



RNs in Long-Term Care: A Portrait

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ONA is the union representing more than 65,000 registered nurses and health-care professionals, as well as 18,000 nursing student affiliates, providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.



A Message from ONA President Vicki McKenna, RN

Registered nurses in all sectors of health care are well educated, skilled and most importantly, passionate about providing high-quality care to those who need it.

As RNs, we are often drawn to work in specialized units or specific sectors of care, such as public health, community care or long-term care.

We know that many RNs do not consider working in long-term care and many do not even consider it as a career choice. This is due to the lack of awareness of opportunities in long-term care and promotion of long-term care as a rewarding career choice, as well as the working conditions. And, we know that long-term care needs more funding, and more RNs and front-line staff. Yet, for anyone who has ever had a loved one in a long-term care home, the compassion of RNs in these homes has been of great comfort.

As the province takes receipt of the report of the Inquiry into Long-Term Care in Ontario, this ONA-commissioned special report tells the stories of our dedicated nurses working in this sector.

For nurses, there will be some surprises.

For instance, the ONA members interviewed for this report all came from other health-care sectors – long-term care was not where they started their careers. Yet, they found the close working relationships between nurses and the physicians in long-term care who rely so heavily on RNs, as well as RPNs and PSWs, to be incredibly rewarding. Our RNs talk about the sense of teamwork and family that develops, stemming from caring for people in the place they live.

No nurse will be surprised to hear that the ability to develop long-term relationships with both residents and their families is one of the most rewarding aspects of long-term care nursing. It's what every nurse hopes they can do in these times of lean staffing in so many sectors.

Despite the challenges – “being pulled in 100 directions” or being responsible for the care of dozens of residents – the skills, knowledge and love that our RNs put into their practice each and every day – and night – and weekends – is inspiring.

These RNs mourn the residents who pass away. They care for them through the most challenging times of their lives, ensuring they live and die with dignity and respect. Our long-term care members are deserving of our deep respect and gratitude for the work they do.

A handwritten signature in black ink that reads "Vicki McKenna". The script is cursive and fluid, with the first name "Vicki" and last name "McKenna" clearly legible.

Direct quotes are taken from two sources: focus group interviews with nurses from across Ontario attending a conference, and individual interviews with nurses from a wide range of homes in the province.

Interviews have been transcribed verbatim. Only identifiers of the individual or the home, and pauses such as umm, ah and others have been removed.

All the names have been changed in the quotations.

Three periods indicate a break, usually where repetition has been removed.

“Nurses are very dedicated people. We want what’s best for whomever we are taking care of. That’s the bottom line. It’s also the camaraderie and the personal connection that we have with families and residents.”

Judith is a 70-year-old registered nurse working in long-term care with 48 years of nursing experience also in the hospital and community sectors.



Introduction

Nurses consistently tell us that working in long-term care is both rewarding and challenging.

Let us explain.

Registered nurses, registered practical nurses and personal support workers (RNs, RPNs and PSWs, respectively) truly get to know the residents and their families and form deep and meaningful relationships as they provide care over months and often years, at all hours of day and night, for the 78,000 or so residents in Ontario's 625 homes. The majority of residents living in long-term care have extensive care needs that preclude them from living independently or in another residential setting in the community. Along with their physical care requirements, many residents and their families have significant emotional support needs as they come to terms with this life change.

While nurses, and other long-term care workers acknowledge the intensity of care needs in this sector, they also report loving their work and being unable to imagine working anywhere else. Nurses often come to see themselves, and are viewed by their residents and the families, as family. They value care as a relationship between themselves and their residents, recognizing that it extends to the families. In other words, care – and being able to provide quality care – is closely connected to building and sustaining relationships with residents and families. It is a relationship built on familiarity, trust and continuity. Staff also know that the conditions of work are the conditions of care. By this, we mean it is imperative that their working conditions be structured to allow these relationships to flourish.

Nurses working in long-term care utilize a wide range of skills to provide holistic care to residents with significant frailty and ever increasing levels of complexity. In fact, more than half of long-term care residents are over 85 years of age and almost all live with two or more chronic conditions. According to one measure (MAPLe), on admission in early 2014, 83 per cent of residents had high or very high care needs, up from 77 per cent just four years previously.¹ A more recent report indicates that 86 per cent of residents require extensive assistance with activities of daily living.² Furthermore, nearly 70 per cent of residents have some form of dementia.³ They come from a widely diverse range of cultural backgrounds and languages spoken, especially in large urban areas, increasing the complexity of care.

While nurses and PSWs become very close to their residents, the increased acuity of residents' needs when admitted, in addition to the growing waiting list for long-term care beds,⁴ mean that staff not only must adjust to losing individuals with whom they have developed close relationships, but they also need to become familiar with newly admitted residents. With each new resident, there is a rush to complete the extensive, required documentation. The homes must fill the "beds" quickly to maximize provincial funding and address the lengthy wait lists for admission. Although only those with the most complex needs make it onto wait lists, nearly 35,000 individuals were listed in October 2018. They waited an average of 142 days before admission.⁵

1 OANHSS (2015) *The Need Is Now: Addressing Understaffing in Long Term Care*.

2 Ontario Long-Term Care Association (2019) *This Is Long-term Care*. Toronto: Author.

3 AdvantAge Ontario (2019) *The Challenge of a Generation: Meeting the Needs of Ontario's Seniors*, p. 6, citing Ministry data.

