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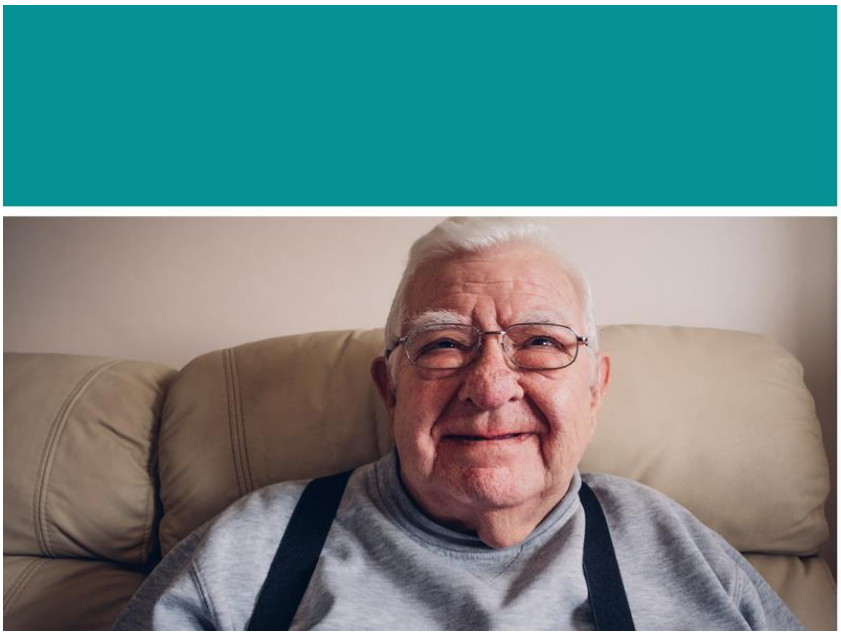
FIX RESIDENTIAL LONG-TERM CARE WORKERS' CONDITIONS OF WORK, TO IMPROVE CONDITIONS OF CARE



SUBMISSION TO THE NOVA SCOTIA EXPERT ADVISORY PANEL TO RECOMMEND IMPROVEMENTS IN LONG-TERM CARE

Respectfully submitted on behalf of CUPE Nova Scotia and the CUPE Long-Term Care Coordinating Committee:

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Executive Summary and Recommendations

CUPE Nova Scotia welcomes the opportunity to share our views and recommendations on improving quality of care in long-term care (LTC) for consideration by the Expert Advisory Panel convened to review this matter.[1]

Nova Scotia has an opportunity to become a leader in the delivery of high quality seniors' care by addressing a key determinant of care quality – a stable and adequately resourced team of care staff.

It is urgent and important that Nova Scotia get residential long-term care right. We have the highest percentage of the population aged 65 and older in Canada. The elderly population will only continue to grow as a share of our population: the first wave of baby boomers born in 1945 turned 73 this year.

Nova Scotia provides provincial funding to support a staffing minimum of 2.45 hours per resident day (hprd). This is inadequate, and CUPE has called on the Government of Nova Scotia to increase funding for CCAs to 3.1 hours per resident day effective immediately, so that the care standard can eventually be raised to 4.1 hours per resident per day.

In 2016 the Nova Scotia Government cut funding transfers to long-term care by 1%, making an already poor staffing problem worse. This came on top of cuts to transfers to most LTC facilities in 2015. The system is in crisis and must be funded properly.

In a 2018 survey of 677 CUPE Members carried out by the Long-Term Care Coordinating Committee, we found 95% of residential long-term care workers have been affected by working short. Seventy-five per cent of workers said they work short either daily or weekly (37% daily, 37.5% weekly). The result is that CUPE continuing care assistants, LPNs and other workers do not have enough time to adequately meet the needs of residents.

Inadequate staffing levels exacerbate high rates of musculoskeletal injury and resident-on-worker aggression. This has resulted in the astounding fact that workers in the Nova Scotia's LTC sector have the highest injury rate of any workforce sector in the province, and four (4) times the provincial average. Although workers in the home care, long-term care and disability support program account for only 7% of total provincial assessable payroll, they make up 22% of workers' compensation time loss claims.[2]

When long-term care workers are off work, it takes an average of 30% longer for them to return to work when compared to all employees in Nova Scotia.[3] This comes with significant social costs to seniors and care workers, as well as a financial cost to employers through higher WCB Nova Scotia premiums.

Based on the academic research and the experience of CUPE members, it is clear that the conditions of work are the conditions of care. Therefore, by increasing staffing levels

and improving working conditions, the Nova Scotia government will significantly improve the quality of seniors' care.

The Nova Scotia government should adopt promising practices from other jurisdictions, and the experience in Nordic long-term care facilities is particularly compelling. Generally, in Nordic countries, a greater share of GDP is spent on LTC, resulting in higher staffing levels and better individualized resident care.

Establishing legislated minimum staffing levels plus enhanced staffing based on higher levels of acuity is long overdue. These legislated standards must be enforceable through strong accountability measures including robust reporting requirements and regular monitoring and audits.

