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The Future of Long-Term Care is Now

Addressing nursing care needs in Manitoba's Personal Care Homes

Manitoba nurses Union

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Message from MNU President Sandi Mowat

Nurses understand the challenges facing our health care system. Every day, they are on the frontlines delivering care to Manitobans, often in trying and difficult situations. The Manitoba Nurses Union is proud to represent over 12,000 nurses from across the province, and I am committed to making sure their voices are heard. This report will identify and discuss the challenges facing nurses working in long-term care, who are uniquely qualified to provide care to seniors and other vulnerable Manitobans.

In 2007, MNU released its first report examining Manitoba's long-term care (LTC) sector. We closely examined pertinent issues affecting the provision of safe, quality care for LTC residents such as nursing shortages, increasing acuity and insufficient funding. Our findings proved that significant improvements had to be made to meet the current and future needs of Manitoba's LTC sector.

Nurses' voices were the driving force behind MNU's lobbying campaign to call on government to improve safe staffing guidelines in LTC. In 2008, the provincial government listened to nurses and invested in a $40 million recruitment strategy to increase nursing care, provide more supports in personal care homes and increase Manitoba's staffing guidelines. These accomplishments made Manitoba a leader in addressing key challenges facing LTC services in Canada.

Nonetheless, there are many systemic challenges within our health care system that must be addressed. Once again, nurses and LTC residents are asking the provincial government to listen to their concerns. It is imperative that our province has the necessary resources and infrastructure in place to absorb the growing demand for LTC services as the baby boom generation ages.

MNU has worked tirelessly to address issues in LTC. Time and again, I have heard from nurses about ongoing challenges in LTC, specifically related to insufficient staffing, increased workloads and the increase of highly acute residents with complex care needs. I applaud the many nurses and members of the public who came forward to share their experiences and provide insight into a fragile system.

It is important to remember that the acuity of current and future LTC residents is not reflected in the current staffing guidelines personal care homes are expected to abide by. Tragically, there are many cases where facilities are staffed below these guidelines. This is cause for growing concern for care providers and residents' loved ones, as residents are increasingly unlikely to receive the care they rightfully deserve.

Addressing challenges in our health care system requires a team effort. It requires collaboration between government, health care professionals, unions, and employers. Together, we must develop well-founded policies that can address the root causes of the issue.

Thank you for taking the time to read this report. With your help, we can meet the challenges head-on and improve LTC standards for the benefit of all Manitobans.

Sincerely,

Sandi Mowat
President
Manitoba Nurses Union

Executive Summary

The future state of seniors' care in Manitoba is faced with a considerable amount of uncertainty given the limited supply of financial and human resources, availability of personal care home (PCH) beds and antiquated staffing guidelines. The positive correlation between staffing capacity, care quality and care outcomes is irrefutable. However, nurses and other health professionals continually express concern about the significant impact low staffing levels pose to the provision of safe resident care. Moreover, the policy direction of the provincial government suggests these issues may be exacerbated as the baby boom generation ages; in 2018, the Manitoba government cut funding for long-term care services by $2.3 million.

This report examines the manner in which nurse staffing capacity impacts care quality within LTC settings and aims to address longstanding challenges nurses and other health professionals continue to face with respect to the provision of safe, quality care. MNU's research efforts included a comprehensive literature review revealing safe staffing parameters for PCHs; analyzing data from Workload Staffing Reports (WSRs) to identify care hazards resulting from insufficient staffing levels, and lastly, qualitative and quantitative findings from frontline nurses collected through a random-sample survey (N=501) and focus groups (N=28).

Key Findings

Those who reside in PCHs often have the most chronic and complex needs. For instance, more than three out of four residents (77%) are now diagnosed with a neurological disease in which over half have dementia (60%). Approximately 10% of PCH residents require clinically complex care; over one-third (37%) require extensive assistance completing daily living activities such as dressing, bathing and eating; and over half (58%) of residents have reduced physical functionality. While the care has become more complex for PCH residents, staffing guidelines have remained the same over the past ten years, placing a burden on the health care team to provide a higher level of care with limited resources.

MNU's research draws attention to the fact that Manitoba's existing PCH staffing guidelines contradict with evidence-informed best practices confirmed throughout numerous peer-reviewed research studies. As it currently stands, there is no legislative requirement for minimum staffing guidelines in PCHs. Instead, staffing levels are enforced through a government directive referred to as *Personal Care Home Staffing Guidelines*. Initially developed in 1973 and amended in 2007, Manitoba's PCH staffing guidelines require all LTC facilities to provide enough staff to provide 3.6 paid hours of care per resident per day (hprd). This level of care is significantly lower than the expert-recommended 4.1 hprd of direct care.

Manitoba's staffing guideline not only fails to meet what experts argue to be the threshold required for residents to sustain a healthy life, it fails to reflect direct care hours. "Paid hours of care" includes a variety of factors such as direct care time, indirect care time (time spent on duties such as training, meetings, and administrative duties) and time paid but not worked, such as breaks and sick leave. While paid hours of care may reflect the cost of employing care providers, it does not reflect the amount of direct care residents actually receive. As such, the actual amount of direct care hours provided to PCH residents in Manitoba remains unclear, but it can be reasonably assumed it is less than 3.6 hours.

In addition to inadequate staffing guidelines, it is common practice for employers to treat the 3.6 hprd as a ceiling for safe staffing opposed to a baseline requirement. This is highlighted throughout the profiles of PCHs in Manitoba (page 13, Table 2) as more often than not, nurses are working below baseline staffing requirements. One of the primary contributing factors to understaffing is the reluctance from PCHs to replace vacant shifts, forcing the health care team to work without a sufficient number of nurses, health care aides and other health professionals. This practice ultimately sacrifices the quality of care residents receive and risks resident safety. Based on administrative data from WSRs, the following care hazards occur most often and directly result from low staffing levels and increased workloads:

- Resident falls;
- Processing of medication/orders not completed on time;
- Insufficient psychological and social support provided to residents;
- Failure to reposition/turn residents within appropriate timeframe as per care plan guidelines;
- Delayed or missed monitoring of vital signs;
- Lack of communication regarding resident care; and
- Delayed, missed or rushed care interventions and meals for residents.

Increased workloads, complex care needs and low staffing levels also impact nurses' perception of care quality and the overall practice environment in LTC. Nurses consulted by MNU revealed the following:

- **64%** of nurses attest that very little to no improvements have been made with respect to care quality in LTC facilities over the last few years.
- **56%** of nurses do not believe current baseline staffing requirements are adequate.
- **58%** of nurses stated that they do not have enough time to properly care for residents with "not enough staff/too many residents to care for" as the main contributing factor.
- Workplace violence continues to be a pervasive issue in LTC as **58%** of nurses experience physical violence, **51%** experience bullying or aggressive behaviour from residents and residents' families, and **51%** of nurses receive unwanted sexual attention from residents and/or residents' families.

Recommendations:

The Government of Manitoba must use evidence-informed best practices to improve care quality in LTC and ensure there is the right supply and skill mix of the right health professionals to provide the highest level of care residents require. As such, MNU proposes the following recommendations to improve safe staffing and care quality in PCHs:

1. For the Government of Manitoba to amend existing staffing guidelines to ensure every licensed personal care home provides a minimum of 4.1 direct care hours per resident per day.
2. For the Government of Manitoba to amend the *Personal Care Homes Standards Regulation* to legislate staffing guidelines.
3. For the Government of Manitoba to support and provide sufficient funding to ensure PCHs employ the appropriate number of nurses, HCAs and other care providers to meet the minimum staffing threshold of 4.1 direct care hours per resident per day.
4. That the Government of Manitoba, with input from relevant health care stakeholders, develop and implement a provincial health human resource strategy by April 1, 2019. This strategy should acknowledge existing gaps with respect to Manitoba's health human workforce and include a specific focus on the human resource supply for Manitoba's LTC sector.
5. To ensure all PCHs in Manitoba report resident data to Manitoba Health, Seniors and Active Living, who in turn will publicly release the data on an annual basis.
6. For the Government of Manitoba to conduct a provincial review that examines the current and future supply of PCH beds in all geographic regions of Manitoba.

These recommendations require commitment and investment from the provincial government. At a time when government has decided to reduce funding for LTC services, a renewed focus must be made towards evidence-based planning that utilizes best-policy practices across Canada. The challenges in Manitoba's long-term care sector must be met with long-term solutions that ensure the provision of safe, high-quality care for a growing LTC resident population.