4 Ontario Health Coalition (2019) *Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care*. Toronto: Author.

5 Ontario Long-Term Care Association (2019) *This Is Long-term Care*, op. cit.

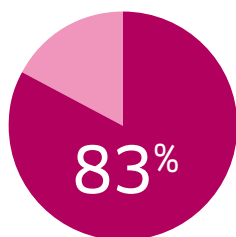
78,000

Residents living in long-term care

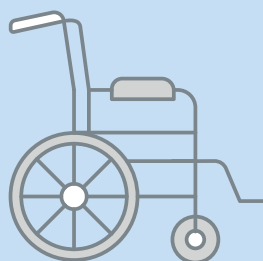


625

Long-term care homes



Residents with high or very high care needs



More than half of long-term care residents are over 85 years of age and almost all live with two or more chronic conditions.



35,000

Individuals on a wait list

142

Average number of days before admission



70%

Residents who have some form of dementia

.75

RN

.55

RPN

2.8

PSW

Minimum hours necessary for appropriate care: 4.1 hours

2.71

Average hours in Ontario



Meanwhile, despite the rising needs of new residents, sufficient new resources are not forthcoming. As a consequence, staff experience mounting stress, burnout and violence.⁶ They are often deeply stressed about being unable to meet even the clinical needs of their residents, much less provide for their personal and social needs. In 2001, when acuity levels were lower, expert opinion in the United States made it clear that 4.1 hours of nursing care (.75 hours RN, along with .55 hours RPN, and 2.8 hours PSW) per resident per day were the minimum necessary for appropriate care.⁷ The Ontario government did promise in 2017 to “increase the provincial average to four hours of direct care per resident per day, once fully phased in,”⁸ but even this average is far from becoming a reality. One estimate placed the average hours in 2016 at 2.71.⁹ It is important to note that this minimum applies to nursing and PSW staff alone and does not include the dietary, housekeeping, laundry, clerical and other workers whose presence relieves and supports the workload of the nurses and PSWs.

Legislation requires that every home have an RN on staff 24/7, recognizing the need for their skills and oversight. One of the many reasons for ensuring an RN is on the premises is due to regulations on who can do what for whom. RNs working in long-term care have significant accountabilities and responsibilities. For example, they are often the supervisor of the home and as such, need to ensure the safe operation of the facility and a safe environment for the staff and residents. They are also responsible for providing leadership to the interprofessional team and supervision over the provision of care to residents by that team, which can include a number of different designations and practitioners. Additionally, they are required to understand the complex long-term care regulatory environment and ensure compliance with numerous standards and regulations that are intended to support the provision of safe, ethical and resident-centred care. RNs can often find themselves working in isolation, as in many of the smaller homes, they may be the only RN on duty.

6 Braedley, S., Owusu, P., Przednowek, A., & Armstrong, P. (2017). “Suck it up”: Long-term care workers’ psychological health and safety. *Ageing International*. Published online May 5, 2017. P. 1-19. DOI: 10.1007/s12126-017-9288-4.
7 U.S Centers for Medicare and Medicaid Services, Abt Associates Inc. (2001), Appropriateness of Minimum Staffing Ratios in Nursing Homes: Report to Congress.
8 Ontario (2017) Aging with Confidence: Ontario’s Action Plan for Seniors, p. 31.
9 Ontario Health Coalition (2019) Situation Critical: Planning, Access, Levels of Care and Violence in Ontario’s Long-Term Care, p. 26, calculated from the Ministry Database: Ontario Long-Term Care Homes Staffing Data 2009-2016.

One of the challenges today is the increasing complexity of the resident. Effective care provision in this complex environment is dependent upon teamwork and communication. PSWs and the regulated nursing staff (RNs and RPNs) must work in tandem to ensure that any changes in a resident's condition receive appropriate attention. This can be a challenge in a busy home where staffing levels, as already noted, are below the recommended levels.¹⁰

The complexity of resident needs and the highly regulated nature of the long-term care environment have increased the job demands in this sector. Along with the above responsibilities, nurses are accountable for documenting a large number of clinically based indicators as both the key measures of quality, and also for managerial resource allocations (funding is dependent on residents' assessed clinical needs).¹¹ In addition, there are extensive regulations relating to a broad cross section of factors such as location and time of meals that have implications for everyday work. This has created further demands on staff, with often unrealistic expectations and timelines for the completion of these lengthy assessments.

Daily documentation is also primarily electronic and requires a significant amount of time to record a resident's status, care interventions and resident response. In addition, through the Long-Term Care Home Quality Inspection Program (LQIP), the government organizes regular inspections and special ones (in response to verified complaints or an increase in some indicators, such as falls). Most homes meet the quality requirements in large measure because the staff make it work.

While much of the Ministry of Health and Long-Term Care reporting is a response to significant deficiencies in resident care reported in the past, inspections are often a

stressful event, as staff feel that they are largely punitive in nature, and the process limits the time available for care. Additionally, there is growing concern that regulations ignore important quality of life factors, such as knowing which residents need to awaken slowly (or they become anxious or distressed), or which residents have supportive family members and which ones never have visitors. Care relationships and teamwork are very important to the quality of care for residents, but are challenged in a system that does not prioritize social and emotional care needs.

Moreover, while governments have increased the detailed regulations that apply to staff, they have not introduced regulations about staffing levels that are known to have a profound impact on the quality of care. Although, for example, AdvantAge, the association representing non-profit homes states that it "would never advocate diluting rules that protect seniors," it also points out that "long-term care regulations and oversight are overly burdensome, fundamentally punitive and wasteful of precious health resources."¹²

In spite of increasing resident frailty, the growing complexity of resident needs, and increasing regulatory and other demands on those who

provide care, registered nurses continue to voice their passion and commitment to long-term care residents. While subjected to increasing workloads and reporting requirements, in addition to critically low staffing levels, most residents receive the care they need primarily because staff work extremely hard to fill the care gaps. Committed RNs, RPNs and PSWs are crucial in this struggle to make care as good for residents, families and staff as it can be. It is clear that nurses find joy and reward in the work they do. In the next section, we illustrate their commitment to go above and beyond to ensure their residents receive quality care.