In summary, CUPE Nova Scotia offers the following recommendations for the Expert Advisory Panel for a plan of action by the Nova Scotia government:

1. *Conduct a comprehensive review, involving leading health policy and long-term care experts, and key stakeholders, to establish an appropriate legislated minimum staffing level for CCAs, and all members of the care team that is necessary to provide quality care. Such a review should:*

    - *Examine acuity levels and their variance by facility characteristics and ownership type across the province and consider enhanced staffing levels in relation to acuity*

    - *Examine how to enhance and implement person-centered and relational care models in publicly funded LTC facilities*

    - *Develop a model of care to respond to the increasingly complex needs of clients living with cognitive impairment and significant behavioral and psychological symptoms*

    - *Examine and recommend a funding formula and accountability measures for LTC operators*

    - *Recommend measures to increase financial accountability, and*

    - *Compare the difference between public, non-profit and private for-profit facilities on working conditions and quality of care.*

2. *As an urgent interim measure before an appropriate legislated level is determined, immediately increase funding so all publicly funded LTC facilities reach a minimum staff funding for CCAs of 3.1 hprd. This immediate staffing increase should be supported by new funding to the health authority and include:*

- *Recruitment of more continuing care assistants, and other members of the care team*

- *Reinstatement of the financial support for CCA program students at a Nova Scotia public institution ($5,000 bursary) cancelled in 2013 and a new financial support program of grants for study.*

- *Accountability requirements to ensure new funding is directly applied to care*

- *Standardization of the calculation, collection, and reporting of staffing levels, and*

- *Standardization of musculoskeletal and violence prevention programs including training across employers.*

3. *The collection of data and create a seniors' advocate:*

    - *Require the health authority to track and report staff turnover and retention, contracting out, the number of public, non-profit and private for-profit beds and other data necessary to enhance evidence-based decision making*, and

    - *Create a Nova Scotia Seniors' Advocate to monitor and analyze seniors' services and issues and make recommendations to government and service providers to address systemic issues.*

Introduction

The Canadian Union of Public Employees (CUPE) represents residential long-term care workers in every province. Collectively we represent more residential long-term care workers than any other union - approximately 60,000 members – and between 90-95% are women. Our members work in public, non-profit and private facilities, delivering services like nursing, personal care, dietary, cleaning, trades, and more.

In Nova Scotia, CUPE is the leading union in the residential long-term care sector, representing 4800 members at 45 facilities. Our members work in residential care as continuing care assistants, LPNs, dietary workers, cleaners, facility maintenance, administration, physiotherapy, recreation programming, as well most other work classifications in the sector.[4]

Province-wide, while long-term care is the largest portion of our membership, CUPE Nova Scotia represents a total of 18,000 working women and men employed throughout the public sector.

Our members demonstrate an unwavering commitment to the residents they work with. They entered the field to enhance the lives of seniors and these workers derive great satisfaction when they are able to do that. Increasingly though, stories of insufficient

numbers of staff resulting in an inability to meet even the basic needs of residents, have become common.

Inadequate staffing levels coupled with higher acuity rates compound this situation. CUPE members face unmanageable workloads and regularly go home feeling distressed from being constrained from delivering the kind of care they want to provide.

Furthermore, inadequate staffing levels exacerbate high rates of musculoskeletal injury and resident-on-worker aggression. This has resulted in the astounding fact that workers in the Nova Scotia's LTC sector have the highest injury rate of any workforce sector in the province, and four times the provincial average. Although workers in the home care, long-term care and disability support program account for only 7% of total provincial assessable payroll, they make up 22% of workers' compensation time loss claims.[5]

CUPE has been working with its members, other unions, health and safety agencies, academics, and community organizations across Canada for many decades to establish improved care for seniors. We published our report "CUPE's Vision for Residential Long-Term Care" in 2009.[6]

We believe a robust review of staffing levels is necessary. Stakeholders and experts must be engaged not only to determine an appropriate minimum legislated staffing level, but also to establish what a quality resident-focused model of care looks like.

A mandated staffing level is only effective to the extent that care facility operators will be held accountable to implement it. Reporting methods for staffing, clinical accountability as well as financial accountability are currently lacking and need to be improved upon if the Department of Health and Wellness intend to enforce staffing levels.

Our union welcomes the opportunity to participate in the review process and assist in developing staffing levels that result in the delivery of appropriate and quality care. The ensuing discussion and recommendations are limited in scope to the most pressing issues touching on staffing levels.

Should a broader review be undertaken, CUPE will have more recommendations on related aspects of care delivery including the role of support staff in LTC facilities.

What does good care look like?

Quality care is built on relationships

The work of caregiving is intimate. Seniors are bathed, toileted, fed, and groomed by their care staff in their last years. They share their fondest and their darkest memories with staff. They are held and consoled by their caregivers in their final hours. These are

acts that would have most people receiving them, feeling potentially vulnerable, somewhat powerless, and understandably apprehensive. It is relationships of mutual trust, dignity, and respect that help to mitigate vulnerability, but these types of relationships can only be created when there is ample time and space permitted to form them.

In Nova Scotia and most of the North American context, caregiving in long-term care homes has become focused on the physical and medical aspects of residents' health. The term 'warehousing' has come to be used to refer to an assembly line approach to ensuring that seniors have a roof over their head and have their basic physical needs attended to. Facilities are institutional in appearance, house large numbers of residents, and are typically unable to accommodate much diversion from an established schedule of care to suit individual wants and needs.

