SUMMARY

Violence, Insufficient Care, and Downloading of Heavy Care Patients: An evaluation of increasing need and inadequate standards in Ontario's nursing homes.

The Ontario Health Coalition has, in consultation with seniors' groups, nurses' organizations, physicians, community coalitions, unions, members of residents' and families' councils, come to a consensus set of key recommendations regarding quality of life and quality of care in long term care homes. Chief among our concerns is the lack of daily care for residents, and inadequate accountability for the levels of care provided by operators.

> *It should not be expected that seniors are engaged in the act of dying. Instead, we should be supported in life-giving, loving environments where we can live life to the fullest until life ends."*
> *(Resident, Mississauga, 2007)*

The recommendations are based on half a decade of research in which we conducted three cross-province consultations on care in Long Term Care (LTC) homes, with more than 1600 people attending public hearings and in-depth interviews with more than 40 residents, care workers and staff. In addition, we reviewed all the major medical journals research into violence, downloading of patients and improving care in long term care homes and have included the major studies and their findings. Finally, we have looked for the best practice research on care standards. These have led us to our priority recommendation that a regulated care standard, with an average of 3.5 hours of hands-on care, contoured to measured resident need, be instituted across Ontario's long term care homes.

Everywhere in Ontario we heard from frustrated caregivers, residents and family members who cannot give the care they want or cannot access the care they need. From urban to rural areas, north to south, people are identifying that heavier care residents now live in the homes. Staff feel unequipped to appropriately care for residents with cognitive difficulties and behavioural problems. Careworkers feel alienated from the charting process - terming it "charting for dollars" because they do not see a connection between funding increases and improved staffing.

Priority Recommendation

Our priority recommendation is a regulated care standard that would set a minimum staffing level of 3.5 hours of hands-on care per resident per day for LTC homes. The minimum would be attached to the average acuity - higher for homes with higher acuity, and lower for homes with lower acuity. Thus, the standard would be contoured to resident need. As recommended in the research and best practices, the standard would cover direct care staff including RNs, RPNs, and PSWs/HCAs, excluding administrative staff. It would reflect worked hours as opposed to paid hours. It would be subject to a robust compliance and enforcement regime.

> *Toileting does not happen on a regular schedule. I don't care who you are or where you work. It happens for those that ring a bell, but not for those that can't. Those that can't ring get checked in the morning and the afternoon. If you have two staff and one is on lunch and someone is a mechanical life -how do you do it? Two people are required for a mechanical lift."*
> *(Personal Support Worker, Ottawa area, 2008)*

This care standard would finally provide a clear connection between assessments, funding and amount of care as recommended by the provincial auditor. It would set an expected level of care, weighted by the assessed acuity of the residents in the home. This would provide one of the most important tools in assessment of appropriate funding, measuring outcomes that result from increases in funding, and provide greatly improved opportunities for accountability.

Many of the for-profit long term care chains operating in Ontario also operate in the U.S. where they have had a robust public discussion about reform in long term care over the last decade and a half. Scandals, lawsuits, and horrific tales of neglect - like those we have seen in Ontario - captured the attention of politicians. The resulting ground-breaking report commissioned by Congress found that there were care thresholds below which poor quality of care outcomes were measurably increased and thresholds above which care outcomes do not measurably improve. Our recommendation is based on these findings which are the best practice in research on this issue to date. As a result, the majority of U.S. states and Canadian provinces have moved toward establishing regulated care standards. If the government of Ontario chooses to reject these findings, it cannot do so without full explanation and evidence.

Key Findings

Increased acuity.

- Resident acuity in Ontario's LTC homes has increased by 29.7% since 1992 as a result of hospital cuts, ageing, and the downloading of mental health patients from hospitals
- By 2007, 74% of Ontario's 51,440 LTC residents classified that year were classified as Category F (the second highest acuity category). This represents a substantial increase in acuity over the last decade.
- Across the province, long-term care workers report that people with serious behavioural problems, psychogeriatric patients, and younger adults with disabilities are being moved into LTC homes with increasing frequency in the last half decade. These residents have complex care needs that result in repeated reports of inadequate training, inadequate staffing levels, improper placement and unacceptable rates of violence.