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10 Ontario Health Coalition (2019), op. cit.

11 Armstrong, H., Daly, T & Choiniere, J. (2016). Policies and Practices: The Case of RAI-MDS in Canadian Long-Term Care Homes, *Journal of Canadian Studies*, 50:2.

12 AdvantAge Ontario (2019), *The Challenge of a Generation*, p. 16. See also Armstrong, Daly & Choiniere (2016), op. cit.

Rewards

It may be surprising for many to learn, as we did through our interviews with nurses, that long-term care can bring significant rewards to those who work there.

One relatively young nurse we will call Mary summed up a host of rewards.

Like many graduating students, she did not plan to seek employment in long-term care but stayed because of the rewards she found in the work. She wanted to be a pediatric nurse the entire time she was in nursing school. This decision was confirmed when she worked in a long-term care home as a nursing student. Upset by what she saw, she left saying, “I am never going to work in a long-term care home. This is ridiculous.” After she had worked in a couple of different hospitals, her father urged her to apply for a job advertised for a nursing home near his small town. She applied to please her father and six months later, took the offered full-time job. A reluctant recruit, she has never looked back nor regretted taking the position. “And, I’ve been there seven years ... I’ve really become passionate about it and I love my residents, I love my team and I love what I do.”¹³ She goes on to explain why.

It’s the people: residents, colleagues and families

“It’s totally different and just the connection you make with the people that you work with. It’s something you don’t get anywhere else and ... I truly love it.” Time allows relationships to develop.

Oh, that’s one of the best ... the connections you build [with residents]. Of course, with the staff too ... from my experience from hospitals, we didn’t have PSWs ... on the floor like we do in the long-term care home and we’re getting to build that

relationship with the residents, it’s ... really special ... even though they tell you, “Oh, you’re not allowed to get attached,” it’s impossible. You’ve known these people for years sometimes and you become ... part of their family ... our home is their home ... And you become ... part of that home in that home environment. ... They look forward to seeing you when you come in every day and if you haven’t been there ... “Where have you been?” ... “Are you okay? We thought maybe you were sick.” ... that relationship that you build with them ... helps you to care for them because you get to know them on a different level and you get to know exactly what their needs are and how to approach them when it comes to certain things. Especially ... when you get them when they come in.

Mary was far from alone in stressing the rewards that come from long-term connections with residents. “They’re there for a long time. They’re not your family but they bond with you ... they know when something is wrong,” as one nurse put it. A nurse who worked in the same home for 19 years said, “I love it.”

The residents. The residents ... are ... [people] just like you and ... [me] ... [except] that they are an older person. They have history. They have things to tell you. They have things to teach you ... I’ve heard so many things that I would not have heard anywhere else ... from speaking to residents ... Their former history, things that were, that ... [are] no longer. Things like that ... It is rewarding ... just to take care of people. I love that population.

¹³ These direct quotes are taken from two sources: focus group interviews with nurses from across Ontario attending a conference and individual interviews with nurses from a wide range of homes in the province. Interviews have been transcribed verbatim. Only identifiers of the individual or the home, and pauses such as umm, ah and others have been removed. All the names have been changed in the quotations. Three periods indicate a break, usually where repetition has been removed.

“It’s about making a real difference in my residents’ lives. If they are hurting, I can help ease that suffering for the most part. I can make them warm. I can get them something to eat. I can help them find something that’s lost. I can help them with social activities. Those little things are all about quality of life.”

Jean is a registered nurse who has worked in long-term care for 28 years.





After four years in a home, one of the rewarding things a nurse finds “about nursing in a nursing home is that having known them [the residents] for years, I’ve developed [such] a relationship with all of them that they will come up to me, [and] we’ll joke.” A nurse reported that her first job was in the laundry at a long-term care home, followed by work in the dietary department. When she went to work in a hospital after graduating with her nursing degree, she found that she “didn’t get the same satisfaction because it’s the connections you make.”

I really enjoyed that aspect and I really looked at ... that time, old people, because that’s what you had mostly in the nursing home, the whole wealth of knowledge and life experience they had ... And, listening to their stories and how they got to where they were, where they’re at. It was fascinating.

Like Mary, other nurses found the teamwork rewarding. A nurse who has been employed in long-term care for 19 years explained that

Teamwork is important because when you pull together, you get the best outcome and when you

also work as part of a team, you know it makes life more joyous in a nursing home, if you all get along especially.

Working with the same staff over time can also be satisfying. “And that’s the good thing about long-term care when you have consistent workers in a consistent area ...” Another nurse adds, “And you also get camaraderie with your coworkers. You know the PSWs that you can count on and the ones that need a little bit of work. You know if you’re working short, your dietary staff might do some of the serving.” And the joking is not only with residents. With staff continuity comes support, “like when you work with people who have a good sense of humour, for example, making jokes or are able to laugh about stuff that happens in our day, I think that improves the work environment ... people that you work well with and have a good team dynamic and support each other.” Or as another put it, “You have people that you’ve worked with for years and you just ... know you ... can work so well together.” And it is not only RNs and RPNs on the team. “I can’t stress the importance ... we depend on our health care aides, PSWs ... so much. I mean so much.”

Good relationships with the physicians can contribute both to the ability to respond to resident needs and to the rewards of the job.

