Concerns regarding "Hours of care" in Continuing Care Facilities

"Hours of care" is a central issue of concern in both funding and care quality. Staffing costs are 70% of the operating costs of facilities, and staffing issues are the basis of most of the resident and family concerns about quality of care.

Both the Auditor General's 2005 Report on Seniors and the MLA Task Force Achieving Excellence report acknowledged staffing concerns, and the Minister of Health responded by announcing "increased hours of care". The increase, we were told, would be from the 1.9 hours in the 1985 Nursing Home Act regulations, to 3.1, 3.4, 3.6, and, by 2008, to 3.8[1] (or 4.1[2]). The initial increases to 3.1 and 3.4 did not appear to have much effect in the care facilities, and so we asked what "an hour of care" meant.

The Minister explained that the number was "*a measurement of paid hours of care* (which includes) *considerations such as vacation time, sick days and training time*".[3] Since clearly an "hour of care" does not mean 60 minutes during which care is being provided to residents, we made some further inquiries, and learned that:

- "Hours of care" is the primary "quality measure" required by AHW, since 2006.[1] Prior to that, the term "hours of care" was not used to describe services provided in long term care facilities.[4]
- "Paid hours of care" includes direct care time (during which care is provided to residents), indirect care time (non-resident specific duties, including training, meetings, and administrative duties), and time paid but not worked, provided by care staff (Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses, and/or Personal Care Aides) assigned to a unit or units.[5]
- In 2004, the Alberta Long Term Care Association reported that funding for 3.1 hours of care provided an actual 2.5 hours per resident per day.[6] Neither the Ministry nor the Regional Health Authorities have provided a similar description of the actual care time provided in an "hour of care".
- The current "blended jobs" staffing models for care staff include duties previously designated as "non-care" and not included in the "care services" funding, such as daily housekeeping and social/recreational activities. This, together with the high proportion of indirect care duties currently assigned to professional nursing staff, seriously erodes actual care time.[7]
- A similar ambiguity regarding hours worked/ paid hours exists with respect to "full time equivalent", used as an alternative workforce measure: AHW has variously

[1] Health Authority Accountability in Alberta's Health System (2006),
[2] AHW Guide to Health Authority Accountability Documents 2005
[3] Personal correspondence, April 26, 2006.
[4] Statistics Canada Residential Care Facilities 2003/2004 surveys collect data on care to residential facilities; the staff data requires number of staff employed and total paid hours, including holiday and other paid leave time. The survey definition specifically addresses the "expense" of care; the report distinguishes this from level of care, acknowledging that these two variables are closely linked. http://www.statcan.ca/english/freepub/83-237-XIE/83-237-XIE2006001.pdf http://www.statcan.ca/english/sdds/instrument/3210_Q1_V8_E.pdf
[5] Interview and correspondence with Capital Care Group and Capital Regional Health Authority,
[6] ALTCA Newsletter, Fall 2004 (Issue Two Volume Two)
[7] We note that a similar situation does not occur under the Child Care Regulation, where specifically qualified staff must be on duty to meet the required staff/children standards

defined an FTE as calculated from "*total number of hours worked*" [8] and from "*total paid hours*" [9].

The cost of benefits, including time paid but not worked, is a significant cost item for employers, and will change over time as collective agreements define new or increased benefits, affecting both the average time and the proportion of time for each employee category which is actually worked.

The 'hours of care' funding model and accountabilities distinguish the proportion of PCA/LPN/RN staff hours, which are not described by the reported average.

The number is an average for all care staff (for each facility, each RHA, and finally as a provincial average), and gives no information about unit or facility staffing numbers or competencies in relation to the number or care needs of the residents.

The facilities are not required to record or report actual time worked for the purpose of reporting delivery of care services.

The Alberta Employment Standards Code requires employers to record, detailed information and to provide that in writing to each employee at the end of each pay period.

There was no information available to us to clearly define the "1.90 paid hours" of care in the 1985 Nursing Act Regulation. In 1988, A New Vision of Long Term Care reported that average hours of nursing care worked per resident was "*average 1.65 worked hours*" in nursing homes, and "*3.6 paid hours (may go up to 4.0, based on specific conditions)*" in auxiliary hospitals.[10]

It is not at all clear that using a gross payroll calculation to define care time is an industry standard in Canada.[11]

The Canadian Institute of Health Information, which works to standardize data recording and reporting, confirms there is no standard definition for care time, and no requirement to report time spent by staff delivering care services.

The American federal regulations of publicly-funded care facilities are specific that the reported care time must be recorded by time actually worked by distinct caregiver classifications providing direct care specific to a resident or residents, and require daily posting in each unit of resident census, shift schedules and hours worked by staff classification.[12]

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[8] Health Authority Business Plan and Annual Report Requirements 2001 – 2004. The "Health Workforce Plan Template" on page 44 requires personnel counts as both "total Employee Count" and "total FTE".