We can't be patient focused. Staff is so task focused they are rushing, they're rushing to get to the next person, there are problems like skin breakdown. It is ridiculous! You wait until it [the diaper] is 90% full, we don't do that to babies. These people have put their time in and given to society, it is not dignity. It is not dignity as these homes profess it is; it doesn't come close.
(Registered Nurse [RN], Southeastern Ontario, 2008)

Ontario Has Second Worst Staffing Levels in Canada

According to Statistics Canada, Ontario has the second worst total staffing levels in residential care facilities of the country. Only British Columbia has fewer hours per resident-day and the gap between Ontario and the rest of the country is widening significantly. This data measures all staff, not only the direct hands-on care staff measured below.

Hands-On Care Levels of Care in Ontario Stagnant Despite Funding Increases, and Below Recommended Standards

According to MOHLTC figures, average worked hours per resident day for *direct care* staff categories from 2004 - 2006 shows 2.375 HPRD in 2004 and 2.573 HPRD in 2006.(Letter from Dan Bryant, Program Advisor, Access and Privacy Office MOHLTC to Shelley Martel MPP Nickel Belt, March 14, 2007.) These levels do not meet the best-practice research for minimum thresholds to prevent from harm and are far short of maximum recommended thresholds to improve outcomes.

Hours per resident day (HPRD average):

Phases	Paid Hours					Worked Hours				
Phases	**1**(Jan-Jun 2004)	**2** (Jun - Dec 2004)	**3** (Jan - Jun 2005)	**4** (Jun - Dec 2005	**5** (Jan-Mar 2006)	**1**	**2**	**3**	**4**	**5**
Nurse Practitioner	0.0002	0.0001	0.0001	0.0001	0.0001	0.0002	0.0001	0.0001	0.0001	0.0001
Clinical Nurse Specialist	0.0003	0.0003	0.0003	0.0003	0.0003	0.0002	0.0002	0.0003	0.0003	0.0003
Infection Control Practitioner	0.0005	0.0005	0.0005	0.0005	0.0007	0.0004	0.0005	0.0005	0.0005	0.0007
Registered Nurse	0.341	0.354	0.363	0.366	0.364	0.312	0.319	0.332	0.331	0.331
Registered Practical Nurse	0.361	0.376	0.380	0.388	0.395	0.329	0.335	0.344	0.345	0.354
Personal Support Workers	1.9	1.972	2.046	2.071	2.081	1.725	1.760	1.852	1.844	1.877
Total	2.611	2.710	2.798	2.836	2.851	2.375	2.421	2.538	2.529	2.573

Note: "worked hours" is defined as including breaks, but excluding vacation, statutory holidays, sick time, education, bereavement, and other paid absences. The phases reflect quarterly reporting by facilities up to the final quarter (#5) ended March 2006.

After these results were released, the Ministry of Health delayed public release of any further staffing data, despite repeated requests. Finally in April 2008, in response to a second Access to Information request from the Canadian Auto Workers, updated staffing levels were revealed as follows:

Total Hours Per Resident Day **Source: April 10, 2008 letter in response to Freedom of Information Request from Dan Bryant, Program Advisor, Access and Privacy Office, Ministry of Health and Long Term Care. covers same staff as chart above (paid hours only)**

	Jan - Jun 2004	Jul - Dec 2004	Jan- Jun 2005	Jul- Dec 2005	Jan- Mar 2006	Apr - Dec 2006	Jan-June 2007
LTC Sector-wide	2.61	2.71	2.79	2.83	2.85	2.84	2.85
Municipal (public)	2.713	2.927	3.010	3.039	3.135	3.039	3.098
Charitable (non-profit)	2.728	2.780	2.925	2.910	2.893	2.904	2.918
Nursing Home (non-profit)	2.538	2.637	2.814	2.846	2.840	2.865	2.881
Nursing Home (for-profit)	2.637	2.715	2.752	2.768	2.769	2.773	2.770

This data shows that subsequent to the time period reported initially, care levels actually fell even as the government announced new funds directed towards hiring new staff and large overall budget increases for the sector, only recovering to early 2006 levels in the last half-year. In addition, the new data reveals:

1. Government announcements about funding and staffing increases do not correspond to increased hands-on care for residents.
2. Since 2005, for two years, we have not seen any notable improvement in care levels. Thus, the significant budget increases over the last two years have not resulted in any significant increase in daily hands-on care.
3. Currently, the lowest levels of care in provided in the for-profit nursing homes, with the highest levels of care provided in the publicly-owned municipal homes.
4. Over the period from 2004 - 2007, the largest increases in hours of care occurred in the publicly-owned municipal homes (14.2%), followed by the two types of non-profit homes (10.2%), with a much slower rate of increase in the for-profits (5%).
5. The levels of care are not tied to the homes' and the government's measurements of resident need. According to the Ministry of Health's Case Mix Index data, in 2007, the measured acuity of residents in nursing homes (both for- and non-profit) was 5% higher than in municipal homes. The staffing data shows that nursing homes are the lowest in actual hands-on staffing levels. Thus nursing homes not only have the lowest staffing levels but also have the highest acuity residents. (It should be noted that all homes receive funding increases for acuity.)
6. Since the new data shows paid hours only, actual worked hours will be lower than indicated here.

Harris-Era Deregulation Has Not Been Reversed

Ontario's long-term care lobby has achieved successes in deregulation, only some of which have been reversed. A partial list (see full report) includes:

- ELIMINATED – Requirement to provide a minimum 2.25 hours of care per resident per day in nursing homes. Eliminated by the Harris government. Not reinstated.
- ELIMINATED - Requirement in the Service Agreement to adhere to planned or budgeted levels of staffing. Eliminated by the Harris government.
- ELIMINATED - Requirement to increase the average staffing per resident as a condition for eligibility for new funding. Eliminated by the McGuinty government.
- COSTS SHIFTED TO INCREASE PROFITABILITY - The government allowed operators to move costs for incontinence supplies, moving, building cameras and surveillance equipment, and accommodation staff, from the accommodation envelope into the nursing and personal care envelope from which direct care staff is supposed to be funded. The accommodation envelope is the only funding envelope from which unspent monies can be taken for profit. The cost-shifting out of this envelope allows more room for profit-taking.

"My mom died in June. I was there every night for four years. I'd get home from work, grab a bite to eat and head to the nursing home. I'd be there from 6:30 to 9:30 to make sure that [mom] was getting care." (Family member, Toronto –2007)

Additional Recommendations:

Appropriate care settings, special care units, review downloading

The government must review the downloading of heavy-care and mental-health patients from hospitals. Special care units for those with cognitive impairment and behavioural problems must be provided and staffed appropriately. The movement of people into long term care homes should not be used as a tool to cut hospital costs, maximize bed occupancy to maximize funding or profit-taking by operators. We support homecare and a range of non-profit or public supportive housing options for people to choose their care setting, whenever possible.

Development of a Health Human Resource Strategy as a priority policy
It must be a policy priority to develop a health human resources plan to address the shortages for the long term. Such a plan must address the aging of the workforce, working conditions that contribute to turnover and recruitment problems in long term care homes.

Provide time and opportunities for staff to talk with residents for social and rehabilitation purposes, and recognize this activity as vital for quality of life for both residents and staff.
Long term care homes are all-too-frequently referred to as “warehouses” in recognition of the lack of care. The Ontario Health Coalition believes that the goals of care in nursing homes should be to improve the health and social conditions of residents as well as to provide quality end-of-life care.

Update the findings of the 2001 PriceWaterhouse Cooper’s Report into staffing and acuity levels in Ontario’s nursing homes as per the Coroner’s Jury Recommendations in the Casa Verde homicide.

This report should not replace nor delay immediate institution of regulated care standards as per our priority recommendation

> *“When the minister [of health] talks about quality of life, what does he mean? He is not paying attention to the faces of the people. Instead of experiencing a quality of life, they are experiencing a ‘wait for death.’”*
> *(Resident, Mississauga—2007)*

Who we are

The Ontario Health Coalition is a network of more than 400 grassroots community organizations representing virtually all areas of Ontario. We are the broadest public interest group on health care in Ontario. Our primary goal is to empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to health care and healthy communities. To this end, we seek to provide to member organizations and the broader public ongoing information about their health care system and its programs and services. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information. We are a non-partisan group committed to maintaining and enhancing our publicly-funded, publicly-administered health care system. We work to honour and strengthen the principles of the Canada Health Act. Our members include more than 50 local health coalitions

Ontario Health Coalition
15 Gervais Drive, Suite 305
Toronto, Ontario M3C 1Y8
tel: 416-441-2502
fax: 416-441-4073
email: ohc@sympatico.ca
www.ontariohealthcoalition.ca