HHRP ISSUES – A SERIES OF POLICY OPTIONS

THE LONG-TERM CARE ENVIRONMENT: IMPROVING OUTCOMES THROUGH STAFFING DECISIONS

Indicators of poor quality of care, rising compensation claims and violent deaths among residents of long-term care facilities have prompted organizations such as WorkSafeBC and the Office of the Chief Coroner for Ontario to investigate and make recommendations about long-term care.[1] A framework for evaluating staff mix in these institutions offers a policy tool for assessing staffing decisions against patient and provider outcomes and allocating resources more effectively.

Context

According to Statistics Canada, more than 150,000 seniors received care in a residential facility in 2005/2006.[2] Trends indicate that 560,000 to 740,000 seniors will need placement in a long-term care (LTC) facility by 2031.[3] Facility-based LTC is provided in residential facilities to people who need supervised health-care and personal-care services (e.g., assistance with eating and personal hygiene) over a lengthy period, often indefinitely.[4] The terms used for LTC facilities vary widely among jurisdictions: "continuing care centre," for example, and "nursing home."[5]

The *Canada Health Act* does not cover LTC, and the provision of this type of care falls under the jurisdiction of provincial and territorial governments. In consequence, there is a range of approaches to funding, regulating and governing LTC throughout the country. This variation results in differences in the types of services provided, the number of spaces available, the out-of-pocket costs to residents and the application of means testing.

In 2005/2006, more than 215,000 staff provided care in residential facilities,[6] including more than 55,000 registered nurses, licensed practical nurses and registered psychiatric nurses.[7] Nurses and personal care workers constitute the majority of staff employed in LTC facilities.[8] However, a variety of other staff are involved, including physicians, physiotherapists, nurse practitioners, housekeepers and administrators.

In 2002, government funding from the province of Alberta provided for three hours of care daily, yet one continuing care centre reported that residents required three hours and 25 minutes of basic care on average.[9] Insufficient care may mean that LTC facilities are not meeting residents' dietary needs or are not providing adequate social interaction. It may also result in unnecessary admissions to hospital.

Still, there may not be enough staff or the right mix of regulated and unregulated providers to provide the appropriate quality and quantity of care. There are concerns that a lack of sufficient funding is resulting in insufficient numbers of health-care and support staff, inadequate staff education and a lack of supports for staff (e.g., equipment, electronic health records, healthy workplaces). Although this policy brief focuses on staffing decisions, the Canadian Nurses Association (CNA) will discuss complementary approaches to improving outcomes – such as changing the number of LTC beds and developing alternative housing options – in future publications.

Patient Outcomes

Fifty-four per cent of nurses working in LTC report that there is not enough staff to get the work done.[10] Staffing decisions therefore have an impact on patient outcomes. For example, the addition of nurse practitioners in LTC facilities in Hamilton, Ontario, averted the need to transfer patients to acute care facilities.[11]

POLICY OPTIONS

Quality of care

Given the different approaches to providing LTC in various jurisdictions, the quality of care necessarily varies and in some cases may be declining over time. In a survey of Canadian nurses, 28 per cent of respondents working in LTC reported that quality of care had deteriorated in the past year. Forty-seven per cent of LTC nurses attributed problems with quality to inadequate staffing levels.[12] Inadequate staff education and inappropriate facilities or staff supports may also contribute to poor quality of care.

Quality of care is often measured by nationally recognized indicators such as number of falls or medication errors. Over a one-year period, 63 per cent of nurses employed in LTC observed a patient injured in a fall, and 23 per cent reported that a patient occasionally or frequently received a wrong medication or dose.[13]

Violence

Recent reports by CBC's *Marketplace*[14] and other media have portrayed increasingly high levels of violence and abuse in LTC facilities. In 2006, 1,415 assaults occurred in Ontario between residents, on average four incidents every day.[15] Violence toward or by staff is also a concern; for example, 50 per cent of LTC nurses reported being physically assaulted by a patient over a one-year period, 48 per cent reported emotional abuse from a patient, and 13 per cent reported emotional abuse from a nurse co-worker.[16]

Insufficient numbers of health-care providers and support staff (e.g., housekeepers, security personnel) and inadequate staff education contribute to violence, as does the prevalence of aggressive behaviour among residents with dementia and other mental illnesses.