Introduction

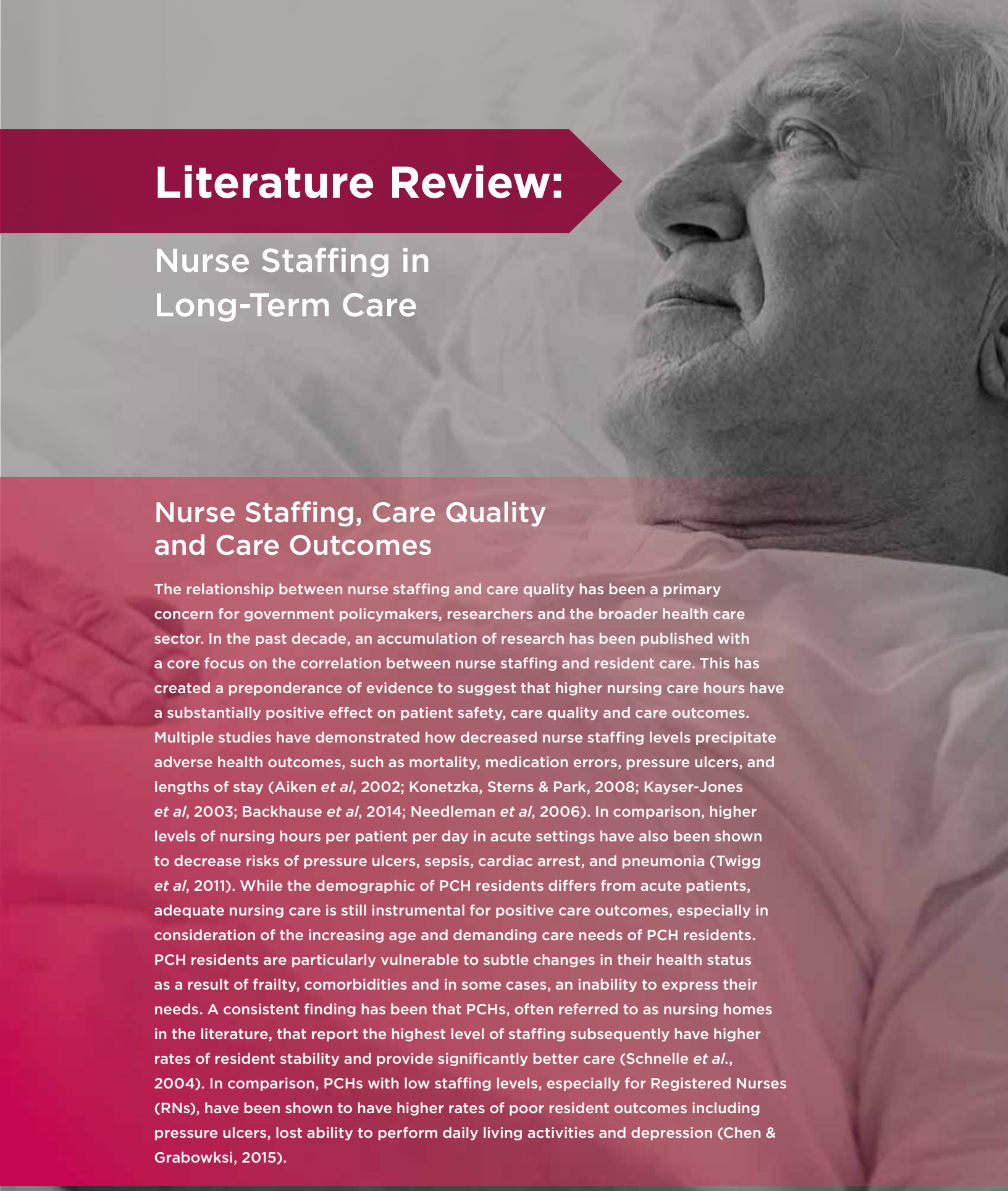
The steady growth of an aging population has been a consistent trend across Canada. This has ignited the public and political debate of how provinces and territories will be best equipped to meet the current and future health care needs the senior population requires. Manitoba has not been exempt from this debate considering 15% of our current population is over the age of 65. Moreover, within the next 15 years, over 100,000 Manitoba citizens will reach the age where they may require long-term care (LTC) services (Manitoba, 2016). Like the rest of Canada, it is becoming imperative for our province to ensure it has sufficient infrastructure and health human resources to respond to the increasing demands in the LTC sector.

Presently, there are 9,697 licensed PCH beds dispersed across the five regional health authorities (RHAs), the majority of which are located in Winnipeg.[1] For the 2016-17 fiscal year, it was confirmed there was a 98.2 % occupancy rate for PCH beds in Manitoba.[2] As of late 2017, almost 1,000 Manitobans were waiting for a bed, and of this amount, 47% were waiting in a hospital.[3] Recent projections have estimated that an additional 5,100 PCH bed equivalents are needed by 2036,[4] aligning with the timeframe in which the baby boom generation will begin to reach 85 years of age, causing an influx in the demand and need for care (Chateau *et al,* 2012). While it is recognized this evidence-informed projection is contrary to that disclosed by the Winnipeg Regional Health Authority (Brodbeck, 2018), it remains obvious that the current and future state of senior care is one of the most critical issues facing Manitoba's health care system today.

Manitoba has made significant strides with respect to developing innovative senior care programs. The 2006 "Aging in Place" initiative produced multiple pathways and programs to help seniors remain at home for as long as possible; however, those who have the highest degree of acuity not only require the most complex care, but are ultimately the core demographic admitted to PCHs. Consequently, this places pressure on our health care system to ensure each PCH has sufficient resources to provide a safe level of care that optimizes residents' health outcomes.

In 2007, MNU explored the relationship between nurse staffing levels and the provision of safe, quality resident care. This research report illuminated the increasingly complex care needs of Manitoba's PCH residents and the demand this places upon the nursing workforce. Unfortunately, PCH residents have become progressively more acute with complex care needs. This paper is a continuation of MNU's research efforts and is intended to help inform the future policy direction for Manitoba's health care system. We examine how longstanding staffing issues have become progressively worse over the last decade, primarily because of outdated staffing guidelines and the increasing acuity of PCH residents. This report examines the correlation between nurse staffing, care quality and care outcomes through the support of a literature review along with qualitative and quantitative data collected from frontline nurses. Additionally, a major component of this paper includes a close examination of Manitoba's existing PCH staffing guidelines. This analysis will prove that Manitoba's current guidelines are no longer sufficient nor sustainable given residents' acuity and care needs. This report concludes with proposed recommendations that chart the necessary steps our government must take to not only improve the provision of resident care but to also uphold the primary principles of ensuring each Manitoba citizen has access to safe, quality care.

[1] As per data provided by Manitoba Health, Seniors and Active Living by email on March 9, 2018.
[2] As per data provided by Manitoba Health, Seniors and Active Living by email on March 9, 2018.
[3] Based on information received from September and October 2017 responses from each RHA to Freedom of Information and Protection of Privacy Act (FIPPA) requests issued by the Manitoba Nurses Union. The FIPPA requests sought confirmation on the number of patients awaiting placement for LTC/PCH bed in the RHA along with the number of LTC/PCH beds currently occupied compared to the total number of PCH/LTC beds in the RHA.
[4] Chateau et al refer to "PCH bed equivalents" as all care provided to older adults that is currently provided via PCHs and in recognition that this care may be provided by alternative sources in the future.



Literature Review:

Nurse Staffing in Long-Term Care

Nurse Staffing, Care Quality and Care Outcomes

The relationship between nurse staffing and care quality has been a primary concern for government policymakers, researchers and the broader health care sector. In the past decade, an accumulation of research has been published with a core focus on the correlation between nurse staffing and resident care. This has created a preponderance of evidence to suggest that higher nursing care hours have a substantially positive effect on patient safety, care quality and care outcomes. Multiple studies have demonstrated how decreased nurse staffing levels precipitate adverse health outcomes, such as mortality, medication errors, pressure ulcers, and lengths of stay (Aiken *et al*, 2002; Konetzka, Sterns & Park, 2008; Kayser-Jones *et al*, 2003; Backhause *et al*, 2014; Needleman *et al*, 2006). In comparison, higher levels of nursing hours per patient per day in acute settings have also been shown to decrease risks of pressure ulcers, sepsis, cardiac arrest, and pneumonia (Twigg *et al*, 2011). While the demographic of PCH residents differs from acute patients, adequate nursing care is still instrumental for positive care outcomes, especially in consideration of the increasing age and demanding care needs of PCH residents. PCH residents are particularly vulnerable to subtle changes in their health status as a result of frailty, comorbidities and in some cases, an inability to express their needs. A consistent finding has been that PCHs, often referred to as nursing homes in the literature, that report the highest level of staffing subsequently have higher rates of resident stability and provide significantly better care (Schnelle *et al.*, 2004). In comparison, PCHs with low staffing levels, especially for Registered Nurses (RNs), have been shown to have higher rates of poor resident outcomes including pressure ulcers, lost ability to perform daily living activities and depression (Chen & Grabowksi, 2015).

Multiple systematic reviews have also verified the correlation between nurses, care outcomes and patient/resident satisfaction. In 2006, a group of researchers undertook a review of over 80 articles to reveal that staffing is one of the most critical factors in determining care outcomes. It was found that more nurses—such as RNs and Licensed Practical Nurses (LPNs)—reduce the risks of pressure ulcers, weight decline and functional ability for nursing home residents (Bostick *et al*, 2006). In 2011, Spilsbury *et al* examined 50 research articles in which their review produced similar findings revealing that nurse staffing levels are strongly correlated with resident care outcomes and resident satisfaction.

Research studies have also asserted the quality of care residents receive doesn't necessarily rest solely upon staffing capacity. Rather, it is important to ensure staffing guidelines consider a range of factors such as staff mix, staff experience, resident mix and care needs. A 2000 study assessed the relationship between different types of staffing levels and care deficiencies in nursing homes. What was found was that fewer RN hours and fewer nursing assistant (equivalent to Health Care Aides (HCAs)) hours were directly associated with quality of care deficiencies and total care deficiencies (Harrington *et al*., 2000b).

Arguments have also been made that a higher inclusion of RNs in the provision of care benefits the health care team skill set in addition to reducing the likelihood of adverse events for LTC residents. This was illustrated in a 2005 study which found that as the amount of direct care hours provided by RNs increased, the risk of developing pressure ulcers and urinary tract infections decreased, as did the likelihood of hospital admissions (Horn *et al*, 2005).

Conversely, one research study proposed that it is the ways in which staffing levels and the skill mix of the overall health care team intertwine that poses a significant impact on resident care. Kim *et al* (2009) examined over 400 nursing homes in California that either met or did not meet state-regulated staffing guidelines to determine the relationship between RN staffing mix and care quality. Interestingly, the researchers found that the relationship is not linear as nursing homes who were already failing to meet staffing standards yet had more RNs on each shift still encountered negative effects for total care deficiencies. This study concluded that increasing the representation of one specific health care provider does not necessarily lead to better care. Rather, it is more important to ensure there is a balanced mix of nurses and other health care staff to provide care relative to the health needs and acuity of each resident.

Further studies continue to confirm the link between adequate nurse staffing and resident care such as those published by Nicholas Castle, a respected academic well versed in LTC issues and health policy. Castle has published multiple studies confirming the link between higher professional, licensed staff mix and greater care quality (Castle, 2008; Castle & Engberg, 2008). One such study involved a literature review of 70 studies that examined the relationship between staffing levels and care quality in nursing homes. Based on Castle's analysis, it was found that 40% of various care quality indicators, such as pressure ulcers, weight loss, incontinence and physical restraints, were associated with inadequate staffing levels inclusive of RNs, LPNs and nurse aides (HCA equivalent) (Castle, 2008).