Promising practices

Looking to Nordic care homes by way of comparison, an alternative experience and greater possibilities for the last years of life are made evident. Scandinavian facilities are typically more home-like than hospital-like. Facilities are smaller. In Denmark and Sweden, almost all seniors have their own room or small apartment. As of 2005/2006, Swedish facilities housed 34 residents on average, while Canadian facilities housed 96.[7]

A scene described by Banerjee and Braedley in *Promising Practices in Long Term Care* details the authors' visit to a Swedish facility. The facility was large for Sweden but divided into units of nine, capitalizing on economies of scale while still personalizing the space and care. The home was a non-profit and thus able to be attached to a charitable foundation. Money generated through the foundation was used to hire additional staff exceeding the numbers stipulated by the home's funder. Workers had time to get to know the residents and their interactions were usually unhurried. Each unit had a complete kitchen. This feature allowed residents to wake and eat when they wished. A nursing assistant put simple breakfast ingredients out on a tray and assisted residents as needed to prepare their meals.

Staffing is such that two nursing assistants were able to spend half or more of their shifts planning activities for the seniors. There was time to discuss resident care among the staff throughout the day and even time for special touches like baking. Each resident was attached to a designated contact, who was usually a nursing assistant who got to know the resident's needs and advocated for them.[8]

Staffing ratios are key to providing the type of care Swedish facilities offer. Sweden spends 2.07 per cent of its gross domestic product on residential eldercare as compared to Canada which spends 1.06 per cent.[9] The hours per resident per day (hprd) for direct care (equivalent of RN, LPN and Care Aide) is 5.2[10] compared to Nova Scotia's funding guideline of 2.45.

Staff care for residents is carried out in a manner that addresses both their physical needs and social needs. The care team is comprised of the equivalent of Licensed Practical Nurses (LPNs) and CCAs with fewer Registered Nurses (RNs) than what are utilized in the Canadian staff mix. The division of duties is less rigid and less hierarchical with the work days of Continuing Care Assistants and LPN equivalents looking very similar.

Both engage in the physical 'bodywork' of caregiving but also do the activity planning. Daly and Szebehely analyzed survey data that found Swedish care workers are more often able to give social care, reporting they are more frequently able to have coffee with a resident or run an errand with them outside of the facility. The number of residents Swedish workers reported helping in a typical day was 8.8, a stark contrast to the 19.9 reported by their Canadian counterparts.[11]

While Canada has fewer facilities utilizing practices as promising as those found in the Scandinavian countries, they do exist here. Ruth Lowndes lists components that supported the quality care offered at a Manitoba facility that provided the basis for her case study, also in *Promising Practices in Long Term Care*. They include management's strong vision of 'resident first' care, staff being empowered to work autonomously, stable, permanent employment with good working conditions, and permanent shifts and units facilitating continuity of care.[12]

Inadequate staffing and working short

Impact of staffing levels on seniors

Conditions at all long-term care facilities in Nova Scotia might not have met all of the criteria Ruth Lowndes outlines, but there was a time in the not so distant past that staff were able to do more for their residents.

There is a clear reason for this. Funding has not kept up with need. In 2016 the Nova Scotia Government cut funding transfers to long-term care by 1%, making an already poor staffing problem worse. This came on top of cuts to transfers to most homes in 2015.

Our members are the first to acknowledge care in Nova Scotia's long-term care facilities is getting worse for seniors. Those which are more seasoned recall earlier years in their career with pride. They typically worked with lower acuity residents and speak about having had time in their schedule to talk with residents, to assist their residents with walking to keep them ambulatory, and to help their residents with styling hair and similar grooming which impacts residents' self-esteem.

The seniors entering care today are indeed older, less physically independent and closer to the end of life.[13] This places greater demands on staff. More hours of care are

required to complete basic care routines, comfort or reassure someone who may be confused, agitated or afraid, or toilet residents in a timely manner.

Working Short

The constant short staffing care workers face:

- as a result of non-replacement of employees who are off sick, on vacation, or
- simply due to structural inadequate levels of staffing.

Regardless of the direct cause, working short creates major quality of care issues for employees and results in burn-out and retention problems.

Staffing shortages are directly related to the inadequate time to care that our members are grappling with, which leads to extremely stressful working conditions. Working short, when coupled with mandatory overtime, acts as a one-two punch that leads to staff burnout, issues with retention and greater rates of injury.

In 2018, CUPE's Long-Term Care Coordinating Committee sent out surveys to members on their experience with working short. We received 677 valid survey responses.

What we found was disturbing:

- 95% of our members have been personally affected by working short
- 37% of our members work short <u>every day</u>, and 37.5% work short at least once a week
- 61% of our members responded that their facility was affected by staff shortages daily, and another 27% responded that their facility was affected weekly
- More than half of CUPE's LTC members (52%) have been mandated to work beyond their regularly scheduled hours
- For 10% of members mandated overtime happens either daily or weekly
- Unscheduled, but not mandated overtime is experienced by 25% of our members at least one a week
- The longest duration our members have ever stayed at work was on average 18 hours
- However, one member responded that she had once stayed at work for 61 hours!

