in their environment and settled in when they leave to work in the not-for-profit homes that pay hospital parity and offer more full-time nursing jobs.

Initial Comments on COVID-19

Finally, the Advisory Group asked ONA to comment on the impact of COVID-19 in long-term care homes.

ONA provided the following information during our meeting with the Advisory Group. Note that these are preliminary comments pending our participation in the independent commission promised by Premier Ford to be set up in July.

The most recent data, as of June 17, 2020, indicates that there are still at least 68 homes currently in outbreak.

From ONA's perspective and the experience of our more than 4,000 members working in long-term care homes, COVID-19 demonstrated the need for urgent attention and training for staff in infection control measures and practices.

COVID-19 showed the impact of having so few full-time staff in homes to be able to meet resident care needs.

ONA has watched the number of full-time positions decrease over the last rounds of our Central Negotiations – particularly in the for-profit homes.

Part-time positions have increased. Many part-time nurses work at multiple facilities.

The Emergency orders required the selection of one home – this decreased the hours staff were booked as they were not topped up by the employer they chose, to offset the decrease in hours and lost wages.

There were huge gaps in skill mix and not enough registered staff to assess the challenges with residents.

COVID-19 was an unknown disease process and staff were bombarded with conflicting advice from government, from public health, and from Ontario Health to employers.

The required staffing in, and knowledge of, Infection control practices is needed, and training is required across all staff groups. ONA members have experienced huge gaps in training, supply of and access to PPE and preparedness of homes.

Hospitals and not-for profit homes increased staffing to prevent COVID outbreaks and minimize spread, including training on infection control measures, screening, and enhanced cleaning. When an outbreak occurred, they had teams ensuring infection control measures were proper utilized, including the donning and doffing of personal protective equipment.

Surge and e-learning training cannot be used to properly teach infection control practices and a pandemic is not the time to teach staff who had never been previously taught infection control processes, especially as fast moving and deadly as COVID-19 is and where staff were attempting to provide the basics of care in a challenging and understaffed environment.

Registered staff became exhausted quickly, became ill themselves, suffered from compassion fatigue and became unable to assist with training, supervise or manage the huge workload and teach skills at the same time. Additionally, they were assigned additional tasks such as Coroner's paperwork and preparing the deceased to be released to funeral homes outside of the home.

Care is and was focused on keeping going to provide the care that was possible in an untenable situation.

The older homes, often owned by for-Profit homes, contributed to the challenges to cohort residents when they became ill.

It is nearly impossible to practice infection control processes in these older homes given the structure – four bed wards, shared bathrooms, and the inability to cohort residents. The lack of surge staffing also contributed to the inability to cohort staff in appropriate ways.

As the Advisory Council is aware, the report from the Canadian Armed Forces from their observations in long-term care homes during the pandemic, pointed out the many deficiencies that need urgent attention in the days and weeks ahead.

The way forward is to recommend improved funding and increase staffing to the minimum required to provide the care to meet resident need. It is essential that the Advisory Council make clear the connection between staffing levels and the conditions of work and the clear link to meeting resident needs and to improved patient outcomes. This should be the focus!

V. Conclusion

In conclusion, ONA looks forward to the recommendations of the Advisory Group and the urgent implementation of the Minister's robust staffing strategy for Ontario long-term care homes.

We trust that this is not the end of consultation with representatives of front-line staff as there is much work to be done related to the response to COVID-19 and to conduct a full staffing study to ensure that four hours of nursing and personal daily care per resident remains sufficient to deliver optimal care to residents.

We encourage the members of the Advisory Group to review the Bruyère Research Institute study from Ontario – a study showing the deficiencies in care in for-profit long-term care homes and a report – a Portrait of RNs in Long-Term Care – that ONA commissioned last summer so you can read about the astonishing commitment to care of their residents that our RN members truly embrace.

It is significant that the Bruyère study clearly concludes that publicly funded **for-profit** facilities have significantly higher rates of both mortality and hospital admissions. This is a key finding that the Advisory Group must keep top of mind when investigating staffing in long-term care.

We urge the Advisory Group to move forward with more registered nurse staffing in long-term care. Our residents are counting on it.

End Notes

[1] Access ONA's recommendations to the Public Inquiry: https://www.ona.org/wp-content/uploads/ona_recommendationsltcinquiry_20181002-1.pdf

[2] A USCMS study in 2001 established the importance of having a minimum of 0.75 RN hours per resident day (hprd), 0.55 LVN/LPN hprd, and 2.8 (to 3.0) CNA hprd, for a total of 4.1 nursing hprd to meet the federal U.S. quality standards. See U.S. Centers for Medicare and Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes.* Report to Congress: Phase II Final. Volumes I-III. Baltimore, MD: CMS; 2001. This recommended minimum threshold level was later confirmed in a 2004 observational study of nursing home staffing and in a reanalysis by Abt Associates in 2011. Note that some experts have recommended higher minimum staffing standards (a total of 4.55 hprd) to improve the quality of nursing home care, with adjustments for resident acuity or case mix. See Harrington C, Kovner C, Kayser-Jones J, et al. *Experts recommend minimum nurse staffing standards for nursing facilities in the United States.* Gerontologist. 2000;40(1):1–12.

[3] See, for a summary of their research: https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2020/04/Reimagining%20residential%20care%20COVID%20crisis.pdf The full body of their extensive evidence and research can be found at: https://reltc.apps01.yorku.ca/

[4] See Dr. Samir K. Sinha, MD, DPhil, FRCPC Provincial Lead, Ontario's Seniors Strategy. *Living Longer, Living Well* Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario. Available at: http://healthcareathome.ca/centraleast/en/news/Documents/Seniors_Strategy.pdf

[5]See, for example, this recommendation: "Strategies are developed to consistently provide staff learning and development opportunities, including on the job mentorship and coaching time." See Shirlee Sharkey, *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes.* 2008. Available at https://www.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=5987&cf_id=68&lang=en