It is important to acknowledge the lack of recent research available that exclusively examines the role of LPNs and Registered Psychiatric Nurses (RPNs) in the provision of LTC services. When completing the literature review, it was evident that the majority of research articles focus primarily on RN staffing for PCHs. With respect to RPNs, the lack of research may be attributed to the fact that only four provinces and one territory in Canada currently regulate psychiatric nursing as a profession. Research examining the role of LPN staffing primarily did so within the confines of how LPNs interact with the overall health care team or broader nursing profession; however, we were able to find research from the late 1990s that examined the impact of LPN staffing in LTC. This research confirmed how increased LPN staffing can improve functional outcomes (i.e. requiring assistance for bathing, feeding, dressing, toileting and mobility) for PCH residents (Cohen and Spector, 1996) along with proving that increasing LPN FTEs (full-time equivalents) per every 100 beds can lead to a decreased use of physical restraints in nursing homes (Castle, 2000). Additionally, one study noted nursing homes that offer a skill mix containing greater LPN hours per resident per day, in addition to RN hours, were associated with better care outcomes (Anderson, Hsieh &

Su, 1998). What is most important to understand is that all nurse categories are valuable in the provision of quality health care services and maintaining a high standard of inter-professional practice for the health care team. There is also an opportunity for future research to examine the role of RPNs and LPNs in LTC settings more extensively.

The Value of Nurse Practitioners

Ensuring adequate health human resources for LTC is pertinent to another theme explored within the literature: the role of Nurse Practitioners (NPs) in LTC settings. NPs possess advanced, specialized competencies which are valuable in optimizing care in various practice settings yet considerably underutilized in LTC. Studies have documented the pivotal role NPs have in PCHs and have shown NPs to directly improve resident care quality, reduce ER transfers, reduce hospital admissions, increase nurses' ability to provide wound care, enhance skill development amongst the health care team, and improve access to primary care (Rosenfeld *et al*, 2004; Sangster-Gormley *et al*, 2013; Canadian Nurses Association, 2013). These positive traits also contribute to significant cost-savings for the health care system. Specifically, for Manitoba, a 2013 presentation from the WRHA noted an 83% decline in hospital transfers, 75% decline in hospital admissions and 86% decline in ER visits through incorporating NPs in LTC (WRHA, 2013). Hiring more NPs in PCHs also ought to be a health human resource priority for Manitoba as the number of NPs employed in this practice setting is quite low throughout the province.

The Economic Benefit of Safe Staffing

Establishing staffing thresholds not only contributes to better care, but also improves the financial sustainability of a health care system. For example, one study in the US evaluated the economic impacts associated with adequate RN staffing levels. In 2005, a group of researchers completed a retrospective cost-study that estimated the net societal cost savings accrued by facilities that employed enough nurses to provide 30 to 40 minutes of direct care per resident per day (Dorr, Horn and Smout). Residents included in the study were those who were already at risk of adverse outcomes including developing pressure ulcers, urinary tract infections and hospitalization. Their analysis calculated that the facilities who provided enough nurses to provide the threshold of direct care hours produced an annual net societal benefit of $3,191 per resident per year.

Staffing Guidelines and Skill Mix in LTC

The impacts of minimum nurse staffing guidelines relative to resident care has predominantly been discussed within the confines of the U.S. health care system, such as state-regulated nurse to patient ratios. In PCHs, care quality and quality of life are not exclusively related to skill mix and the number of nurses to residents, but are further compounded by the amount of time nurses are able to spend on direct resident care. This is referred to as *hours per resident per day (hprd)*.

Research has frequently examined the effects of hprd and PCH resident care, most of which is intended to establish a threshold for the level of care required for residents to lead a healthy, dignified life. Two of the most profound studies examining safe staffing thresholds for LTC originate from the U.S. In 2001, the Centres for Medicare and Medicaid Services (CMS) commissioned a study of over 5,000 LTC facilities across 10 states. This study aimed to identify the threshold of care required to prevent negative outcomes for residents. As such, 4.1 hrpd of direct care was identified as the minimum threshold in which resident care and safety would not be compromised. Of the 4.1 hours, 2.8 hprd is the threshold of care for HCAs and 1.3 hprd is the threshold for licensed nurses. Within the licensed nurse hours (1.3 hours), approximately 0.75 hours (approx. 58% of licensed care hours) was recommended to be provided by RNs. (CMS, 2001).

While the CMS study identified the minimum level of care required to sustain current health status, an earlier study identified a threshold to improve resident health outcomes. In 2000, a panel of geriatric experts conducted a review of peer-reviewed research and facility data in which they determined that approximately 4.55 worked hours (equal to direct care hours) per resident day was found to improve residents' wellbeing. Of the 4.55 hprd, it was proposed that 1.85 hours (41% of total care hours) should be provided by nurses and 2.7 hours (59% of total care hours) should be

provided by HCAs. Additionally, the panel went so far as to recommend a minimum ratio of 1 licensed nurse to every 15 residents during day shifts, 1:20 during evenings and 1:30 at nights. The study also recommended for staffing to be adjusted upward for residents with higher care needs (Harrington *et al*., 2000a). A 2004 study later identified the range of 4.5 to 4.8 worked hprd as the threshold of care required to prevent deterioration and improve care outcomes (Schnelle *et al*., 2004).

While skill mix and direct care hours are proven to have consequential impacts on resident care, adequate staffing goes beyond ensuring a minimum number of staff. Rather, ideal staffing models should consider residents' needs and provide enough flexibility to ensure nursing resources can be allocated to meet those needs (Mueller, 2006). Linking staffing models with the demographic of PCH residents continues to be discussed throughout multiple research studies. In 2006, a cross-sectional study examined staffing standards across 50 U.S. states. What this study found was that it is the way in which nurse staffing is organized along with general working conditions that may be more strongly correlated to care quality than strictly the number of staff scheduled for each shift. Additionally, the study confirmed that resident acuity must be considered when staffing standards are set rather than setting an arbitrary minimum number of required staff (Muller *et al*, 2006). Recent research from Harrington *et al* also produced compelling evidence that not only illustrates the importance of higher staffing standards but ensuring these standards can be adjusted for resident acuity to optimize care (2016).

A flexible approach to staffing has also been considered a best practice by Australia's Ministry of Health. In 2010, the Ministry of Health advocated for a "principles-based" staffing model where a variety of factors are considered when making staffing decisions for LTC. These factors include resident dependency, staff experience, financial resources, model of care, patient demand, and the provincial need to provide clinical leadership and evidence-based practice. Furthermore, the model adopted by the Ministry is also inclusive of frontline nurses and relies on their experience with direct resident care to inform staffing decisions. The Ministry noted that regardless what model is used to direct LTC staffing, nurses must have direct input into the budget and all other policy and practice decisions impacting resident outcomes (State of Victoria, 2010).

Legislating Staffing Guidelines

While there are various avenues to improve staffing standards, research points towards legislation as the most effective pathway. Previous studies originating from the U.S. have dismissed the notion that financial incentives increase compliance with staffing standards. One study examining the implementation of Florida's 3.9 hprd staffing standard noted that staffing only improved when minimum standards were legislated, despite a $40 million incentive package. Additionally, improved staffing levels led to improved satisfaction amongst residents and residents' families. The study also identified valuable lessons to consider if staffing standards are to be effective. This includes ensuring standards are robust and delineated by caregiver group (i.e. RNs, LPNs, HCAs) to prevent facilities from replacing certain care providers with those that cost less. Additionally, staffing standards should be flexible to reflect resident acuity (Hyer, Temple & Johnson, 2009).

Legislating or standardizing staffing has also been shown to reap economic benefits for the health care sector. Higher minimum staffing requirements have not only been shown to improve resident outcomes (Bowblis, 2011), they have also been shown to address chronic human resource issues such as turnover, low levels of job satisfaction and burnout (Chen & Grabowski, 2015).

Safe Staffing and Workplace Safety & Health

The widespread presence of workplace violence in health care settings is also correlated with safe staffing. Workplace violence has been a longstanding topic, especially within the confines of the health sector in which international studies have found those who work in health care are more likely to be assaulted at work than prison guards or police officers (International Council of Nurses, 2004). In 2008, a team of academic experts from York University and Carleton University linked staffing shortages with resident to caregiver violence in LTC. The research study found it crucial for governments to recognize short-staffing as a key contributor to workplace violence and that they must ensure safe staffing by legislating adequate care standards and providing funding to meet these standards (Banerjee *et al*, 2008).

Manitoba's Long Term Care Sector

The Nursing Workforce

Currently, all nursing classifications are employed within Manitoba's LTC sector. This includes NPs, RNs, RPNs and LPNs. As previously highlighted in the literature review, NPs, along with other nursing classifications, are considerably underused in LTC. In June 2017, the Canadian Institute for Health Information (CIHI) released its annual report highlighting data and trends for the national and provincial/territorial nursing workforce. The most recent report, *Regulated Nurses*, 2016 revealed the following:

- Only three NPs (1.9% of Manitoba's NP workforce) are employed in nursing homes/LTC facilities.
- 12% of Manitoba's RN workforce is employed in nursing homes/LTC. For the most part, the representation of RNs in LTC has remained unchanged since 2007.
- 16% of Manitoba's RPN workforce is employed in nursing homes/LTC and has declined since 2007 (26%), representing a 10-percentage point decrease. Since 2007, the amount of RPNs employed in nursing homes/LTC has declined each subsequent year.
- LPNs are well represented in Manitoba's LTC sector as 42% of Manitoba's LPN workforce is employed in nursing homes. The representation of LPNs in LTC has been declining since 2007, but at a smaller rate compared to RPNs.

(Canadian Institute for Health Information, 2017 June).

PCH Staffing Guidelines

Staffing guidelines for PCHs in Manitoba are not governed by legislation. Rather, they are mandated through a government directive referred to as *Personal Care Home Staffing Guidelines.* The only staffing components governed by Manitoba's *Personal Care Homes Standards Regulation* (as per *The Health Services Insurance Act*) is the obligation for each PCH to provide nursing services (s 21); designate at least one RN or RPN to be in charge of administering nursing services and supervise nursing care; (s 22(1) – (3)); establish nursing policies and procedures (s 23(1)); and ensure there is adequate space and supplies to fulfill nursing requirements (s 23 (2)).