Such long shifts are clearly not in the interest of workers or clients.

We know this is a vicious circle, where workers get injured or burned out from the heavy workload. With additional workers off sick and very few facilities working with a pool of

casual workers to fill vacancies means that workers will again experience staff shortages, and workers get injured or burnt out.

Impacts of staffing levels on care workers

CCAs and LPNs are an older, predominantly female workforce. Burnout is a key impact of low staffing on this workforce. The environmental factors that precipitate burnout such as frequent exposure to dementia-related responsive behaviours, high workload, high acuity of residents, and little time to perform tasks for residents were all present in the Estabrooks study.[14]

Their reported job efficacy however was unusually high, that is, they felt strongly that their work was meaningful and with purpose. This combination seems especially hazardous to women who face enormous pressure to adopt caregiving and nurturing as significant aspects of their gendered roles, and who in turn come to measure their own value as a person by their ability to provide these things to others.

In our experience, as backed up by the survey response from Nova Scotia CUPE LTC members, the care team routinely works short staffed. Failure to replace workers for vacations and sick time has become the norm. Added to the stress and extra work of being short-staffed, mandatory overtime and the inability to get approval for vacation or leave is common.

Recruitment and Retention

Our members experience critical staff shortages in every occupational category, undermining teamwork for care.

It is very difficult to recruit to a sector where the pay is poor, there is mandatory overtime, the work is challenging, and you are unlikely to ever get your requested vacation time off in the summer until you have earned enough seniority. Our members used to enthusiastically recommend their profession to younger relatives and neighbors. Sadly, this is no longer the case.

For this situation to change the underlying issues must be resolved.

First and foremost, pay and related benefits must be raised and to reinstate LTC work as a ‘good job’ in all regions of the province.

Workers must be treated with respect by managers and by the government. The last five years have seen new lows in labour relations in Nova Scotia. Cuts to government funding, imposed contracts and stalled collective bargaining have increased tensions and soured relations in nearly every home in the province. Treating the workers who provide the care for LTC residents poorly is not a starting point for high quality care.

Facilities should be required to report publicly on staff turnover and retention rates. Badly managed facilities or other factors that lead to staff leaving at higher than average rates can be highlighted.

It is clear to all that staff shortages will increase dramatically in the near future This is a direct result of many older workers nearing retirement and because those currently employed have been working hard to overcome gaps in care, a pattern that is less likely in the future.

It is therefore necessary the government take aggressive action to attract new workers to the sector. CUPE strongly recommends the Government reinstate the $5,000 bursary for CCA tuition that was cut in 2013.

The Government should go further by providing study grants in addition to bursaries as an incentive to attract students. The high cost of tuition, books and taking the time off to study is a real barrier for Nova Scotians.

CUPE Nova Scotia argues with an increase in pay and benefits, and supports to recruit and support students, we can find most of the future long-term care workers necessary to fill spots and to compete with other sectors of the economy for workers. With the correct level of support, it would also help encourage low income Nova Scotians to enter the workforce by removing a significant barrier.

We know employers have argued that the only way to recruit an adequate workforce is through temporary migrant workers and increased immigration.

CUPE does not oppose labour migration to Canada if, after fixing the underlying issues with barriers to education, training and poor compensation, and overwork, there still remains a shortage of workers. If Nova Scotia finds it needs to bring in immigrant labour to assist in staffing LTC, we advocate for <u>permanent</u> immigration which allows for workers to put down roots and bring their children and family members with them.

Whether migrant workers are temporary or permanent has not been a concern for employers in the sector. Employers' proposals for increased recruitment of <u>temporary</u> migrant workers will negatively affect the quality of care. Not because the workers are from overseas or that they are not 'as good' as Canadians – but because temporary or agency workers inserted into the care team mix has the impact of increasing turnover within the team.

Furthermore, in our experience migrant workers fill LPN and RN positions more than CCA positions. Workers may start in a CCA position, but they are simply biding their time until they get licensed in Nova Scotia and move on as quickly as possible to the higher paid nursing positions. This dynamic does not lead to stable staffing and adds to turnover.

High turnover and low retention in staffing are relevant because they obstruct the delivery of quality care. Studies have consistently offered evidence that high turnover is associated with poor quality of care.[15] One large U.S. study (8,023 nursing homes) found less use of restraints, catheters and fewer pressure sores in homes with less turnover (when staff stayed 5 years or more).[16]

Another study that looked at over 5,000 facilities in the U.S. saw a strong relationship between nursing assistant retention (U.S. equivalent to CCAs) and whether a facility fell into the worst 10 per cent of those studied for quality measures.[17]

As noted previously, for most seniors in care, the nature of the assistance they depend on means that they require familiarity and relationships with their caregivers. This is of even greater importance when working with seniors with dementia, which is three in five residents in care facilities.[18] The Alzheimer's Society of Canada promotes consistency of staff assignments as a best practice in providing dementia care.[19]

Pamela Ramage-Morin's examination of factors influencing seniors' self-perception of health found that social network and social involvement were not surprisingly, influential. Seniors in institutions who reported being close to one staff member had higher odds of having positive self-perceived health.[20]

The quality of relationship that comes with continuity of care is well established as being critical and aids caregivers to learn about a residents' preferences, triggers, and typical state of health. The more information that is available, the better. The ongoing connection between a caregiver and resident also reduces the confusion and heightened agitation that can accompany change for these seniors.