Our physicians are extremely involved ... I'm in a small town and our physicians are extremely involved in our patient care. And a lot of times they had them [the residents] out in the community and so they do know them well and the ones they don't, ... they are very involved ... [and] make sure they talk to all the families and get the complete history, and we're very good about making sure [of what they've got] ... Alzheimer's dementia, Vascular dementia, ... Korsakoff's, ... Lewy bodies, ... we have those ... we signify and we've actually done treatment pathways in accordance ... [O]ne gentlemen [was] ... recently ... diagnosed with Lewy bodies dementia, I'd say in the last year or so. And this whole time they thought he had schizophrenia. His whole life, he's been treated for schizophrenia and he had Lewy bodies dementia... it was only because ... our physicians and our geriatric psych team ... were able to identify his true needs and then ... give him the correct care that he needed. But, if he was anywhere else, he might not have been able to get that.

It works both ways. Another nurse adds, "The doctors rely on us. They do. They want to hear ... our opinion."

Good relationships with families also provide rewards. In Mary's experience, "the families are extremely involved in our home with everything." The families provide her with both support and recognition while also contributing to the work. Other nurses echoed Mary's view. "And for me also, families, when they say, 'thank you very much for taking care ... talking to them, talking to us, letting us know'" ... Also, when families ... seek you out by name and [say] ... 'I wanted to wait so I could deal with just you because I knew you could help.' I think that's rewarding." Families can also become advocates for nurses, supporting them in improving conditions or in responding to unfounded complaints.

In a group responding to a question about what they find rewarding, one nurse said, "people," another added, "the residents," a third, "the people that I work with," while the first nurse interjected to say, "and their families."

While the connections with people are central to the rewarding nature of the work, they are not the only rewards.

It's the skills that are utilized

The growing complexity of residents' needs, combined with the increasing emphasis on treating residents where they live rather than sending them to the hospital, expands the range of skills required and practiced. Mary contrasts this with her hospital work.

I'm [a] charge nurse in my home and I just really enjoy ... [it], and now especially with ... the acuity of nursing homes and how ... they're escalating ... I get to practice a lot of skills that I know from hospital settings in [a] nursing home, which is one thing that I was really worried about ... so now I get to do ... dressings and IV therapy and ... all these things that we would never have gotten to do in long-term care homes before. Now I'm doing [it] all, so I get ... the best of both worlds and I really enjoy it.

Most of the residents have dementia, but Mary does not see this as a problem. Unlike her experience in hospitals, residents' long-term stays allow the nurses to get to know them and respond to their differing capacities and needs.

A lot of people ... in long-term care have dementia and so when you get them in their early dementia and you get to really know them, when they progress to the point where they're no longer able to communicate with you, you have that special bond where you knew them before and you can still implement the things you know they really love, which makes sure you're giving them that quality care that they deserve.

Most of the residents have dementia, but Mary does not see this as a problem. Unlike her experience in hospitals, residents' long-term stays allow the nurses to get to know them and respond to their differing capacities and needs.

Just over a year ago, to the surprise of her colleagues, another nurse chose long-term care instead of a hospital as her place of employment.

[I] always get the question, “Oh are you going to go work at the hospital? Are you working anywhere else? What made you not want to go to the hospital?” Well, because I love long-term care. I always say to people ... “I do love the chaos.” I know it comes with its challenges but ... anyone who tells you long-term care is easy is lying to you. Or they haven’t worked in long-term care.

Another nurse stated,

I have a guy who’s having a heart attack over there, a stroke over there, this one’s got a pic line, this one’s got this ... I have all sorts of complex wounds ... so I’m running my own blood work, x-rays and everything else ... I’m actually operating to some extent at a higher level than you would as a hospital nurse.

A nurse who has been working full-time in long-term care since she graduated adds, “You get so resourceful. You know exactly where to find everything.”

A 20-year veteran of long-term care who now works full-time as a clinical nurse doing staff development, expanded on the opportunities for not only practicing skills, but also for learning new ones. As a result of the union contract, all the training is done on paid time and during their shift. Both full- and part-time staff are included. The range of on-the-job training is broad.

[I]t would be abuse prevention, zero tolerance for abuse... responsive behaviours, resident bill of rights, knowledge of the *Long-term Care Homes Act* and their expectations, critical injury reports, ... if a resident is injured, how do you document ... it? ... infection control ... and blood-borne pathogens, what do you do? So that is basically the training ... in the *Long-term Care Homes Act and Regulation*, it says that I have to train [a] general orientation. This is what I have to train them [on] and then they have to have yearly training or refresher training.

Along with this required training, she offers a program that teaches staff members how to deal with responsive behaviours and emergency preparedness. And, teaching is rewarding. “I can tell you that education and teaching is my forte ... I just love it.”

In addition to the skills most commonly associated with nursing, skills like distributing medications and inserting IVs, these nurses manage staff and staffing, figure out how to use new equipment and communicate with families and hospitals, to name only a few of the additional knowledge factors they acquire and apply. Listen to this nurse summing up the skills of nurses in long-term care:

In long-term care, there’s a lot of opportunity. There’s a lot of opportunity to learn, and some people have the misconception that they’re [going to] lose their skills. The skills that they develop in long-term care are skills of organization

and leadership and decision-making and collaboration, and there’s so many skills that you learn in long-term care and the kind of residents that we’re getting today are challenging medically ... So there’s a lot of opportunity in wound care and specializing in infection control. That’s one of the reasons I stayed in long-term care ... I became a wound care

nurse and I got all this education and I became a specialist in wound care and I don’t think I would have had the same opportunities. And, of course to be a Bargaining Unit President and represent my members and be involved in negotiations and grievances ... even that is very fulfilling to me because I represent my members. [A]nd so, there [are] a lot of opportunities in smaller facilities and in long-term care, and that’s why I stayed.

Another nurse added, “I think the stuff we have to do calls on so many aspects of nursing that would blow a hospital nurse’s mind. I really do.” There are multiple and changing demands, but “once you get into that groove and it’s not unfamiliar territory anymore, you just feel like you’re on top of the world. And ... I can handle it. It doesn’t matter.”