When staffing guidelines were created in 1973, staffing was based upon the level of care residents required, with each resident assessed and categorized into one of four care levels. In 1993, the guidelines were amended to mandate each PCH to have at least one RN or RPN on staff each shift to directly supervise the provision of care. This is also reflected in the *Personal Care Homes Standards Regulation* (s 22 (1) – (3)). In 2007, the Government of Manitoba completed a provincial review of nurse staffing levels, resulting in the requirement for all PCHs to provide 3.6 **paid hours** of care per resident per day (hprd) (emphasis added). In November 2007, a memo was sent to all RHAs outlining specific requirements of the new staffing guideline. For facilities with 80 beds or more, 30% of the care must be provided by nurses (15% from RNs/RPNs and 15% from LPNS). This translates to 1.08 hours of care. The remaining 70% of care hours (2.52 hours) is provided by HCAs. For sites with less than 80 beds, 35% of care is provided by nurses (20% by RNs/RPNs, 15% by LPNs) and the remaining 65% provided by HCAs.

What is most important to note is that the 3.6 hprd stipulated in the guideline does not translate to direct care hours. Through a conversation with the WRHA in December 2017, it was confirmed that the 3.6 hprd reflects paid hours which means this is the amount of time nurses are paid to be at work, not necessarily the time spent on the direct provision of health services. "Paid hours of care" includes a variety of factors such as direct care time, indirect care time (time spent on training, meetings, and administrative duties) and time paid but not worked, such as breaks and sick leave. Paid hours of care also hides the reality of how many care providers are working short because of chronic staffing issues such as absenteeism, sick leave and overtime (Armstrong *et al*, 2009). The WRHA confirmed that relief funding is also built into the 3.6 hprd which currently is allocated at 15% (0.54 hours). As such, when removing relief funding from the staffing guideline, care hours would be reduced to 3.06 hprd of paid hours of care. When considering the 3.6 hprd as referenced in the guideline, Manitoba falls below what experts recommend to be the threshold to maintain safe resident care (refer to Table 1 for comparison).

Reports from nurses working in LTC also suggest that current staffing guidelines are not only inadequate to provide safe, quality care but oftentimes, facilities are staffing below the guidelines. Table 2 (page 13) highlights personal accounts nurses have shared with MNU about the staffing, workload and resident care challenges occurring at their facilities.

Table 1
Actual versus expert recommended hours per resident day

	Licensed Nursing Care (Hours)	Health Care Aide Care (Hours)	Total Care Hours Per Resident Per Day
Current Staffing Guideline in MB*	1.08	2.52	3.6
Expert Recommended	1.3	2.8	4.1
% Difference	20.4%	11.1%	13.8%

Table adopted from Nova Scotia Nurses' Union report: *Broken Homes*, 2015

*Manitoba's current staffing guideline is for paid hours whereas the expert recommended is for direct care hours, or 'hours worked'.

Table 2
Examples from Manitoba LTC facilities

This table highlights personal accounts nurses have shared with MNU about the staffing, workload and patient care challenges occurring at their facilities.

At a private 175-bed facility in Winnipeg, it is common practice for units to work below the full complement of scheduled staff, often referred to as "working short". This has left nurses fulfilling more non-nursing duties, compromising their ability to provide safe resident care. Additionally, there are incidents where the resident care manager failed to appear at the facility for scheduled shifts, forcing two nurses to provide care for 175 residents. Workload Staffing Reports (WSRs) have consistently noted that during the day shift, the health care team is often short one nurse and five health care aides. This poses significant consequences to resident care as there has been an increase in resident falls, insufficient staff available to respond to "code blue" calls, and insufficient psychological and social support provided to residents. Unfortunately, rather than replace vacant shifts, management has recommended for nurses to take earlier breaks. This response fails to acknowledge the risk of compromised care due to the lack of available nursing staff.

At a privately-owned 276-bed personal care home in Winnipeg, the shifts most often affected by staffing shortages are evenings and nights. If a replacement for a vacancy cannot be arranged, a reallocation of staff is required to prevent a unit of residents from having no nurse. On the night shift, this translates to 1 nurse assigned to 160 residents for one area of the facility, and 1 nurse to 116 residents for the remainder. This temporary solution is not effective as it produces a "snowball effect" in which staff from other units now have an increased workload on top of their own resident assignment. It is also unsafe, because the stretched resources mean a nurse will have multiple competing responsibilities should something unforeseen happen.

When nurses work short, patient care is directly impacted. Nurses at this facility have reported delayed, missed or incomplete treatments, an inability to review lab results with physicians, missed or delayed specialist consultations, and delayed updates to RAI-MDS. In addition, there is an increase in the use of temporary staffing solutions, such as agency nurses, which is negatively impacting resident care. Most often, agency nurses are not familiar with the residents, their care routines and facility policies. This contributes to incomplete or delayed assessments, inability to follow-up on treatment care plans, missed wound care treatments, delayed medication passes, and late or sometimes missed neurological and vital checks for ailing residents.

One PCH in rural Manitoba provides care for 89 residents. For the night shift, only one nurse and five HCAS are scheduled for the entire facility. While nurses increasingly report that this is unsafe for patient care, this is the baseline staffing guideline for this facility. Additionally, there have been reports that there is rarely a charge nurse or resident care manager on staff during the weekend evening shift which contravenes the essential services agreement for this facility in which at least one resident care manager is to be scheduled. Nurses working at this facility also confirmed a memo was sent from the employer confirming that the first sick call for HCAs will no longer be replaced, forcing nurses and HCAs to work short. Nurses have expressed significant concern as this practice is currently impacting resident care. Nurses have recently reported that residents either miss or receive scheduled baths late if staff are not replaced.

On one particular unit in an urban LTC facility, insufficient nurse staffing and increasingly heavy workloads have posed significant risks to providing safe patient care. Staffing guidelines specific to this type of unit care mandate 4.6 hprd in which the care composition is split equally between nurses and HCAs. Both nursing staff and management agree that current staffing guidelines and current staffing levels are not sufficient to provide optimal care given the complex care requirements patients on this unit have. The evening and night shift are usually the busiest, primarily because unlike most LTC units, medications are administered throughout the entire night. There are also more patients who require closer monitoring, especially those who require tube feeds, resulting in more frequent calls for assistance. During the night shift, there are currently two nurses and two HCAs on staff to provide care for 29 patients. During the evening, there are three nurses and three HCAs, however this level of staffing is not sufficient as there is a higher than average rate of medication passes and more specific, strict directives for care.

In general, the staffing level for this unit is too low as there are multiple patients who require more extensive supports, such as two-person assists, and bariatric patients in which 3 to 4 staff members are required to provide care. An inadequate amount of supplies is also common, diverting nurses to go searching, often on completely different units. This has caused significant delays in essential care. Nurses note that wound dressings changes should take an average of 20 to 30 minutes however given factors such as supply shortages, acuity of the wound, and patient cooperation, this often takes upwards of 60 minutes.

The burdensome workload has had significant impacts on the recruitment and retention of staff as reports from nurses confirm the most experienced nurses will not apply for vacancies in this unit and there is a significantly higher turnover rate for HCAs compared to other units in the facility. Nurses have brought these concerns to the attention of senior executive management within the facility and have brought these issues forward regionally to the Director of Long Term Care.

Resident Acuity and Complexity of Care

Individuals residing in PCHs are highly acute with more complex health care needs. According to the 2016-17 Continuing Care Reporting System (CCRS) report, published by CIHI, the average age of PCH residents is 85 years, ranking Manitoba second with British Columbia as the province with the oldest LTC resident demographic (Nova Scotia ranks first with 90 years of age as the average). In addition to illustrating that Manitoba's population is now living longer, CIHI's report also illustrates how LTC residents possess complex health care issues and needs as evident in the following:

- Approximately **10%** of PCH residents are assessed as clinically complex which refers to individuals who have comorbidities of several medical conditions. Over one-third require extensive assistance completing daily living activities such as dressing, bathing and eating (**37%**). Additionally, **32%** of PCH residents are dependent upon nursing care for daily living activities.
- The majority of PCH residents in Manitoba have significant physical and cognitive comorbidities. Over half (**58%**) of residents have reduced physical functionality, **13%** experience daily pain, and almost one-third (**32%**) of assessed residents are categorized as high risk for developing pressure ulcers (Pressure Ulcer Risk Scale score of 3 to 8).
- In terms of cognitive and behavioural acuity, **77%** of residents are diagnosed with a neurological disease and the majority of residents have dementia (**60%**). Over one in four (**26%**) residents have severe cognitive impairment (scores of 4 or higher on the Cognitive Performance Scale).
- Over one-third (**39%**) of residents have symptoms of depression or possible depressive disorder (scale of 1 to 3 or more on the Depression Rating Scale).
- **15%** of residents are either severely or very severely aggressive (rating of 3 to 6+ on the Aggressive Behaviour Scale), (CIHI, 2017).[5]

Despite this data being restricted to the WRHA's resident population, what remains clear is that as care becomes more complex there is an increased need to ensure the level of staffing is adequate to provide the level of care residents require relative to their diagnoses and health needs.

Resident Safety

Patient/resident safety is also concomitant of chronic understaffing and has received considerable attention in our province. In 2015, what is now the Department of Health, Seniors and Active Living released a final report pertaining to the Frank Alexander Inquest. This inquest was initiated after a 2011 critical incident in which a PCH resident, Frank Alexander, was severely injured and ultimately died as a result of an aggressive, abusive incident from a fellow resident.