[9] Multi-year Performance Agreement, 2003

[10] The Committee on Long Term Care for Senior Citizens, report to the Alberta Legislative Assembly; Table 10-1.

[11] The Task Force on Resident/Staff Ratio in Nursing Homes (2001, Nova Scotia) used a survey that distinguished between hours worked and hours paid; the report concluded that staffing data from several provinces, including Alberta, was not comparable, and included only data from Nova Scotia, Manitoba, New Brunswick and Newfoundland.
http://www.gov.ns.ca/heal/downloads/taskforce_report.pdf

[12] Federal Register / Vol. 70, No. 208 / Friday, October 28, 2005 / Rules and Regulations
http://www.nursinghome411.org/documents/finalnhstaffpostingrequirements.pdf and
http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/05-21278.htm

Department of Health and Human Services, Centers for Medicare & Medicaid Services, Form CMS-671 http://www.cms.hhs.gov/cmsforms/downloads/CMS671.pdf
The staff function definitions specifically separate resident assessment, reporting time, all housekeeping duties, and medication management oversight from direct care to residents.
See also http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter03-14.pdf ;
http://www.cms.hhs.gov/CertificationandComplianc/downloads/2005NHActionPlan.pdf

It is probable that the Alberta Long Term Care Association's recommendation to increase the hours of care to 4.0 hours of care per day[13] influenced the government's decision. It should be noted that the ALTCA recommendation was based on staffing recommendations from predominantly American studies[14], most of which used the OSCAR data, and a very different and specific definition of care hours. (see footnote 12.)

The Alberta Long Term Care Association calculates "hours of care" from confidential financial information provided by its members.[15]

There is no information available to report the basic care being provided to facility residents by family, volunteers, or staff paid privately by families to supplement the facility care.

There are several accountability issues in this situation:

1. "Hours of care" as defined is measure of staffing costs; it is misleading as a measure of the care actually being provided, even on average, to residents.
2. The average number of hours worked by total staff, even in a single facility, does not provide useful information about the care being provided. The context of care quality requires information about the number and the care levels of the unit residents, the numbers and competencies of the staff, and a distinction between direct care, indirect care, and other duties such as administration and supervision. (In contrast, home care data reports minutes of actual care by type of care provided (assessment, hands-on, and communication/consultation) and the qualification of the staff providing the care.)
3. The issue of appropriate and quality care is the central and most significant concern of the resident and his/her family or representative; any measure used to represent quality should be accurate, relevant, understandable, readily available, and audited.
4. Where a standard includes a specific detail of measure, such as the ratio of RN/RPN, LPN, and care aide staffing), the data reported should acknowledge that.[16]
5. Any changes in a definition of the measure (such as the inclusion of work duties previously assigned to a different accounting category, or the ratio of professional staff) should be clearly and publicly identified.

There are related questions arising from the increased hours of care and the funding provided for that purpose:

6. There was an indication in the Minister's statements in the Legislature[17] that an analysis of how the increased staffing was achieved by numbers of additional staff

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[13] ALTCA Response to the MLA Task Force, September 2005

[14] Residential Continuing-Care Facility Staffing: A Systematic Literature Review Donna Wilson RN, PhD. 2005; commissioned by the ALTCA

[15] Personal email correspondence, Dianne Nielsen, June 6, 2006

[16] Nursing Home Act Operation Regulation 258/85, 14 (5) and (6); relevant directives from AHW

[17] Alberta Hansard, March 1, 2006, Ms Evans: "*We will provide an analysis of how many staff were added, but I want to make clear that I will define it in two ways: the number of staff that we believe were added not so much as a result of the move to 3.4 hours of care per patient but equivalents so that we're comparing apples with apples and not just looking at the numbers that have been inflated because people have moved into long-term or continuing care residence. The other part, though, I should tell you is that in some cases dollars that were provided for long-term care were provided to increase the salary levels of people who were advanced either by merit or by some other agreement with their institution, so it not only provided more dollars for increasing the number of hours of staff care on that patient ratio but increased the number of dollars that individual providers received for the work they did interfacing on the front lines.*"

and by increased “hours of care” (FTEs); it will also be significant to report how direct care has been increased. That has not yet been provided.

7. The purpose of the funding and the increased paid hours was to improve the quality of care; there has been no indication of how achieving that purpose will be measured or reported. The relationship between funding, staffing and quality of care is complex, and cannot be measured simply by the cost of staffing.
8. The increase in “hours of care” coincides with an increase in administrative duties in respect of medications administration and the MDS assessment and reporting systems, and there has been no indication of how this will affect time available for actual hands-on care to residents.