Reasonable workloads, fair compensation, open communication, respectful management, and a stable sector all factor heavily in maintaining cohesive, consistent care teams, and quality care conditions.

Mental and emotional impact

The work of caregiving is emotionally and mentally draining. In addition to the sheer volume of work, the nature of the job is taxing. It requires skilled and constant communication in a high-pressure environment. Deep attachments are formed, and the care team grieves these relationships regularly when the residents they have cared for, die. It is a regular part of the job but there is no support or space offered to deal with this grief.

Workers feel inadequate when they are unable to deliver the care, they feel seniors deserve. Almost 40 per cent of Canadian personal support workers/care aides/continuing care assistants reported feeling inadequate all or most of the time. Seventeen per cent said that work almost always kept them awake at night.[21] In another worker's words, "I feel such guilt for not being able to do more, [I] see my co-workers

stressed and irritated as they try and meet basic needs of people they care about. We are constantly being asked to do more, without additional staff. This is putting everyone at risk."[22]

Physical injuries and related impacts

> **"**If you work in home care, long term care or DSP [disability support program] sector, you are more likely to be injured on the job than most other kinds of worker in Nova Scotia. The wide range of workplace environments, diversity of clients and spectrum of their needs makes this sector one of the most complex occupational health and safety landscapes".[23]

There is a simple and inescapable fact: **without healthy long-term care workers providing care, there is no quality care.**

Although the overwhelming majority of research in the area of staffing ratios focuses on the positive relationship between higher staffing levels and resident outcomes, important observations are made also concerning the relationship between workplace safety and improved work environments and greater staffing levels.[24]

Most injuries fall into the category of over-exertion from patient handling.[25] CCAs are the group most likely to experience musculoskeletal injuries (MSI) such as back and shoulder strains because they perform the bulk of the work that involves moving and handling patients.

Inadequate staffing levels exacerbate high rates of musculoskeletal injury and resident-on-worker aggression. This has resulted in the astounding fact that workers in the Nova Scotia's LTC sector have the highest injury rate of any workforce sector in the province, and four times the provincial average. Although workers in the home care, long-term care and disability support program account for only 7% of total provincial assessable payroll, they make up 22% of workers' compensation time loss claims.[26]

And when long-term care workers are off work, it takes an average of 30% longer for them to return to work when compared to all employees in Nova Scotia.[27] This comes with significant social costs to seniors and care workers, as well as a financial cost to employers who pay more than $30 million in higher WCB Nova Scotia premiums annually.[28]

In 2016, work-related injury or illness resulted in the equivalent of 320 full-time home care, long term care and DSP workers being absent from work for a full year.

In 2017, the number of equivalent full-time employees lost to injury in just the long-term care sector in Nova Scotia increased by more than 10% from the year before: from 177 FTEs (2016) to 186 FTEs (2017). The steadily increasing injury rates are reflected in soaring WCB premiums for the LTC sector, which increased by 50% between 2009 and 2015.[29]

A collaborative Workplace Safety report was clear on the impact of staffing shortages in creating additional problems for the sector:

> A key finding from both the research and stakeholder consultations is that the current rate of workplace injury is having a major impact on staffing shortages. Home care, long term care and DSP workplaces are in a vicious cycle where injured workers are off the job and leaving the employer short-staffed, which in turn puts those remaining workers at higher risk of injury themselves.[30]

Musculoskeletal injuries are responsible for the majority of time-loss claims in LTC (83%), followed by slips, trips and falls (13%).[31] However, workplace violence was listed as the third highest reason for time-loss at (8%). It is to the impact on quality of care of workplace violence that we now turn.

Workplace violence

One of the most significant areas in which a correlation between increased staffing and workplace safety is found relates to resident-to-staff violence. The majority of this kind of violence happens during direct care, such as bathing, feeding and toileting.

The research has found organizational conditions provide an important context for resident-to-staff violence – most notably, when staff have insufficient time, low autonomy and there is inadequate staffing – violence is more likely to occur.

A British Columbia study by WorkSafeBC and partners compared high injury rate facilities (HIRFs) and low injury rate facilities (LIRFs), examining the relationship between both MSI and violence-related injuries, and risk factors including workload, and staffing levels. The research included ergonomic indicators of physical workloads which demonstrated higher spine compression, strongly correlated with low back pain, among care staff at the HIRFs.[32] The relationship between staffing levels and injury rates was significant with HIRFs averaging 16:1 residents to staff compared with 12:1 residents to staff at LIRFs (average day shift across all units).[33]

These findings echo research carried out with continuing care assistants in the long-term care sector across Canada which found 43 per cent of CCAs experienced physical violence “by a resident or their relative” on a daily basis and 23 per cent on a weekly basis.[34] Verbal violence including racial slurs were found to be common.