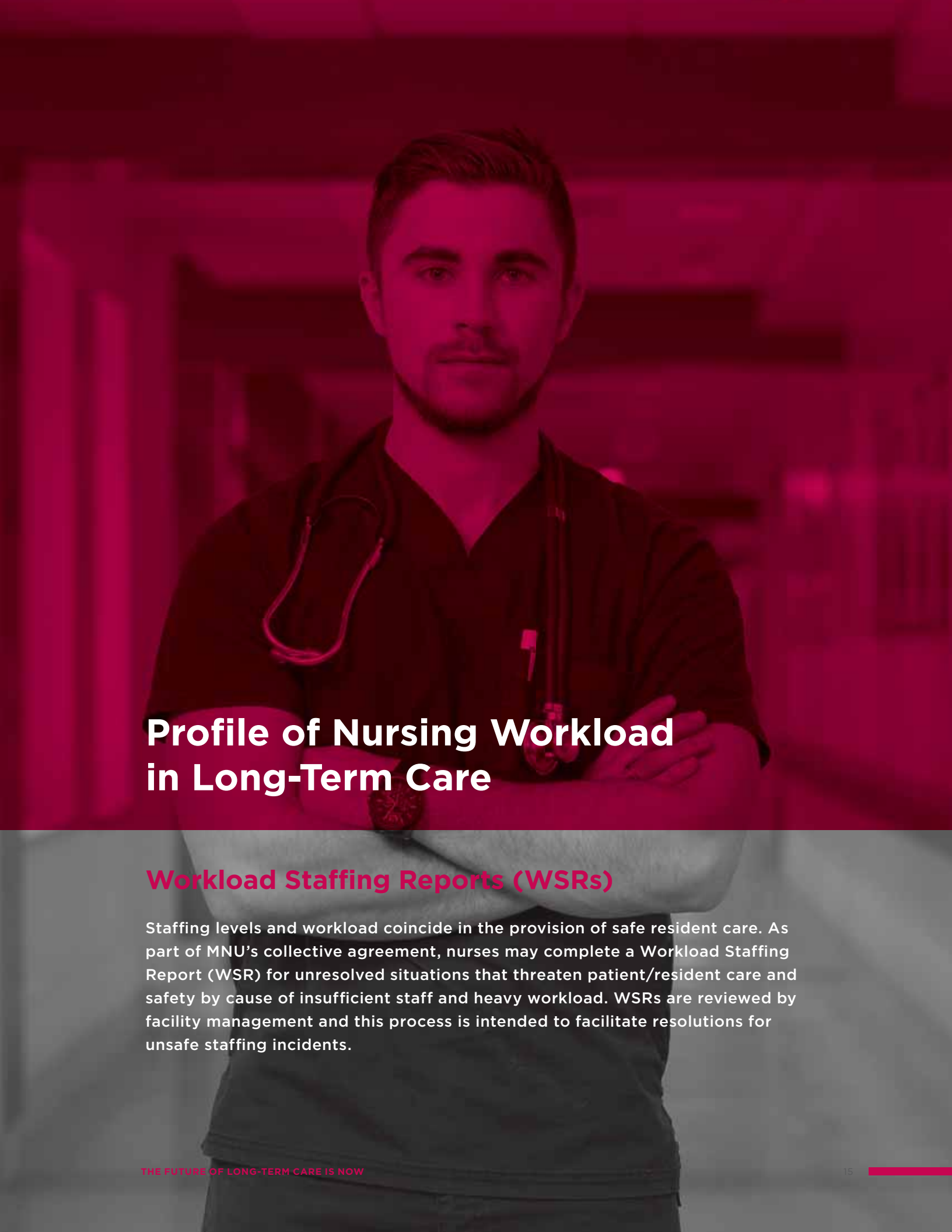
One recommendation most relevant to safe staffing was for the Government of Manitoba to implement short and long-term human resource plans to meet the needs of Manitobans requiring care in the LTC sector (Manitoba, 2015). This recommendation stemmed from the belief that an adequate number and mix of staff will prevent unsafe, critical incidents in LTC.

Despite recommendations from the Frank Alexander Inquest, very little has been accomplished to address the ongoing rate of critical incidents in PCHs, including employing a sufficient level of staff. Between April 1, 2011 and March 31, 2017, there were over 800 critical incidents involving PCH residents within the WRHA, the majority of which were identified as falls and pressure ulcers.[6] As per the *Regional Health Authority Act*, a critical incident is any unintended event that results in a consequence to patient/resident that is serious and undesired, including death, injury or disability.

What is most interesting is the number of critical incidents, particularly those identified as serious falls, have decreased in 2016. This is the result of changes made by the WRHA with respect to its interpretation of which falls are considered serious or critical incidents (Nicholson & Kubinec, 2018). As it currently stands, the only falls that will be deemed a critical incident by the WRHA are those that "result from malfunctioning equipment or staff issues" (Nicholson & Kubinec, 2018). Despite this change, the WRHA did confirm the number of falls is relatively the same as previous years and it is only those identified as critical incidents that are decreasing.

[5] Data from CCRS Quick Stats excludes residents in hospital-based resident care and is representative of those residing in residential care facilities. CCRS only reflects submitting facilities and presently, the WRHA is the only RHA who submits data to CCRS. Therefore this information reflects the resident acuity for this demographic.

[6] Manitoba. Critical Incidents Reported to Manitoba Health. http://www.gov.mb.ca/health/patientsafety/report.html



Profile of Nursing Workload in Long-Term Care

Workload Staffing Reports (WSRs)

Staffing levels and workload coincide in the provision of safe resident care. As part of MNU's collective agreement, nurses may complete a Workload Staffing Report (WSR) for unresolved situations that threaten patient/resident care and safety by cause of insufficient staff and heavy workload. WSRs are reviewed by facility management and this process is intended to facilitate resolutions for unsafe staffing incidents.

Over the last few years, hundreds of WSRs have been completed by LTC nurses documenting the adverse consequences to resident care resulting from low staffing levels. As documented in the WSRs, the following resident care hazards occur most often within PCHs:

- Resident falls
- Processing of medication/orders not completed on time
- Insufficient psychological and social support provided to residents
- Failure to reposition/turn residents within appropriate timeframe as per care plan guidelines
- Delayed or missed monitoring of vital signs
- Lack of communication regarding resident care
- Delayed, missed or rushed meals for residents

Nurses continuously confirm that increasing workloads and insufficient staffing pose significant challenges to meet professional practice standards set forth by their respective regulatory body, such as the College of Registered Nurses of Manitoba, the College of Licensed Practical Nurses of Manitoba and the College of Registered Psychiatric Nurses of Manitoba. Additionally, staffing challenges and the impact to resident care may be more pervasive than what is presently reported as LTC nurses confirm the under-reporting of workload and resident care issues through WSRs. This is primarily because the increasing demands of documentation and administrative tasks nurses are expected to complete demotivates nurses from completing WSRs. Additionally, many nurses are met with resistance when they bring these issues forward to their manager. This fuels nurses' presumption that very little will change with respect to unsafe workloads. As such, nurses are beginning to normalize unsafe practice environments and adopt a "just deal with it" approach.

> **"A big concern from time to time is about aggression from other residents… it all comes back to there is nobody around to watch these people."**
>
> **— Daughter of PCH Resident***

Providing adequate care is also directly influenced by the supply of health human resources. Recently, WSRs from both private and public facilities note that management was either unable to fill vacant shifts or they are unwilling to replace the first sick call. Not replacing the first sick call is a cost-saving measure for many facilities, both LTC and acute, that was implemented to respond to the fiscal savings target recently set forth by the Government of Manitoba. Reluctance to replace vacant nursing shifts has led to increasing reports of facilities using other health care workers, such as HCAs, to replace nurses, further compounding the challenges of providing quality resident care.

Nurses in LTC recognize the valuable contribution and impact HCAs have in the provision of care. However, nurses possess a higher level of education, medical competence and clinical expertise; they are responsible for delegating and supervising the work of HCAs. Maintaining an adequate skill mix for a PCH health care team is a concern both nurses and HCAs share. Given the high degree of expertise nurses provide to the health care team, it is imperative to ensure that nurses are not replaced with other health care workers.

RAI-MDS

All Winnipeg PCHs along with Valleyview PCH (Brandon) use RAI-MDS to measure and inform care interventions and outcomes for residents. RAI-MDS requires nurses and other care providers to assess residents for physical, cognitive and functional characteristics (i.e. vision, nutritional status, skin condition, medications, suicide risk, etc.) in which the information received from the observation and assessment is inputted into the RAI-MDS system. This information is then used to determine care needs and formulate an individual care plan for each resident. Resident assessments are completed upon admission to a LTC facility and on a quarterly basis thereafter. More assessments are completed if there are significant changes in acuity and health status.

*Quotes from family members of PCH residents were collected in interviews conducted by MNU in March 2018.

While RAI-MDS provides valuable data and is an important vehicle for care plans, nurses have expressed significant concern about how time-intensive RAI-MDS can be especially if they are not provided sufficient resources and time to complete assessments and data input. Nurses are provided a seven-day assessment period to observe residents to assess their health status and needs. Nurses confirm the assessments are valuable and although timing can be a factor, it is not the assessments themselves that impede upon nurses' workloads, but rather it is the time required to input data in RAI-MDS. Nurses must translate and input data from multiple sources, such as resident charts, daily care records and assessment frameworks, to prepare for the data input. RAI-MDS is also a comprehensive data system containing numerous platforms to reflect different forms of data pertaining to resident care. Inputting and updating data into RAI-MDS is believed to take the most time. For example, nurses estimated that if they were to dedicate a full 8-hour shift to inputting and updating resident case files, they would only be able to complete two to three resident cases. After the data is inputted to RAI-MDS, there is an additional one week to ensure that the comprehensive, individualized care plan is correct and complete with the addition of any information that may have been triggered by RAI-MDS.

Completing RAI-MDS assessments and reporting is part of provincial care standards; therefore, nurses are required to fulfill this responsibility in addition to providing direct resident care. The lack of time and resources dedicated to RAI-MDS, primarily inputting the data, has led to an increased workload for nurses to complete this task. To not jeopardize resident care, many nurses are asked to work unpaid or overtime to complete and enter information into RAI-MDS.