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Attach: What’s in an hour of care?

## What's in an hour of care?

In a 2000 newsletter, the Bethany Care Society published a basic care schedule:

24 hour care schedule for a dependent resident (total, 205 minutes, 3.42 hours)

| | | |
|---|---|---|
| 30 minutes –morning: toilet, mouth care, wash, dressing | 15 minutes – help with lunch (again, 3 - 4 people) | 5 minutes – medication administration |
| 5 minutes – medications, 10 minutes – 2-person transfer into chair | 15 minutes – 2-person continence care or toilet, transfer /lift to bed for nap | 15 minutes – lift onto bed, 2-person continence care or toilet |
| 15 minutes –breakfast (each caregiver assisting at least 3 residents) | 10 minutes – check on resident several times; provide fluids, snacks | 15 minutes – bedtime mouth care, wash, make comfortable in bed |
| 15 minutes – assist with toileting (2-person transfer) | 10 minutes – 2-person transfer/lift to wheelchair | 10 minutes – late evening check and care |
| 10 minutes – help finish off getting ready for the day | 15 minutes –assistance with dinner | 10 minutes – nighttime care and comfort |

The article noted that a great many every-day needs (portering to a church service, going outside for a while, talking about family) weren't included; and the 3 hours of funded care were expected to include: care management ( physicians' medication orders, care conferences, care assessment and planning, calling family to update them on changes, charting, organizing appointments and transportation, etc.); clinical care and therapies (wound care, insulin, swallowing assessment, exercise/rehabilitation, recreation activity, social work support, pain; control, palliation and address unpredictable changes in clinical status); staff vacations, sick time, holidays and other leave.

This kind of routine care schedule is fairly common, based on "time-motion" studies of routine daily tasks for an "average" resident in actual time worked by a competent care-giver with no distractions or other responsibilities.[18] The discussion of appropriate "hours of care" is simply an academic exercise without the context of the care needs of the residents. Caring for impaired and ill people is not comparable to a controlled assembly-line process, with discrete and predictable manual tasks.[19]

[18] The Task Force on Resident/Staff Ratio in Nursing Homes (2001, Nova Scotia) http://www.gov.ns.ca/heal/downloads/taskforce_report.pdf

[19] Reclaiming Medicare Parkland Institute, 2002

http://www.ualberta.ca/~parkland/research/studies/index.html "Women's health policy expert Pat Armstrong of York University in Toronto is critical of reducing nursing work to countable tasks: A bath is reduced to a quick application of water to skin, and the way nurses use the bath to comfort, support, educate and assess disappear, as do the varied skills involved in getting the patients to co-operate and in lifting them without injury. Any time not spent directly on tasks is defined as wasted, not productive... (Armstrong, 2001: 136). She also points out that rigid formulae for length of hospital stay and maximum home care hours per day leave no room for professional judgement, a patient's condition, or the preferences of paid or unpaid caregivers. Colleen Flood of Dalhousie University's Health Law Institute in Halifax provides other examples of important quality of care indicators that are overlooked with a narrow administrative focus; for example, how long a patient is left in distress or in pain without help, how quickly a diagnosis or treatment is given to relieve anxiety, and whether providers respect the wishes of patients (Flood, 1999)."

Residents are not only older and more disabled today, but they are sicker. In 2003, over 75% of the residents were in the 3 (of 7) highest care needs categories; in 2004, care needs were up by 35% from 1990[20]. 75% have a diagnosis of dementia.[21] Most residents have complex medical conditions, and their health is unstable; change, whether a change in an existing condition or a new or secondary problem, can happen very quickly; the signs are sometimes subtle. In 1992, residents over the age of 65 had an average of 4.6 diagnoses of serious illness.[22]

In 2003, 92% of the residents were over the age of 65; 49% were over 85.[23] 75% have a diagnosis of dementia[24]. (Dementia is a set of disorders that involve declining intellectual ability, memory, judgment, social skills and control of emotions, caused by illness, strokes, trauma, and some medications.)

What kind of care do residents need?[25]

- 98% need assistance with eating (41% need constant assistance or feeding).
- 90% need assistance with dressing.
- 91% need assistance with transfers.
- 80% need assistance finding their way around the facility.
- 80% have urinary and bowel incontinence; 43% need 2-person assistance with toileting.
- 63% have impaired communications abilities.
- 40% resist care or treatment; 76% have other “behaviours requiring care”.
- 33% show aggressive or angry behaviours; 35% show agitated behaviours.

Most frequent medical diagnoses in 2005**[26]**:

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[20] Report of the Auditor General on Seniors Care and Programs, 2005 http://www.oag.ab.ca/html/2005%20Seniors%20Report.pdf

. Calgary Herald Aug 13, 1993: “*On average, Carewest long term care patients have more than 6 diagnosed problems each, such as heart failure, incontinence and other illnesses. As many as 50% of the patients have behavioral problems like dementia and other psychogeriatric problems.”* (Marlene Raasok, vice-president of operations for Carewest, says in an interview with the Herald.