In addition to the skills most commonly associated with nursing, ... nurses manage staff and staffing, figure out how to use new equipment and communicate with families and hospitals, to name only a few ...

“My residents are like family to me. I love the interaction with them. They can tell you so many stories because they are so much older. Some can tell you about the war and the struggles they had as children. We get to know them on a personal level because they stay longer. In fact, we’ve had some residents in our home for more than 20 years.”

Shelley has been a registered nurse for 23 years, having worked in a hospital, private nursing and the community before moving to long-term care almost 14 years ago.





It's making a difference

Hospitals may seem like the place where the employment of skills has the most dramatic results, but those who work in long-term care gain tremendous satisfaction from the difference their work makes to residents and families.

As a 73-year old nurse put it, “[T]he valuable thing about long-term care is the interaction with people.” The work allows her “to treat a few things that make the quality of their life as long-term care [residents] better.” ... It’s rewarding [if] I go home at night knowing that I make a difference.”

Making a difference is a common refrain. Another nurse with long experience explained that when she was on the day shift, she would “tend to see ... a vast difference ... You’ll see a resident smile ... On those days, I did a lot of dressings ... [I] see the completion of the dressing, a wound heal.” Residents regularly express their gratitude and recognize the contributions nurses make. Offering an example, the same nurse said, “Last night, I was off for two days, Tuesday and Wednesday night. And, a resident said to me this morning, “Oh Sally, I missed you.” I was surprised that she knew that I was off for two days.”

The nurses make a difference to families too. “You get really close to their families ... And it’s problem-solving. If they know your face, they can come to you and they know you’re not ... [going to] just drop it. You’re ... [going to] try to find an answer for them. It makes a difference. We help them and their families ... at end-of-life ... make sure that they’ve got comfort, that the families are supported.” The families make it clear that such support makes a huge difference. “They make me feel good. That ... [I’m] doing something good.”

Not all residents have families or have families that are involved. In this case, the staff take the place of the family, a practice that becomes particularly evident when a resident is dying.

And if there’s no family, then the staff are there to support the residents throughout their journey, whether it’s activities, or even just on our break ... the resident is alone and if we have time, we just go and sit with them and hold their hand or whatever they need ... [W]e’re very involved and we make sure that they’re not alone.

At her current home since 1997, a nurse reports that she has contributed to changes that support dignity when people are dying.

[W]hen you're in long-term care, you do a lot of palliative work that's also helping people to die the best death with dignity and as pain-free and comfortable as possible, and dealing with those families as well ... when you're an old nurse like me, then I'm comfortable doing that and that's really important as well. It's long-term care."

Summing up how she sees her work, another experienced nurse said:

It's just rewarding ... when I go to work and I'm ... stressed ... a resident can sense it and they smile at me and they say, "Thank you," and you know the person ... [who has] behaviours ... [with] other people but not with me ... I call myself the nurse whisperer because the residents love me ... that's what's rewarding. I love my job and everybody says more of the bad part of it. I had to go to a therapist and a psychiatrist and they both said, "Leave your job." But I like my job.

Another added, "I think it's making relationships with residents and actually affecting their [lives] that you can really make a positive difference and it doesn't take a whole lot." Another nurse provided an example of the difference it makes to residents feeling as though the home is *their* home. "[W]hen they go to hospital, they are very happy to come back," a sentiment echoed by another participant, "They want to come home, which ... [makes me] feel pretty good."

Although the work is demanding and too often exhausting, unions have been able to ensure some important protections.

Jobs and benefits

As is the case with Mary, the possibility of full-time, continuous employment has attracted many nurses to long-term care. Moreover, as one nurse put it, "You'll never get cancelled and sent home in four hours [be]cause they don't have the clients." Emphasizing the differences in workplaces, another said, "[I]n long-term care, there are more places that have permanent shifts and you don't have that in hospitals." Confirming the advantages of these unionized workplaces, yet another nurse pointed out that "[i]f you get full-time, it's great. I can start getting benefits."

There are many stories of nurses who began working in the laundry, the kitchen or as care aides and worked their way into nursing. Once they received their registration, they often quickly moved through a range of positions and up the hierarchy. Long service brings a number of rewards, as a 20-year veteran put it, "I feel that for me, a nurse, Monday to Friday, 8:30 to 4:30, weekends and holidays off, I have ... a dream job ... I have six weeks of vacation. I have benefits."

"[I]n long-term care, there are more places that have permanent shifts and you don't have that in hospitals." Confirming the advantages of these unionized workplaces, yet another nurse pointed out that "If you get full-time, it's great. I can start getting benefits."



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Challenges

At the same time as nursing work in long-term care can be rewarding, it can also be challenging.

Regular irregularity

Health care is, by its nature, full of irregular demands. This is particularly the case in long-term care. The varying demands mean constant interruptions, especially with the growing complexity of residents' care needs. Listen to this nurse who has worked in the same home for 20 years:

So generally, depending on the day, as an educator ... I arrive by 8:30 and I always have all sorts of emails, all sorts of messages from not only RNs and RPNs, but PSWs, saying, "Hey, this has happened. How can I deal with that?" "We need your help here. Can you come and assist us with this?" Because most of the nurses ... are overwhelmed and there ... [are] just so ... [many] complexities ... Whether it's new equipment, whether it's issues that they haven't dealt with ... some sort of issue. So generally, right away I'll be dealing with the issues. We try to get to a meeting at nine o'clock ... [b]ut most days, we don't get to that because we're dealing with ... putting out fires first of all.