> **"A lot of falls and hospital visits resulting from falls could be avoided if they had somebody that could keep watch."**
>
> **— Daughter of PCH Resident**

Lastly, nurses have voiced frustration and concern toward the lack of on-site training provided to nursing staff for RAI-MDS, especially given the ongoing changes and modifications made to the system and assessment framework. This has created inconsistencies with respect to proficiency among the nursing workforce using this system. Nurses have also expressed frustration that it remains unclear about how the data is ultimately used by RHAs and how this information contributes to changes to improve resident care. For example, if there are increased reports in RAI-MDS of more highly acute residents with more complex care needs, nurses rarely witness changes resulting from this information such as increased nursing care hours or increasing the availability of specialized supports.

Private vs. Public Facilities

Data received from WSRs, along with personal accounts from nurses and residents, demonstrate growing concerns regarding staffing and care quality in Manitoba's PCHs. However, it is important to note that these challenges are most pronounced at privately-owned and operated facilities. Research has shown private facilities do not provide the same standard of care quality and health human resources as public, non-profit facilities. North American studies have extensively illustrated that for-profit facilities are increasingly employing fewer nursing staff than non-profit facilities and are thereby more likely to jeopardize the provision of safe patient care (McGregor et at. 2010; Berta et al. 2005; McGregor et at, 2005; Harrington et al, 2001; Comondore et al, 2009). Indeed, MNU is witness to this issue based on more recent direct reports and data from nurses and residents.

Over the past six months, there have been increasing reports of decreased public funding and investment for PCHs, including one-time funding decreases for Winnipeg PCHs to reducing the number and funding of public PCH beds. Most recently, Manitoba's 2018-19 budget revealed a $2 million funding decrease for LTC. These cuts are a step in the wrong direction as they fail to address growing demand for LTC services and raise the possibility of privatization. Despite ample evidence illustrating that private facilities do not provide the same standard of care as public facilities the provincial government has continued to promote the

privatization of health care services and public private partnerships to fund future PCHs. The trend toward privatization is greatly concerning to nurses, other health care providers, residents and their families as it calls into question the future of LTC in Manitoba. Moreover, budget cuts will only make it more difficult to ensure adequate staffing and parity of care at all PCHs. Instead, Manitoba should be increasing funding for LTC services through a robust public model as a means of enhancing staffing guidelines for the benefit of current and future residents.

> **“ To have 6 months of no stimulation laying around in bed with dementia certainly is not going to improve anything. That’s my biggest concern being a citizen of this community. People are spending too much time in the wrong environment. ”**
>
> **— Son of PCH Resident**

Term Care Survey and Focus Groups (2017)

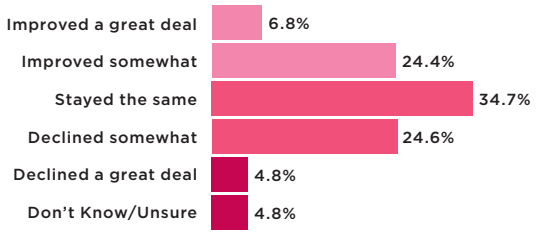
In January 2017, Viewpoints Research surveyed 501 LTC nurses on behalf of MNU through a random-sample telephone survey. The majority of questions were also asked of LTC nurses in 2006 and 2014 to identify common trends and identify areas of progress for specific issues in LTC. This included care quality, resident acuity and workplace health and safety. MNU also conducted four focus group sessions (N=28) to consult with LTC nurses throughout January and February 2017. The purpose of these focus groups was to explore nurses' views on topics relevant to the LTC sector. Focus group sessions were held in Winnipeg and Brandon. Participants included RNs, RPNs, and LPNs with diverse levels of professional experience.

A. Survey (N=501)

Quality of Care

Of the surveyed nurses, only 26% rated the quality of care provided in their facility as "Excellent", remaining unchanged since 2006. Comparatively, 64% of nurses confirmed very few to no improvements have been made with respect to care quality in their respective facility *("stayed the same", "declined somewhat", "declined a great deal")*. For those who noted a decline in care quality *(declined somewhat, declined a great deal)*, almost two-thirds (64%) attributed this to increased workload whereas one in five nurses (20%) identified fewer nursing staff as the core cause.

Over the past few years, has the quality of care available in your facility:



Baseline Staffing and Overtime

Over half (56%) of nurses do not believe current baseline staffing levels are adequate. What was most telling from respondents was the perceived reluctance from the employer to address chronic nursing shortages. Oftentimes, nurses are either mandated to work overtime or replaced with temporary nurses or HCAs. This was found in approximately 46% of nurses confirming they worked overtime because of staffing shortages while 17% confirmed vacant nursing shifts are often replaced with HCAs.

Use of Agency Nurses

In addition to overtime and replacing nurses with unlicensed staff, LTC facilities continue to rely heavily on agency nurses to address staffing shortages. A total of 58% of nurses confirmed agency nurses are used in their facility, representing a 14% increase since 2014. Of this amount, almost 30% of nurses confirmed the employer uses agency nurses on a weekly basis whereas over one in ten nurses (12%) confirmed agency nurses are used daily. Agency nurses are more likely to be used daily or almost every day in Winnipeg facilities (21%) compared to rural facilities (6%). They are also more likely to be used consistently (daily or almost every day) in private facilities (16%) compared to public facilities (10%).

The increasingly high use of and reliance on agency nurses is an emerging issue for Manitoba's health care system. While agency nurses are licensed, practicing nurses, they do not possess the familiarity with the facility or its residents which is necessary to provide consistent care. This places residents at risk for unintended negative care outcomes, which has been explored and confirmed in detail in previous research studies (Castle & Engberg, 2007, Castle, 2009). The time for staff nurses to orient an agency nurse to the facility/unit and the resident population is time taken directly from resident care.

Relying on agency nurses to fill chronic staffing shortages is not cost-effective nor is it in the best interest of care continuity and care quality. In Manitoba, RHAs are required to pay agency nurses their salary and travel time. MNU's current collective agreement requires each RHA to report on the number of times agency nurses are used to replace nurses. However, there have been inconsistent reporting practices amongst each RHA. We know from recent reports from the Interlake-Eastern RHA, that from April 2017 to January 2018, the RHA spent over $400,000 on agency nurse salaries for PCHs. The Northern RHA also experiences a chronic use of agency nurses. From April to September 2016, $1.4 million was spent on agency nurses throughout the entire region whereas Flin Flon PCH exclusively spent over $25,000 on agency nurses for this period.

Resident Acuity

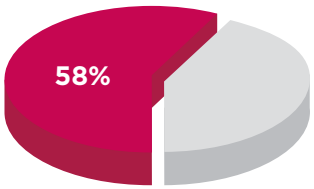
Nearly two-thirds (65%) of nurses believe the acuity for LTC residents has increased over the last three years. Of this amount, over one third (34%) confirm resident acuity has increased substantially. The perception that acuity has increased is at its

highest level to date, with MNU completing four waves of tracking since 2000. This perception is also positively correlated with nurses' years of experience working in LTC, from 58% of those who have been working for less than 5 years to 72% of those working for 20 years or more.

Provision of Resident Care

Increasing resident acuity combined with an insufficient amount of staff has a direct negative impact on the quality of care residents receive.

More than half (58%) of nurses stated that they do not have enough time to properly care for residents.



Of this amount, almost two-thirds cite lack of nursing staff or too many residents as the main reason (63%) for incomplete care while 28% said they are assigned too many non-nursing duties. Furthermore, most nurses (70%) reported their facility has necessary supplies and equipment for treatment only most of the time.

Non-Nursing Duties

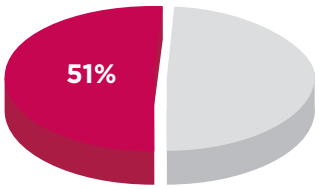
Despite the increasing nursing shortage in LTC, nurses are increasingly expected to perform non-nursing duties. Non-nursing duties has been discussed at considerable length within research and often refers to work performed by professional nurses that is below their scope of practice, knowledge or skill level (Bruyneel *et al*, 2012). Non-nursing duties are also associated with tasks that are not related to direct patient/resident care or tasks that do not require professional nursing skills (Al-Khandari & Thomas, 2008). At least three in four nurses indicated they are delegated and expected to complete tasks outside their scope of practice. The non-nursing duties most commonly reported by nurses are typically administrative tasks such as filing and photocopying (90%), stocking carts, procedure kits and supplies (86%), searching for equipment and supplies (85%), reporting supply shortages (75%), collecting and removing garbage (60%) and performing security tasks such as locking and unlocking the facility (53%). The completion of the above-mentioned duties was found to directly impact the amount of time nurses can spend on direct resident care as over three out of four nurses (79%) confirmed that completing non-nursing duties limits the time they are provided to complete nursing responsibilities. Unfortunately, over half of the respondents (60%) indicated the delegation of non-nursing duties to nurses is a consistent practice that has been ongoing for quite some time. This is significant as more than one quarter (26%) of surveyed nurses have worked in LTC for more than 20 years. As mentioned previously, the care needs of current residents are more time-intensive than in the past. Yet, well-educated nurses who are often working short are expected to complete these tasks rather than assigning these responsibilities to another member on the health care team.

> **"There needs to be more contact time… I don't see a whole lot of nursing contact. I know they give pills and if he [my husband] needs his ointment applied they do that. Other than that I don't think he sees a nurse."**
>
> **— Spouse of PCH Resident**

Workplace Violence, Aggression and Critical Incidents

Workplace violence is a pervasive issue within the health care system. It has been proven to diminish work satisfaction amongst employees, compromise the provision of quality, safe care, and impact the productivity of organizations. Workplace violence is especially predominant in LTC practice settings. Only 28% of nurses feel safe at work on daily basis. This is because two out of three nurses are frequently subjected to verbal abuse from

residents and residents' families, 58% of nurses fall victim to physical violence, while over half **(51%) are faced with bullying or aggressive behaviour from residents or residents' families.**



What is most surprising is the high rates of sexual harassment nurses endure while at work. Over half (51%) of nurses confirmed they have received unwanted sexual attention from residents and/or residents' families at least once throughout their career.