There is a concern that the high prevalence of violence, compounded by inadequate staffing, has led to a culture of acceptance among staff and residents. Through education and advocacy, professional associations are working to improve work environments and to eliminate violence in health-care facilities.[17]

Provider Outcomes

Some evidence indicates that LTC staff may be working in less healthy work environments and may have poorer health than workers in other sectors. For example, significantly more LTC nurses report their health as fair or poor, compared with their counterparts who work in hospitals (8.5% versus 6.4%).[18] In addition, 10 per cent of nurses in LTC reported a work injury in the past year.[19] LTC employers may be able to offer a variety of supports to staff to improve health. For example, only 45 per cent of nurses reported a place to purchase healthy food in the workplace, and only 20 per cent of nurses had access to fitness and recreation services.[20]

In addition, only 60 per cent of nursing and residential care facilities provided on-the-job training in 2001, whereas 95 per cent of hospitals did so.[21] Residents in LTC require specialized care because of their frailty and the high prevalence of dementia and other mental illnesses.[22] Various

judicial inquiries have recommended better access to appropriate continuing education for staff as a way of supporting safety and quality of care.[23]

Finally, many staff working in LTC facilities report feeling undervalued by their peers in other sectors. There is a sense that LTC is viewed as less challenging and as requiring less skill,[24] a perception that contributes to low morale, high staff turnover and unhealthy workplaces.[25]

Impact on the Health System

A number of statistics raise concerns about the impact of the LTC work environment on overall performance of the health system, including workforce productivity. Absenteeism, one factor in workforce productivity, is higher in LTC than in other settings. For example, over a one-year period, 62 per cent of nurses missed at least one day of work because of a health problem, and these nurses missed, on average, 29 days in total.[26] Throughout Canada's LTC nursing workforce, this amounts to 3,811 full-time nursing equivalents.[27] In addition, 36 per cent of LTC nurses work part-time but would prefer to work full-time. This mismatch between aspirations and reality is higher than for any other health-care setting and may be a source of frustration. In fact, 15 per cent of LTC nurses reported job dissatisfaction, compared with 13 per cent of nurses working in hospitals and only 8 per cent of nurses working in community health.[28]

Policy Approaches

Concerns about and issues related to quality of care, violence, and provider health and performance are all connected to staffing decisions. There is a need to identify the appropriate staffing level and mix for each LTC facility and to assess the need for staff supports. CNA recommends that employers evaluate staffing, including numbers, patient ratios, mix, delegation, education needs, physical and electronic supports and perceived value of work.

A number of tools for evaluating staff mix are available, including the *Evaluation Framework to Determine the Impact of Nursing Staff Mix Decisions* (http://www.cna-aiic.ca/CNA/practice/environment/nurse/default_e.aspx). This tool helps employers assess how effectively they are using their nursing resources, including registered nurses, licensed practical nurses and registered psychiatric nurses.[29] It provides a framework for determining how well nursing staff, organizational characteristics and client needs are matched, and for understanding the effects that these combined factors have on client, provider and system outcomes. With this information, employers can more effectively decide how to deploy their staff.

Clearly, most staffing decisions – including decisions to increase the number of staff, establish patient ratios or specify minimum hours of care per resident – will have significant implications for funding.

In addition to optimizing staffing decisions, the LTC sector can apply other, complementary approaches to improve patient, provider and system outcomes. Examples include standardizing the collection of data on quality, making regulatory policy more consistent and requiring accreditation of facilities. These approaches must be matched with changes in the broader context of LTC, including funding options, infrastructure and healthy-aging policy.

[1] CBC News. (2007, October 22). *Nursing homes: Fear and violence*. Retrieved November 9, 2007, from http://www.cbc.ca/news/background/nursing-homes/

[2] Statistics Canada. (2007). *Residential care facilities 2005/2006*. Ottawa: Author.

[3] National Union of Public and General Employees. (2007). *Dignity denied: Long-term care and Canada's elderly*. Nepean, ON: Author.

[4] Health Canada. (2007). *Long-term facilities-based care*. Retrieved November 6, 2007, from http://www.hc-sc.gc.ca/hcs-sss/home-domicile/longdur/index_e.html; Canadian Healthcare Association. (2004). *Stitching the patchwork quilt together: Facility-based long-term care within continuing care – realities and recommendations*. Ottawa: CHA Press.