Or ... [I] may just have one unit that has all sorts of issues. They may have a fall, and someone is going to the hospital. They may have someone coming back from the hospital ... that's a lot of times what happens ... Friday night ... they're pushing everyone out of the hospital ... Or we may have an IV that has just come back. We may be short PSWs and RPNs and we need to give insulin or do other things.

The irregularity can mean "you're just pulled in a hundred directions." "Yes, you are," a second nurse adds. "I cannot finish one task without being interrupted to do something else."

One nurse's detailed description of an evening shift nicely captures this irregularity.

Sometimes I get there at five to [three]. It depends. I get reports from two different nurses. One that does [the] second floor and one that does [the] main and first ... after ... reports, I do a narcotic count ... read the building report; usually by then, it's ... 3:30 and I walk through the building. I go upstairs and look to see each floor. Whenever the doctor orders something, you have to tell the family, as well as do ... what you have to do ... So, I stop and I do the orders. Maybe I can't finish ... [orders] on my first pass so I might do one ... If there's anyone that's not well, I visit them while I'm on that floor. Anyone that's dying, I go down and sit a few minutes. See how they are. See if they are looking comfortable.

It's evening ... I have to reach the dining room by five o'clock. Then I'm going to go to the other floor and ... see what's going on up there too ... I'm in the dining room ... until 20 past because my RPN will go on her break and the ... [residents] have not finished leaving the main floor to go back to their floors so you can't leave them alone ... I'll be there until about quarter to seven. If the RPN is up there, she will receive my medication. She'll be in the med room and if she's not there, the PSW will page me to let me know pharmacy's there and I'll go up and sign the medication. Then, I have to receive the medication ... and distribute it to each floor ... After that, I will see my residents on my floor.

I will come down to see them to see what's going on and if they have an injury, do my vitals, or anything like that ... by then ... it's ... 7:30ish ... So, I will pop back upstairs on the second floor ... to finish their meds, doctors' orders ... I may come back down by about 8:30 and I'll be on my floor to give ... meds at that time, and then after ... meds, something usually happens upstairs ... [and] I end up going back.

... By 10 o'clock ... [registered staff] are finishing their meds to come down and give me their report and ... I count the [narcotics] bin with them ... and then in between ... I still go upstairs and make sure that the floor is okay, make sure everything is signed off and put away because another nurse is coming on.

So, then when I sign off with ... [registered staff], I sign off their medication. I go upstairs [again] and take a look and make sure that it's okay ... before you know it, the night nurse is here and ... I eat my dinner while I'm giving her ... [my] report ... [I] will sign off the three narcotics bins with her and by then it's ... 20 past 11... I'll probably be ... [out of] there ... by quarter to twelve, sometime[s] just after. Sometime[s], I take my sandwich with me as I'm walking. I walk with my tea and my sandwich as I'm going, ... and if we have a palliative care person, I try to go in and spend a little quality time with them ... because I'm not sure when I come [in] tomorrow that they're ... [going to] be there.

'Routine' would not capture a shift at work for these nurses, as this exchange among them makes it clear as they each add their bit.

... We deal with human beings ... They're all different, it's a different day, every day.
We deal with dementia, palliation, we deal with ... Families.
Behaviours ...
Families, behaviours, physical and verbal ...
... It can add up.

Multitasking

As Mary so eloquently explained, nurses in long-term care get to use the entire range of skills they have learned. There is a sense of confidence and contribution that comes from employing those skills. The demands also mean that there is considerable variety in the work, variety that can itself be rewarding. However, nurses tell us the skills required often go well beyond those learned in nursing programs, and very often nurses need to take on the responsibilities that would normally be performed by others in the home. A nurse, who started as a health care aide after she immigrated to Canada, and obtained her nursing degree while continuing to work in long-term care, has rich experiences from many positions and all shifts. She describes the complexity of nursing in long-term care:

[With] 40 residents plus their famil[ies], ... five PSWs ... to supervise, family members calling you wanting to know ... So, a nurse in a nursing

home, especially days and evenings (not nights that much), but [on] days and evenings, you're the nurse, you're the pharmacist ... [Families say] "My mother's food. She's not eating the right food and this isn't what she's to get." So, you're the dietitian. "Oh, my mother's hair needs cutting. My dad's hair needs cutting." You become the barber, the hairdresser. "My mother's toenails." So, ... every ... aspect of that, every discipline ... comes to the nurse. "I can't find my mother's clothes." Laundry. "My mother's room is cold." Maintenance ... every aspect.

This is especially the case on evening and night shifts, when many of the dietary, clerical and maintenance staff, as well as the doctors, have gone home.

How many wheelchairs have we repaired and how many times have we problem-solved the bed raiser motor? ... You're often the only person around to do all these things. You're mopping the floor when there's a flood ... You're calling maintenance, trying to figure out why there is steam billowing out of some pipe someplace.

And it is particularly the case when they are the only RN on the floor. "... We're trying to give out meds, do treatments, talk to families, do doctor's stuff, help with toileting ... Another nurse adds, "You're spread all over the place." And a third, "Fix the toilet. I'm the best plumber." It is not only plumbing.

So, we've had ... residents break off the top of a toilet seat and leave it as a sharp point. We call[ed] ... and the manager said there's no maintenance. I [asked] ... "There's no maintenance?" I can't leave it ... you can't when you have residents wandering around with a sharp point on it. So I ... [went] down to the basement and grabbed a new one and changed it.

"So, everything, every job you can think of, a nurse becomes." These are not exactly the skills taught in nursing programs.

How many wheelchairs have we repaired and how many times have we problem-solved the bed raiser motor? ... You're often the only person around to do all these things.

“The reason many nurses don’t pick long-term care is because they just don’t know. There’s a stigma associated with working in nursing homes; yet, we have the same skills, we just use them in different ways.”