Unwanted sexual attention was experienced on a daily or weekly basis by one third of care staff surveyed.[35] This unwanted attention took the form of sexist comments but also sexual violence from male residents toward female CCAs in the form of groping or in some instance, attempted assaults while the care aide was bathing or showering residents.

It is also important to note it has been estimated that no more than 15 per cent of violent incidents can be viewed as random or unexpected attacks. Evidence shows the majority of violent incidents occur at the point of care, where staff are in direct contact with a patient, resident or client.[36]

Given the potential for violence that exists in the provision of personal care, it is necessary for members of the care team to have established familiar, trusting relationships with those they are assisting. Inadequate staffing levels obstruct relationship building by preventing the care team from having the time they need to provide respectful, safe and dignified care. The lack of staff and time is a significant contributory factor in triggering aggression on the part of frustrated, sometimes frightened residents. In other words, given sufficient time within a shift, many of the situations and conditions which trigger aggressive behaviours could be anticipated and reduced, if not prevented altogether.

The impact of violence on care staff comes at a high cost and cannot be underestimated. Violent incidents can leave staff demoralized, traumatized, anxious and exhausted. It is not uncommon for those who have experienced a violent incident to internalize trepidation, fear, and diminished confidence which compromise their ability to provide quality care going forward.

Recommended minimum staffing levels

Continuing care assistants and the whole care team need the time to care – the current Government hprd for CCAs of 2.45 is seriously inadequate.

CUPE has formerly tabled a proposal with the Government to raise CCA funded hours per resident day to 3.1 as a minimum staffing level, provided it is fully funded and mandated in regulations, and it is based not on paid hours, but hours worked. Paid hours are about 14% more than actual hours worked when holidays, sick time and breaks are taken into account.

These minimum requirements must apply only to direct personal and nursing care as provided by CCAs, LPNs, and RNs, with additional funding to be made available for activities and rehabilitation. The recommendation of a minimum requirement of 3.1 hprd for CCA staffing is for ‘old build’ homes.

Additional staffing must be factored in to the minimum requirements for ‘new build’ homes where CCAs take on additional responsibilities that make demands on their time. In homes where CCAs are preparing food, cleaning and carrying out additional duties, we submit that the minimum staffing level should be set at 4.0 hprd for CCAs.

Proper staffing is a necessary starting point for all quality care: proper wound care, patient and worker safety, and the protection of vulnerable persons.

A CUPE Manitoba Report in 2015 found important examples of the relationship between staffing levels and quality of care and resident outcomes:

- Residents who received 45 minutes or more of direct care per day from licensed practical nurses were 42 per cent less likely to develop pressure ulcers than residents who received less care.

- Residents who received three or more care aide hours per resident day (hprd) had a 17 per cent lower risk of weight loss compared to residents who received less care.

- Residents living in higher-staffed facilities spent less time in bed, experience more social engagement, and consumed more food and fluids than residents in lower-staffed facilities.

- Residents living in facilities with higher care aide staffing levels were more likely to be involved in a scheduled toileting program, receive active or passive range of motion training, and receive rehabilitative training for such things as walking, getting out of bed, and moving around.

- Residents had better nutrition and hydration when CCAs could focus on helping to feed or assist no more than two or three residents at mealtime. With less care, residents were more likely to cough and choke during meals and lose weight due to insufficient food intake.

- CCA staffing below two hours per resident day was associated with roughly a four-fold increase in the likelihood of high hospitalization rates for a range of avoidable health problems, including urinary tract infections, electrolyte imbalances, and sepsis. When CCA time fell below 2 hprd, 32 per cent of residents developed pressure ulcers.

- The social-emotional aspects of care are the first to be cut when workloads are heavy, and residents' quality of life suffers. Meaningful activities and positive relationships are particularly important for residents with dementia.

Appropriate staffing levels are critical in helping to prevent injury to workers, preventing poor health outcomes for residents and improving the quality of life for seniors and quality of working conditions for care staff. Establishing the precise levels that are 'appropriate' is a labour intensive research process.

Staffing levels of CCAs specifically, where they fall below 2.04-2.06 hours per resident day (hprd), have been associated with a four times higher likelihood of high hospitalization rates for LTC residents.[37]

Horne et al. found that residents who received 2.25 hprd of continuing care assistant time were 41 per cent less likely to develop pressure ulcers than those receiving less

than 2.25 hprd.[38] In a comparison of 21 care homes, Schnelle et al. found that the facilities with the highest staffing levels performed better in 13 of 16 outcomes.[39] The study found that:

- Residents at high staffed facilities received a greater number of walking assists and had greater ability to bear weight

- Residents received seven minutes on average of feeding assistance compared to low staffed facilities in which they received 2.5

- Thirty-one per cent of residents responded yes to having to wait too long for toileting assists in high staffed facilities compared to 49 per cent at low staffed homes.[40]

The connection between staffing levels and care is clear.

There are no Canadian studies that attempt to establish the level of nurse (RN, LPN, and care aide) staffing levels required to maintain or improve quality of care/health outcomes. Two notable studies conducted in the U.S. however, have made recommendations.