The insufficient number of staff within LTC facilities is not only correlated with quality of care, it is also directly linked with the increasing rates of abusive incidents. As per MNU's collective agreement, employers are obligated to notify the union of abusive incidents occurring within facilities. In the past year alone, we have seen an increasing amount of incidents from residents and residents' families such as inappropriate sexual comments made to staff and other residents; hitting, kicking, biting, spitting and punching staff/residents stalking; personal threats; and verbal abuse including profanity and racial slurs to staff/residents. A concerning trend within the nursing profession is to normalize inappropriate behaviour from patients and residents, including violent aggression and sexual harassment. It is often assumed by nurses and other health professionals that very little can be done if residents with dementia or cognitive impairment express themselves inappropriately and cannot be held accountable for their behaviour. This has led to an underreporting of abusive incidents. There have also been instances where nurses reported sexually inappropriate behaviour to their direct supervisor/ manager yet their reports were not taken seriously or investigated as there is an organizational culture of minimizing or normalizing this type of behaviour in health care work environments.

Two out of **three** nurses are subjected to verbal abuse.

58% of nurses fall victim to physical violence

B. Focus Groups

Sentiments provided in the focus groups corroborate with the survey findings however, there are key themes worth mentioning:

Chronic Understaffing

Nurses identified chronic understaffing as the worst part about working in LTC. The majority of nurses attested that understaffing contributes to heavy workloads resulting in an inability to spend adequate time with residents and increased delays in care. Nurses also noted that chronic understaffing and vacancies force them to rush many aspects of nursing care, such as feeding, and getting residents dressed. This can be demeaning to a resident and destroy a resident's source of independence. Furthermore, something as basic as not enough time to optimize a resident's appetite and nutrition can obviously have serious detrimental effects such as dehydration, increased susceptibility to infection, malnutrition, anemia and many more health effects. Most nurses also believe that critical components of care, such as monitoring, are substantially decreased when there are not enough nursing staff.

> **"My Mom fell, broke her arm... She was sent to emergency by herself. Nobody went with her. 91 years old. She has severe dementia. She was sent by the stretcher service but nobody from the facility went with her. She was alone... [I was told] they don't have the staff to spare for that."**
>
> **— Daugher of PCH Resident**

Decreasing Resident-Centred Care

A common perception amongst nurses was that care has become more task-oriented rather than resident-centred. One nurse noted,

> **“ If we are working short, you have time for the bare minimum. You don’t have time to talk to residents and build a rapport. ”**

The burden of heavy workloads fuels fear amongst nurses as they begin to question their professional ability and ethics pertaining to safe provision of care. One nurse employed in a rural facility noted, *“We have 50 residents distributed between two nurses. It’s too much. I often go home after a shift and wonder how I got through it and worry that I was not able to provide residents with the level of care I wanted to. It can be rough psychologically”.*

LTC has become more acute and the feeling amongst nurses, particularly those who work the night shift, is there is not the appropriate number and mix of staff to provide adequate care relative to residents’ acuity. A few nurses noted that during the night shift, it is often just one nurse and one HCA left to care for all residents on the floor, which depending on the facility can be anywhere from 50 to 100.

Workplace Violence and Harassment

Nurses working in LTC normalize violent and aggressive behaviour and recognize that most episodes stem from an increase in residents with dementia and cognitive impairment. As one nurse explained, “*We know they don’t mean it and it comes from a place of feeling confusion, specifically for residents who suddenly forget where they are. This is why more supports are needed to provide effective care for residents with this level of acuity.*” Nurses also reiterated that they recognize many residents are not capable of controlling their moods all the time so they cannot be held accountable for their behaviour. Other nurses suggested that care challenges and workplace safety and health risks arise when residents are not approached correctly or when staff do not recognize precursors to violent or aggressive episodes. A fundamental aspect of providing care to someone with dementia or cognitive impairment is to approach in a non-threatening manner slowly and provide explanation. It is easy to discern how the constant rushing of staff and the provision of care may contradict with the residents’ care requirement. As reflected by one nurse, *“It’s not fair for the residents. They are at a point where they have slowed down in their life yet we want them to move faster.”*

Non-Nursing Duties

Further to the survey results, nurses from the focus groups substantiated the negative impact non-nursing duties have on resident care. As reflected by one nurse, *“We are consistently assigned to do things that are not nursing duties, especially if you are the charge nurse. We are expected to manage the entire building including the kitchen and laundry staff, replace light bulbs, and call maintenance. We are nurses, we should be providing nursing care.”*

In addition, the increasing amount of paperwork in LTC settings is also placing a burden on the time that is required for direct care. One nurse in a public facility stated,

> **“ There is so much paperwork, from flow sheets, care plans, quarterly plans, annual reviews, so much repetition of information. All of this takes away from the time we have to care for residents. ”**

Poor Standards in Privately-Owned PCHs

Those who work in privately-owned facilities face unique challenges compared to those working in publicly-administered facilities. These nurses noted higher nurse to resident ratios and heavier workloads. One nurse who works at a private facility confirmed on the evening shift, there is one nurse per 40 residents. Additionally, it was found that private facilities rarely replace the first sick call, forcing nurses to work short. Private PCHs face unique recruitment and retention challenges. Private facilities also lose more nurses as they are often paid less than those who work at public facilities. According to nurses who work at private facilities, they are often the most difficult to work at as there are more residents with dementia and higher acuity as families are more willing to pay to get their loved ones to a facility quickly than waiting on the public wait-list. Given inadequate baseline staffing levels, it is becoming increasingly difficult for nurses to provide the most optimal level of care relative to the acuity levels of residents with significant comorbidities.

Lack of Provincial Planning

Nurses in the focus groups also believed that government has no plan in place to address the increasing demands on LTC. One nurse notes,

> **“ Violence has increased in the last five to ten years. People are living longer with multi-morbidities and staffing ratios have not increased to respond to seniors’ health care challenges. ”**

Most nurses expressed significant concern about the growing number of residents with dementia and that the impact of the disease is not being recognized or addressed completely by the RHAs. Nurses believe that a step in the right direction would involve more psychiatric training for those working in LTC, specifically with a focus on resident mental and emotional health.

Recommendations from Frontline Nurses: What Can Government Do to Improve Resident Care

Increasing care needs and workload demands without commensurate increases in staffing levels equates to less time nurses can spend on direct resident care. As such, there is little to no merit in maintaining the existing staffing framework for PCHs. As noted earlier, safe staffing levels must align with and respond to the multiple dimensions of care current and future PCH residents require. Regardless of facility-ownership or shift, it is a common belief amongst nurses that the acuity of current LTC residents warrants improvements to PCH staffing guidelines. Residents now and in the future require a higher standard of care. With this in mind, staffing levels must match acuity levels and health care needs for all PCH residents. If action is not taken soon, the situation will consequently become worse, directly impacting the future stability and quality of LTC services and health human resources in Manitoba.

As it currently stands, over one-quarter (26%) of LTC nurses indicated their plan to retire in the next few years while an additional 14% stated they intend to leave the LTC practice setting altogether.

MNU consistently makes a dedicated effort to consult front-line nurses when our health care system is faced with new and ongoing challenges.

When MNU asked nurses what recommendations they would propose to the Government of Manitoba to improve the current state of the LTC sector, nurses overwhelmingly recommended the following:

- Increase staffing levels and time available so nurses can focus on direct resident care and professional responsibilities.
- Implement more specialized supports for highly acute and aggressive residents;
- Ensure parity of funding and care for LTC/PCH facilities in Manitoba;
- Improve the availability of supplies and equipment in LTC/PCH facilities; and
- Reduce the amount of administrative paperwork that diverts attention from direct resident care.

> **“ In the evenings there are two HCAs for 20 residents. Supper is one hour which is more like 30 minutes. In those 30 minutes the two aides have to get all the food on the tables plus have to feed five in addition to another 15... How are they expected to do that? I know the nurse is supposed to help too but often by the time they get the meds out, which is a full time job, supper is done. ”**
>
> **— Daughter of PCH Resident**

Making Progress across Canada:

Addressing Staffing Shortages in Long-Term Care

MNU is not alone in contributing to the public discourse concerning the future state of long-term care services in our province and throughout Canada. More specifically, nurse staffing shortages in LTC continues to be a pressing topic for nursing unions and health care associations across the country.

Most recently, the Canadian Federation of Nurses' Unions released a 2017 report illustrating the despairing reality of LTC in Canada. A core focus of the report involved examining the ways in which the ongoing nurse staffing shortage has a direct impact on senior care and health outcomes for the elderly. CFNU found one of the most compounding factors to providing timely care is the lack of nurses currently employed in the LTC sector. Labour market information along with patient care data revealed that there are not enough nurses available to provide the care residents require given their increasingly complex health care needs. When nurses are forced to work below baseline staffing, this directly impacts the provision of safe, quality resident care. CFNU's report revealed that chronic staffing shortages in LTC are forcing nurses to either miss or delay essential health care services such as turning residents to prevent bed sores, bathing and feeding. CFNU's research proved that improvements to care quality and care outcomes for LTC residents rests heavily on implementing evidence-based staffing guidelines (Silas, 2017).

In 2015, Pat Armstrong, Hugh Armstrong and Jacqueline Choiniere released, *Before It's Too Late: A National Plan for Safe Seniors' Care*, a report commissioned by CFNU. The report examined a range of topics relevant to ensuring adequate senior care for both the home care and LTC sectors. With reference to staffing, the authors highlighted relevant research studies, some of which were highlighted in this report, proving that staffing levels and staff mix are important for care quality and the safety of both seniors and care providers. In aligning with previous US studies, the authors recommend 4.5 hprd (direct care hours) as the ideal threshold to improve residents' quality of life and that this should be a mandated requirement for LTC facilities throughout Canada. The authors conclude that promoting resident-centred care relies heavily on a stable health workforce, adequate staffing levels and appropriate staff mix. Other key recommendations pertinent to staffing and health human resources included developing national standards for safe, quality patient care, especially with respect to staffing and the enforcement of minimum staffing; and the creation of a human resources strategy for long-term care (Armstrong, Armstrong & Choiniere, 2015).