Mary began her nursing career 40 years ago at a Toronto hospital and has been working in her current long-term care home for the past 18 years.





Families and residents

Many participants shared with us both the rewards and the challenges of engaging with families in long-term care. As one nurse states, “Working with the family and talking with the family is the hardest, some of the hardest stuff that we do. I don’t love it. But it’s very necessary and it is very rewarding.”

As a charge nurse who works on nights puts it, “You don’t only have 40 residents, you’ve got 40 residents plus their famil[ies].” Nurses are required to consult with families on care in the many cases where the resident does not have the cognitive ability to decide, as this nurse explains:

If you get a family member that is ... reasonable, understanding, you can say, “You know something, this is what’s going on.” That’s why we chart, we document. “This is what’s going on with your loved one. This is what we have to do. Do you give consent?” ... [B]ecause every medication, everything that you do, you [have] to call them and say, unless the resident is cognitive and is their own power of attorney, then it’s okay, but

if that family member is not reasonable, “Oh no, I don’t want my mother or ... my father medicated.”

It is often difficult to get families to understand the illness, or to recognize that their limited time in the home does not give them the full picture, as this nurse explains.

... [There are] some that are just abrasive ... people really ... do not understand ... dementia. So what we see every day 24/7... and the family comes in for 30 minutes and they have this little window and this picture of what they see. They see when they come in that their loved one is in bed ... And they’re like, “... Don’t they ever get up and do anything?” Well, my goodness. The person’s been up, and in their chair, and into the dining room, into the exercise class. Now they’re ... [going to] lay down for a rest and then ... get up for lunch ... They just come in and ... have this small window that [they] see and that’s ... [their] perception.

Moreover, families can quarrel among themselves leading to contradictory demands on the nurses.

While residents can bring rewards, they can also be challenging. Nurses see more and more of what is termed responsive behaviours from residents in the wake of the closure of many psychiatric facilities, the increasing mix of residents with complex needs and low staffing levels relative to resident needs. As a nurse educator put it,

[W]e're like mini psych here ... with responsive behaviours ... [S]ince the closing of the [name of psychiatric hospital] ... since the closing of [name] complex care, we've got a lot of ... residents that are here ... [because there is] no place for them.

"... I'm screamed at. I'm yelled at," summed up one description of some interactions. Racism can also be a factor. Asked if the man who is violent only towards her does so because of the colour of her skin, one nurse replied:

...when I show up, ... [it] takes the emphasis off of whatever he's doing. So, if he wants to hit another person and he sees me, he's more interested in me to tell me off and call me things and ... I say, "Thank you for noticing. Thank you so much." ... And sometimes, he follows me out ... [into] the hallway, which is fine. [I] just get him out of the room and ... [he] tells me things and I say, "Thank you. I will be back." I just need to get him out of the room so they can go in and take care of the other person ... And, I just say to him when he's out, "I will be back" and ... he just goes into his room and he sits down and he's quiet.

The nurse quoted below describes what is not an uncommon experience with some residents.

When we have a [resident] that has a behaviour, we fill a form in and send it out and they send a person [behavioural support worker] ... [who] will come in maybe three or four times ... and follow the person [resident] and see what they're doing, trying to figure out what their triggers are ... and then they make a recommendation. But if the [resident] gets really, really bad, ... if they get really violent ... [or] sometimes, we feel like the medication is not working, we'll send them to the hospital and sometimes they have

a needle, that's the PRN [as-needed medication] and we can't give it to them. They're hitting and we may end up getting the needle and they're telling you definitely, "No, no." Even if you call the police, the police won't hold them. Police are just there to talk and they [residents] go to the hospital ... and then they come back ... Because they're quiet in the hospital. They're calm. They don't see anything wrong. In the environment where they are, maybe there's a trigger ... there are people [residents] that hit people. We have a guy that's in the hospital now and he's been there ... about three months and he may go to [name of place] to get ... treatment. We still have his bed and I hear the [staff] say, "Well, we will not take them [residents who are engaging in responsive behaviours] back." ... it's

not as easy as that to not take them back, because once they have a bed, they will treat them somewhere else and then send them back [to the nursing home].

The special behavioural support training and teams can help limit responsive behaviours, but this strategy works most effectively if there is sufficient staffing and enough knowledge of the specific home, the staff and the residents.

Nurses see more and more of what is termed responsive behaviours from residents in the wake of the closure of many psychiatric facilities, the increasing mix of residents with complex needs and low staffing levels relative to resident needs.

Policies and documentation

Nurses understand the need to develop care plans, to monitor residents, and to ensure residents not only receive the care they need but are supported and safe. They recognize this requires documentation and policies to promote the most promising care. But, in spite of the emphasis on resident-centered care, some policies limit the possibilities for attending to the person, as a nurse with 19 years' experience explains:

[T]hey don't realize that people are alive. They have their own idiosyncrasies. They don't fit into those policies ... all the time, so sometimes that's ... a challenge all by itself. Because you have to treat everyone individually ... Each resident is different, so if I'm going to meet that resident's quality of life for that day and this is what it is and your policies say this, it's a very fine line for me to go around the edge of it.

Another nurse echoed this concern with policies that fail to understand what it is like in long-term care.

... [Those] who are making the policies, do you really know what's going on in here? Come and work a day and really see that the things that you're putting in place to protect the resident are actually working ... They're not protecting the resident because ... we're supposed to be having more time with the resident, but it's really not happening because we're getting more paperwork and downloaded with so many duties ... rather than doing bedside care. And as RNs, we're totally taken away from the bedside ... Our PSWs are doing ... the bedside care."