Calgary Herald Feb 17, 2000: "Too often," John Murphy, a professor at Brown University said recently, "illnesses in older people are misdiagnosed, overlooked or dismissed as the normal process of aging, simply because health care professionals are not trained to recognize how diseases and drugs affect older people."

[21] Alberta Long Term Care Association Response to MLA Task Force Seniors Report, 2005. On file with author.

[22] Health Services Utilization in the Population Aged 65 and Older: Review of the Literature 1999 http://www.health.gov.ab.ca/key/01_report.pdf

[23] Alberta Health and Wellness, Alberta Resident Classification System for Long Term Care Facilities, Table E-2 for 2002/2003, http://www.health.gov.ab.ca/regions/e2-03.htm

Total residents assessed, 14, 449; this number does not coincide with the number reported above.

[24] Alberta Long Term Care Association Response to MLA Task Force Seniors Report, 2005 On file with author.

[25] Ontario Ministry of Health and Long-Term Care, 2005 Levels of Care Classification On file with author. Both the Alberta and Ontario governments use the Alberta resident information system, but the Alberta government does not report similar information from the data collected (Email, response to request for information, from Alberta Health and Wellness, February 2007)

| | |
|---|---|
| Mental problems (dementias, brain damage); | 66% |
| Circulatory diseases (heart, stroke, blood pressure) | 62% |
| Musculoskeletal problems (arthritis, bone degeneration, osteoporosis, contractures, fractures) | 52% |
| Endocrine & metabolic disorders (including diabetes) | 36% |
| Neurological motor dysfunction (cerebral vascular accidents, MS) | 35% |
| Sensory disorders (vision, hearing) | 21% |
| Digestive disorders | 18% |
| Pulmonary diseases | 15% |
| Genitourinary disorders | 10% |

Most residents need treatment of existing illness, monitoring for illness progression and new or secondary illnesses; mitigation of the effects of illness that cannot be cured and disabilities that limit function; and personal care to ensure safety, comfort and dignity. This requires skilled nursing services; rehabilitation therapies; attention to physical needs such as vision, hearing, oral hygiene and dental care, podiatry services, and exercise; competent and kind assistance with personal care needs – nutrition and hydration, dressing, toileting, maintenance exercise, bathing, emotional and social support.

It’s very easy to underestimate potential improvements in health, functioning, and well-being. Curative treatments are not always possible for underlying illness or damage; but, with adequate and appropriately skilled staffing, complications and secondary illness can often be prevented, and distress and dysfunction can be improved to attain or maintain the highest practicable level of health and well being[27].

There has been no assessment in Alberta of whether either the clinical or personal care being provided in the continuing care system or in the care facilities is adequate. Any

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[26] Ontario Ministry of Health and Long-Term Care, 2005 Levels of Care Classification On file with author. Comparable data is not available from Alberta Health and Wellness.

[27] Analysis of Interfaces Along the Continuum of Care Final Report: The Third Way: A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families, Hollander Analytical Services Ltd. for Health Canada 2002 http://www.hollanderanalytical.com/downloads/continuum-final.pdf “*. . . the goal of care is generally not to cure a disease or other medical condition, but rather to provide supports and services that reduce the rate at which individuals deteriorate (lose independence), optimize functioning, and provide them with the best possible quality of life* .”

Alberta Medical Association, Brief to the Long Term Care Review Policy Advisory Committee 1999
http://www.albertadoctors.org/ “*the primary objectives of our health care system, and all those who serve through it, should be quality patient care and a quality of life deemed acceptable by the patient.*”

The effectiveness of quality systems in nursing homes: a review Quality in Health Care 2001;10: 211-217 C Wagner et al; http://qshc.bmj.com/cgi/reprint/10/4/211 “*A long term care facility or a nursing home is an institution which provides nursing care 24 hours a day, assistance with the activities of daily living and mobility, psychosocial and personal care, paramedical care, and also a room and board for people whose health has deteriorated to such an extent that they need constant nursing care. The aim of nursing home care is to maintain the limited physical, mental, and social capabilities of residents for as long as possible. . . The ultimate goal of healthcare organisations is optimisation of the health status of individuals and populations . . . The quality of care is the degree to which (a) nursing homes increase the likelihood of desired health outcomes for residents, and (b) the care process is consistent with current professional knowledge.*”

discussion or assessment of appropriate "hours of care" needs to be considered in the context of the care needs of the residents and the desired outcomes of the care; until these assessments are done, any "hours of care" standard or measure is simply an arbitrary and meaningless number.

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