In December 2015, the Nova Scotia Nurses' Union (NSNU) released a report titled *Broken Homes* in which Dr. Paul Curry presented the dire state of Nova Scotia's LTC sector by discussing issues such as workplace violence, care complexity, staffing levels, skill mix, and the fiscal health of the LTC sector. By incorporating personal accounts from nurses, the report demonstrated that many of these issues, if not all, are entrenched in unsafe staffing levels. The report noted how almost all nurses confirmed they are operating below core staffing levels which is quite glaring given the fact Nova Scotia's current staffing guideline is already 15% below the expert recommended minimum (4.1 hprd). NSNU's report has served as a milestone and precedent for health care stakeholders in charting a path forward to ensure the provision of safe, quality senior care. The report proposed 15 evidence-based recommendations for the Nova Scotia government to implement including increasing staffing levels to 4.1 hprd, increasing funding of NP positions in LTC, improving compliance measures for LTC facilities and ensuring parity of care throughout the province (Curry, 2015).

In 2007-2008, an extensive review of Ontario's LTC system was completed to determine the human resource implications related to the provision of quality care. Unanimously, residents, residents' families and care providers identified the need to improve health human resources within PCHs. One specific recommendation from the review called for each LTC facility to develop annual staffing plans in which factors such as the mix of residents, complexity of care, and staff skill mix should be considered in determining how resources can be best aligned to meet care needs and improve care outcomes (Ontario, 2008).

National reports have recognized that developing models for nurse staffing is a complex process. Government leaders, policy makers and health care stakeholders must have a considerable grasp and understanding of the level of complexity involved with patient/resident care to ensure a sufficient health human resource supply (Canadian Health Services Research, 2006). In 2009, the Canadian Healthcare Association noted that an ideal health human resource strategy must be overarching across the entire LTC system to meet future resident

demands. This includes employing sufficient professional and support staff, ensuring the right skill mix relative to resident acuity, and prioritizing staff morale (Canadian Health Care Association, 2009).

Government, labour unions and health care associations throughout Canada also have a longstanding history of advocating for higher minimum staffing guidelines and sustainable funding for the LTC sector. This includes the British Columbia Ministry of Health (Murphy, 2006), the Health Association of Nova Scotia (2012), CUPE Manitoba (2015), the Ontario Association Non-Profit Homes and Services for Seniors (2014), the Ontario Nurses Association (2012, 2014), Ontario Long Term Care Association (2015), and the United Nurses of Alberta (2016). Most recently in Ontario, legislation was introduced to establish a minimum standard of daily care for LTC residents. *The Time to Care Act*, or Bill 33, was introduced October 14, 2016. This legislation would amend the *Long Term Care Homes Act* to mandate every LTC home to provide residents with at least an average of four hours of direct care per day of combined nursing and personal support services. The proposed legislation does not separate the composition of care hours for nurses and personal support services. At the time of writing, Bill 33 passed second reading with all party support; however, government refused to bring the proposed legislation to final reading.

> **“ I know for certain the nurse is pretty busy during the shift. ”**
>
> **— Daughter of PCH Resident**

The efforts previously highlighted are just a few of the many proceedings that have been instrumental in illustrating the realities of senior care in Canada. What has remained constant throughout the various research reports, advocacy campaigns and legislative proposals has been the promotion of increasing LTC staffing to align with evidence-based best practices (4.1 direct care hours per resident per day). MNU intends to continue its advocacy efforts to ensure safe staffing levels are prominent in all practice settings and hopes Manitoba will become a leader in setting the precedent for enforcing evidence-based staffing guidelines.

> **“ Staffing in the evening is one nurse for 40 residents and it takes her the entire shift to complete documentation and meds. If there is a death on the floor, I can imagine it would be chaos because there are a tonne of things they have to do. ”**
>
> **— Daughter of PCH Resident**

MNU's Recommendations

Based on the findings stemming from the literature, survey results and direct consultation with nurses, one thing holds true: when staffing is inconsistent and inadequate, care becomes inconsistent and inadequate. Given Manitoba's existing staffing framework, 3.6 hprd of paid work hours does not permit the provision of safe, quality care.

In a political climate where government emphasizes the importance of exercising fiscal restraint, nurse staffing must be considered more than an expense for our health care system. The points of discussions raised throughout this paper have clearly proven the provision of care for LTC residents cannot be completed effectively or safely without a sufficient amount of direct care hours and an adequate staffing capacity and skill mix to provide these hours.

The future state of health care and the wellbeing of Manitoba's senior population is a priority for government, policy makers, researchers and health care stakeholders alike. As such, improvements must be made to improve staffing levels and direct resident care. This presents a valuable opportunity to improve Manitoba's health human resources as it is crucial for each PCH to ensure there is a sufficient supply of the right health professionals to provide the necessary care relative to residents' health needs. Additionally, an adequate supply of health human resources enables all health professionals to practice fully within their professional scope as opposed to being diverted to perform responsibilities outside their skill set.

Moving forward, it will become crucial for the Government of Manitoba to ensure expert-recommended staffing guidelines are in place at each licensed PCH. This entails allocating necessary funding to ensure there is an adequate supply of nurses and other health care providers to provide these hours. In support of this proposed approach, MNU has developed the following recommendations to improve safe staffing in the LTC sector:

Recommendation #1:

For the Government of Manitoba to amend existing staffing guidelines to ensure every licensed personal care home provides a minimum of 4.1 direct care hours per resident per day.

Based on substantial evidence originating from well-informed research, it is important for staffing guidelines to recognize and align with the complexity of resident care needs in LTC settings.

It is also important for PCH staffing guidelines to clearly delineate and allocate care hours for nurses and HCAs. MNU is supportive of maintaining the current allocation in which 30% of hprd is provided by nurses and 70% is provided by HCAs. With reference to the proposed 4.1 direct hprd, this translates to each resident receiving 1.23 hours of direct care from nurses and 2.87 direct care hours from HCAs.

For PCHs with less than 80 beds, MNU is supportive of maintaining the current allocation of 35% of the hprd (1.44 direct care hours) for nurses and 65% (2.66 direct care hours) for HCAs.

With respect to nursing allocation hours, we recommend maintaining the equal distribution in which the hours are split evenly between Registered Nurse/Registered Psychiatric Nurses and Licensed Practical Nurses. (Eg. 15 – 17.5% of direct care hprd provided by RNs/RPNs, 15 – 17.5% of direct care hprd provided by LPNs).

Recommendation #2:

For the Government of Manitoba to amend the Personal Care Homes Standards Regulation to legislate staffing guidelines.

As confirmed by previous research studies, legislating staffing guidelines will optimize resident care as it will ensure compliance amongst all PCHs to maintain safe staffing levels and ensure parity of care for Manitoba's LTC sector.

Recommendation #3:

For the Government of Manitoba to support and provide sufficient funding to ensure Personal Care Homes employ the appropriate number of nurses, HCAs and other care providers to meet the minimum staffing threshold of 4.1 direct care hours per resident per day.

As previously acknowledged, we recognize staffing is one of the largest expenditures for the health care sector; however, an adequately funded health care system is essential in ensuring optimal resident care and safety. As such, PCHs may require additional funding to staff accordingly to meet the threshold of 4.1 direct hprd.

Recommendation#4:

That the Government of Manitoba, with input from relevant health care stakeholders, develop and implement a provincial health human resource strategy by April 1, 2019. This strategy should acknowledge existing gaps with respect to Manitoba's health human workforce and include a specific focus on the human resource supply for Manitoba's LTC sector.

Advancing the quality of Manitoba's LTC sector and securing a stable delivery of health services relies on ensuring that there is the right supply of the right health professionals. It is equally important to ensure nurses and other health care providers can complete work relevant to their training, knowledge and skills. Specifically for nurses, it is important for nurses to spend more time on direct nursing care as opposed to non-nursing duties.

To ensure Manitobans have access to quality health services, including LTC, our government must be equipped to make accurate predictions pertaining to what health services will be required in the near and distant future. This involves having an accurate projection of how many and what type of health professionals are needed to provide these services. Additionally, government must regularly complete labour market projections for the health sector to determine the availability of health professionals involved in all aspects of health care delivery. A provincial health human resource strategy should address existing and anticipated health human resource gaps shortages. It should also be sensitive to the unique challenges in urban and rural settings. Additionally, it should feature an action plan pertaining to increasing the use of Nurse Practitioners in the LTC.

Recommendation #5:

To ensure all PCHs in Manitoba report resident data to Manitoba Health, Seniors and Active Living, who in turn will publicly release the data on an annual basis.

We recognize there are limitations to data published by CIHI related to the acuity profiles of PCH residents. While PCHs throughout the province currently collect resident data, not all data is included in the CIHI database, and Manitoba has no provincial database dedicated to this information. MNU believes it is in the best interest of our health care system to collect and analyze this data provincially. As such, we recommend that all PCHs in Manitoba should be required to submit resident data to Manitoba Health, Seniors and Active Living. The department should be responsible for storing, analyzing and publicly releasing this information on an annual basis. This will ensure government leaders, policy makers, researchers and health care stakeholders have access to accurate, representative data.

Recommendation #6:

For the Government of Manitoba to conduct a provincial review that examines the current and future supply of PCH beds in all geographic regions of Manitoba.

Ensuring a sufficient and equitable supply of PCH beds throughout the province requires the completion of accurate and comprehensive projection calculations. Similar to other projections completed by respected academics, such as the work completed by Chateau *et al*. (2012), it is important to analyze the existing and future supply of PCH beds in all geographic regions throughout the province and consider existing and future demand for PCH services. While it is beyond the scope of this paper, it is important to note the existing inequities regarding the availability of LTC supports within and throughout each RHA. It is increasingly important for future PCH residents to have the ability to continue to reside in their community and be close to family members.

Conclusion

Our senior population is comprised of individuals who have cared for others. They are individuals who are parents, grandparents, spouses, siblings, relatives. They are someone's loved one. How we treat our most vulnerable patients and residents speaks volumes about the principles of a society and the principles of our health care system. Protecting and preserving the rights of all individuals is rooted in the morals of a modern health care system where continuous progress is made to ensure every member of society receives the care they rightfully deserve. It is also rooted in the principles of nursing, which ensure the rights and dignity of all residents and patients are respected when they are under the care of a nurse. Safe staffing in LTC is about respecting the dignity for all seniors, now and in the future.

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