The documentation often seems excessive and takes time away from care. According to a nurse who has been working days,

We're so bogged down by ... the RAI: MDS [Resident Assessment Instrument: Minimum Data Set]¹⁴ by documentation... [we] don't have that bedside time to give to that resident and that's why residents, when you're walking down the hallway, they're saying, "Can you do this? Can you do this?" because the other staff, particularly the PSWs, may have dealt with them 10 minutes ago and now they're off to whatever emergency there is because they don't have the time ... to do all those little things extra for them.

"It is phenomenal. We have to chart everything from "they wouldn't let us brush their teeth" to ... "they only let us get one shoe on today" or whatever. Another nurse adds, "If it's not written down, then it didn't happen." A nurse with many years' experience reported that the documentation often means working overtime.

The documentation takes a long time ... sometimes, I don't get to do my documentation in the shift or at the beginning of the shift when something happens because my time is already spoken for ... When I go to work - between three and five - I have to do my rounds ... any sick people I have to follow up with them within that time and then come back and give medication on my floor, and by five o'clock, I'm in the dining room feeding and directing and supervising and all of that and I'll be there [un]til six o'clock. By 6:30, medication will come from [the] pharmacy that you have to sign in for each unit and ... things happen in between ... You don't have time right then and there to write

... So when you sit down to document, it takes a whole ... [lot] of time.

Asked what they would tell the Minister of Health and Long-Term Care, a common refrain was "come experience what we do. Don't read about it... Don't hear about it. See it. Live it. Experience it."

Staffing levels

The irregularities of care, the multitasking, the documentation and the family interventions are made more difficult by staffing levels.

Low staffing can undermine teamwork, according to this RN who has worked in the same home for 19 years:

The team does a very good job. They do what they're supposed to be doing, but the bottom line is that it all comes to staffing and there's just never enough staffing ... to deal with the multiple issues and ... [complexities] of the people that are coming into long-term care homes.

Another nurse explained,

It's like that little analogy where you're sitting on an airplane and the oxygen mask drops down. You need to give it to yourself before you can give it to the person beside you. What we're dealing with right now is all the policies and all the red tape that we have to go through.

The low staffing levels can make it hard to follow the policies and regulations. According to one nurse,

The regulations aren't bad as long as you have the staffing to be able to make sure everything gets done.

Asked what they would tell the Minister of Health and Long-Term Care, a common refrain was "come experience what we do. Don't read about it... Don't hear about it. See it. Live it. Experience it."

14 RAI-MDS or Resident Assessment Instrument: Minimum Data Set is an electronic, standardized resident assessment tool.

“Sometimes in the morning, our residents are up quite a bit before breakfast. You instinctively know they are looking for a cup of coffee and you just go and grab it for them, and it makes a whole world of difference. Just a cup of coffee. You know what they take in their coffee without having to ask.”

Sandy is a registered nurse who has spent 38 of her 48-year nursing career in long-term care.



She was supported by a second nurse:

[A] lot of the regulations are there for the safety of the residents, but the amount of work that it takes to get there, there's not enough hands-on front-line people to get it all done in a timely manner.

The already low staffing levels are made worse by short-staffing, itself often the result of staff absences due to illness or injury resulting from the heavy workloads. It happens “almost every day and it's not just RNs, it's everybody.” Working double shifts is common as a result, but it does not make up for all the absences. Such short-staffing is common and disruptive. It can mean nurses take on other work. “For us, when we're short PSW staff, sometimes I am a PSW and then I'll get people up ... but also be in charge. But it's not really the way it's supposed to go.”

It can mean the consultations that are essential to integrated care may not happen.

[A]t our home ... our DOC [director of care] and ... administrator like to speak with the RNs and to see what's going on for the weekend, and have that communication of what urgent things are going on. So, our home likes to keep on top ... [of] that. But again, if we're short-staffed, many times we don't get to that meeting to give them that communication.

She has a full-time job as an educator, “8:30 to 4:30 ... that's my job and because of shortages, I do work as an RN on the floor on the weekend and holidays when they're short.” According to a nurse with 27 years' experience, “Because there's not enough staff ... you have a lot of paperwork ... I don't feel we're able to give enough of ourselves to our residents.”

Based on his years of experience, a nurse summed it up:

The important question to ask is, “What is it going to take for them [Ministry of Health and Long-Term Care] to actually make a change that will help residents, and when is it going to happen?” Because are you going to wait for some major case to happen where someone dies ... because there was not enough staff, or are you going to be proactive and put the staff in there before that happens?

Conclusions

Nurse after nurse said they never planned to go into long-term care. Like the nurse who has worked in long-term care for many years:

[W]hen I went into long-term care, it was early in my career, I worked in a hospital for one year and then I went to long-term care ... the reason was because I could get a full-time job. That's why. But ... I loved palliative care. I loved wound care ... Our home has a ... community ... it feels like home.

Some said they had unpleasant experiences during their education while others said they never had a placement in long-term care. But many nurses have found a host of rewards in long-term care. They have satisfying relationships with residents, families and colleagues. They get the opportunity to exercise and develop a broad range of skills and they know they make a difference. Their union contracts provide important protections.

Their biggest challenge is the low staffing levels combined with short-staffing related to absences due to illness or injury. Along with the extensive paperwork and regulations, they worry that they do not have enough time to care. In addition to more staff, more training and less paperwork, they have ideas for making long-term care a better workplace and better living space. Day care and intergenerational programming are just two of them.

In sum, “They need to make long-term care sexy, [more enticing].”

In addition to more staff, more training and less paperwork, they [nurses] have ideas for making long-term care a better workplace and better living space. Day care and intergenerational programming are just two of them.

Many nurses have found a host of rewards in long-term care. They have satisfying relationships with residents, families and colleagues. They get the opportunity to exercise and develop a broad range of skills and they know they make a difference.





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