A review of On-Line Survey, Certification and Reporting System data for all certified nursing homes in the United States used regression analysis to examine the relationship between staffing hours, nursing home deficiencies and quality of care and quality of life issues. Fewer Nursing Assistant hours were associated with greater deficiencies and poorer outcomes for measures of quality of care and quality of life. Harrington et al. recommended a total *minimum* of 4.55 hprd, adjusting upward for acuity and with continuing care assistants constituting 2.7 of the hprd.[41]

And in what is considered the most comprehensive study on this matter, commissioned by the US Congress, the Center for Medicaid and Medicare Services (CMS) concluded that a minimum level of 4.1 hprd was necessary to avoid deterioration of health in residents and 4.55 to improve outcomes. It looked at data from over 5000 facilities across 10 states. The study utilized regression analysis of empirical data and a simulation analysis on nurse aide time (equivalent of Canadian CCAs) reviewing 5 key activities in addition to routine care: 1) dressing/grooming, independence enhancement 2) exercise 3) feeding-assistance, 4) changing wet clothes and repositioning residents and 5) toileting and repositioning residents.

<u>The staffing levels required of CCAs *alone* as a necessary condition for optimal care was determined to be between 2.8 and 3.2 hprd with the variation being dependent on staff's workload related to the acuity of a specific facility's residents.[42]</u>

It must be noted this study was carried out in 2001. Acuity levels of residents entering long-term care have risen significantly since that time, with residents currently entering

North American facilities at later stages in their lives, with more complex care needs, and with increasing incidents of cognitive disorders such as dementia.

Therefore, our recommendation of 3.1 hprd for 'old builds' and 4.0 hprd for 'new builds' falls in line with the most comprehensive research to date, and if anything, may be too low to achieve the best outcomes for care.

Conclusion and recommendations

CUPE NOVA SCOTIA appreciates the opportunity to provide the perspective of front-line staff on the challenges Nova Scotia currently faces in the provision of high-quality long-term care services.

We have proceeded in this submission to make the argument that our working conditions are the residents' care conditions.

Workplace violence or retention of experienced staff may not appear directly relevant to care conditions at first blush. But, to those who have worked in a care facility know how important these things are to get right. And the research backs it up.

CUPE NOVA SCOTIA makes the following recommendations to the Expert Advisory Panel on Improving Quality in Residential Long-Term Care:

1. *Conduct a comprehensive review, involving leading health policy and long-term care experts, and key stakeholders, to establish an appropriate legislated minimum staffing level for CCAs, and all members of the care team that is necessary to provide quality care. Such a review should:*

    - *Examine acuity levels and their variance by facility characteristics and ownership type across the province and consider enhanced staffing levels in relation to acuity*

    - *Examine how to enhance and implement person-centered and relational care models in publicly funded LTC facilities*

    - *Develop a model of care to respond to the increasingly complex needs of clients living with cognitive impairment and significant behavioral and psychological symptoms*

    - *Examine and recommend a funding formula and accountability measures for LTC operators*

    - *Recommend measures to increase financial accountability, and*

    - *Compare the difference between public, non-profit and private for-profit facilities on working conditions and quality of care.*

2. *As an urgent interim measure before an appropriate legislated level is determined, immediately increase funding so all publicly funded LTC facilities reach a minimum staff funding for CCAs of 3.1 hprd. This immediate staffing increase should be supported by new funding to the health authority and include:*

   - *Recruitment of more continuing care assistants, and other members of the care team*

   - *Reinstatement of the financial support for CCA program students at a Nova Scotia public institution ($5,000 bursary) cancelled in 2013 and a new financial support program of grants for study.*

   - *Accountability requirements to ensure new funding is directly applied to care*

   - *Standardization of the calculation, collection, and reporting of staffing levels, and*

   - *Standardization of musculoskeletal and violence prevention programs including training across employers.*

3. *The collection of data and create a seniors' advocate:*

   - *Require the health authority to track and report staff turnover and retention, contracting out, the number of public, non-profit and private for-profit beds and other data necessary to enhance evidence-based decision making*, and

   - *Create a Nova Scotia Seniors' Advocate to monitor and analyze seniors' services and issues and make recommendations to government and service providers to address systemic issues.*

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Endnotes

[1] CUPE NOVA SCOTIA acknowledges and credits to CUPE and HEU researchers across the country who contributed research material and briefs from which this submission has drawn. As a national union that represents the largest number of health care workers (170,000+) across all classifications, from nursing, continuing care assistants, technicians, dietary, administration, physical plant and maintenance, cleaning, transcription, EMS and many more classifications, we draw on the experience and expertise of our members from every province.

We would particularly like to thank and acknowledge the work of CUPE's Health Care Division in British Columbia – The Hospital Workers' Union – for sharing their brief with us which forms much of the basis of this submission and from which we have reproduced sections for the Expert Advisory Panel's consideration. All mistakes and omissions remain with CUPE Atlantic.

[2] *Workplace Safety for Nova Scotia's Home Care, Long-Term Care and Disability Support Sectors.* Multi-stakeholder Report, Nova Scotia, 2018, p. 11 Accessible at: *https://wcb.ns.ca/Portals/wcb/Workplace_Safety_Report_Final_June7.pdf*

[3] Ibid.