[5] Ibid.

[6] Statistics Canada. (2007). *Residential care facilities 2005/2006*. Ottawa: Author.

[7] Canadian Institute for Health Information. (2007). *Highlights from the regulated nursing workforce in Canada, 2006*. Ottawa: Author.

[8] Canadian Healthcare Association. (2004). *Stitching the patchwork quilt together: Facility-based long-term care within continuing care – Realities and recommendations*. Ottawa: Author.

[9] Ibid.

[10] Shields, M., & Wilkins, K. (2006). *Findings from the 2005 national survey of the work and health of nurses*. Appendix Table 28. Ottawa: Statistics Canada.

[11] Small, N. (1994). The role of the gerontological nurse practitioner in nursing homes. *Nursing Homes: Long Term Care Management, 43*(4), 48-50; McAiney, C. A. (2005). *Evaluation of the nurse practitioner in long-term care project*. Unpublished report by Hamilton Emergency Services Network.

[12] Shields, M., & Wilkins, K. (2006). *Findings from the 2005 national survey of the work and health of nurses*. Appendix Tables 16, 17. Ottawa: Statistics Canada.

[13] Ibid. Appendix Table 18.

[14] CBC Marketplace. (2007, October 17). *Grey, black and blue* [video of television broadcast]. Retrieved November 15, 2007, from http://www.cbc.ca/marketplace/grey_black_and_blue/

[15] Ibid.

[16] Shields, M., & Wilkins, K. (2006). *Findings from the 2005 national survey of the work and health of nurses*. Appendix Tables 21, 22. Ottawa: Statistics Canada.

[17] Canadian Council on Health Services Accreditation. (2007). *Within our grasp: A healthy workplace action strategy for success and sustainability in Canada's healthcare system*. Ottawa: Author; Canadian Nurses Association. (2002). *Violence* [Position statement]. Ottawa: Author.

[18] Shields, M., & Wilkins, K. (2006). *Findings from the 2005 national survey of the work and health of nurses*. Appendix Table 40. Ottawa: Statistics Canada.

[19] Ibid., page 35.

[20] Ibid. Appendix Table 15.

[21] Canadian Institute for Health Information. (2005). *Canada's health care providers: 2005 chartbook*. p. 15. Ottawa: Author.

[22] National Union of Public and General Employees. (2007). *Dignity denied: Long-term care and Canada's elderly*. Nepean, ON: Author.

[23] College of Nurses of Ontario. (2007). *Supporting quality nursing care in the long-term care sector: Results of the 2005-2006 long-term care teleconference series*. Toronto: Author.

[24] College of Nurses of Ontario. (2007). *Supporting quality nursing care in the long-term care sector: Results of the 2005-2006 long-term care teleconference series*. Toronto: Author; Canadian Healthcare Association. (2004). *Stitching the patchwork quilt together: Facility-based long-term care within continuing care – Realities and recommendations*. Ottawa: Author.

[25] Canadian Healthcare Association. (2004). *Stitching the patchwork quilt together: Facility-based long-term care within continuing care – Realities and recommendations*. Ottawa: Author.

[26] Shields, M., & Wilkins, K. (2006). *Findings from the 2005 national survey of the work and health of nurses*. Appendix Table 45. Ottawa: Statistics Canada.

[27] Full-time equivalents (FTEs) were calculated as follows: average number of days missed (29) x absenteeism rate (62%) x total number of nurses employed in nursing homes and long-term care facilities in 2005 (55,112) x 7.5 hours per day ÷ 1,950 hours (1 FTE). Sources: Shields, M., & Wilkins, K. (2006). *Findings from the 2005 national survey of the work and health of nurses*. Ottawa: Statistics Canada. p. 158; Canadian Institute for Health Information. (2006). *Highlights from the regulated nursing workforce in Canada, 2005*. Ottawa: Author. p. 82.

[28] Shields, M., & Wilkins, K. (2006). *Findings from the 2005 national survey of the work and health of nurses*. Appendix Tables 7, 31. Ottawa: Statistics Canada.

[29] Canadian Nurses Association, Canadian Practical Nurses Association, Canadian Council for Practical Nurse Regulators, Registered Psychiatric Nurses of Canada. (2005). *Evaluation framework to determine the impact of nursing staff mix decisions*. Ottawa: Canadian Nurses Association.