[4] With the exception of RNs, and most LPNs, represented by NSNU.

[5] *Workplace* Safety, p. 11.

[6] Accessible at: cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf

[7] Tamara Daly and Marta Szebehely, "Unheard Voices, Unmapped Terrain: Care work in long-term residential care for older people in Canada and Sweden," *International Journal of Social Welfare* 21 2012, 139.

[8] Albert Banerjee and Susan Braedley. "*Promising Practices in Long Term Care: Ideas Worth Sharing*, eds. Donna Baines and Pat Armstrong. , *Sweden:Big City* (Ottawa: CCPA, 2015/2016), 60-62.

[9] Daly and Szebeheley, "Unheard Voices, Unmapped Terrain", 140.

[10] Pat Armstrong et al., eds., They Deserve Better: The long-term care experience in Canada and Scandinavia (Ottawa: Canadian Centre for Policy Alternatives, 2009), 55.

[11] Daly and Szebehely, "Unheard Voices, Unmapped Terrain", 141-143.

[12] Ruth Lowndes, "*Promising Practices in Long Term Care: Ideas Worth Sharing*, eds. Donna Baines and Pat Armstrong, (Ottawa: CCPA, 2015/2016), 41-43.

[13] Margaret J. McGregor et al., *Trends in long-term care staffing by facility ownership in British Columbia, 1996 to 2006* (Statistics Canada, Catalogue no. 82-002XPE Health Reports Vol 2, no. 4, 2010).

[14] Carole A. Estabrooks et al., "Who is Looking After Mom and Dad? Unregulated Workers in Canadian Long-Term Care Homes" *Canadian Journal on Aging*, 34, no. 1 (2015): 54.

[15] Nicholas G. Castle and Ruth A. Anderson. "Caregiver Staffing in Nursing Homes and their Influence on Quality of Care," *Medical Care* 49, no.6 (June 2011): 546.

[16] Nicholas G. Castle and John Enberg, "Further examination of the influence of caregiver staffing levels on nursing home quality," *Gerontologist*, 48, no. 4, (2008): 464. Accessed at: http://gerontologist.oxfordjournals.org/content/48/4/464.long

[17] Marvin Feurerberg, *Report to Congress: Phase II Final Report*. (Baltimore: Centers for Medicare and Medicaid Services, 2001), MD 21244-1850, p 3-31.

[18] Canadian Institute for Health Information, *Caring for Seniors With Alzheimer's Disease and Other Forms of Dementia* (Analysis in Brief, Aug. 2010), 1.

[19] Alzheimer's Association Campaign for Quality Residential Care, *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes* (Chicago: The Alzheimer's Association, 2009), 7.

[20] Pamela L. Ramage-Morin, *Successful Aging in Health Care Institutions,* (Statistics Canada, Catalogue no. 82-003 Supplement to Health Reports Vol 16, 2005), 52.

[21] Armstrong et al., *They Deserve Better,* 113.

[22] HEU Care Aide, Care Aide Testimonials, April and May 2016

[23] *Workplace Safety,* p. 4.

[24] Banerjee et al., "Structural violence in long-term, residential care for older people: Comparing Canada and Scandinavia" *Social Science & Medicine* xxx 2012.

[25] *Vancouver Sun* (Vancouver). 2 January 2016

[26] *Workplace Safety,* p. 4pg. 11 of WCB

[27] Ibid.
[28] Ibid.
[29] Ibid., p. 9.
[30] Ibid., p. 12.
[31] Ibid., p. 13.
[32] Marcy Cohen et al. "Reducing Injuries in Intermediate Care: Risk factors for musculoskeletal and violence-related injuries among care aides and licensed practical nurses in Intermediate Care facilities" (Vancouver, B.C.: WorksafeBC, et al., 2003), 11.
[33] Ibid., 48.
[34] Banerjee et al., p. 4.
[35] Armstrong et al., *They Deserve Better,* 131.
[36] Neil Boyd, *Gently into the Night: Aggression in Long-Term Care*, (British Columbia: Worker's Compensation Board of British Columbia, 1998), 21.
[37] Kramer A. et al. Effects of nurse staffing on hospital transfer quality measures for new admissions. In *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Report to Congress, Phase I* (U.S. Department of Health and Human Services, ed.). Health Care Financing Administration, Washington DC, 9.1-9.22
[38] Horn et al. , "RN Staffing Time and Outcomes of Long-Stay Nursing Home Residents: Pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care." *American Journal of Nursing* 105, 2005, 58-70. In Janice M. Murphy, *Residential care quality: A review of the literature on nurse and personal care staffing and quality of care,* (British Columbia: Nursing Directorate, British Columbia Ministry of Health, 2006), 22.
[39] Schnelle et al., "Relationship of Nursing Home Staffing to Quality of Care." *Health Services Research* 39, 2004, 225.
[40] Ibid., p. 242-242.
[41] Charlene Harrington et al. "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States", *The Gerontologist* 40, No. 7, 2000, 13.
[42] Marvin Feurerberg, *Report to Congress: Phase II Final Report, Volume I*. (Baltimore: Centers for Medicare and Medicaid Services, 2001), MD 21244-1850, 6.