

QUALITY OF CARE in B.C.'s residential care facilities:

*A submission to the
Office of the B.C. Ombudsman on Seniors' Care*

Hospital Employees' Union
January, 2009



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Background

The population of residents living in B.C.'s residential care facilities (RCFs) has changed dramatically since the 1970s and present increasingly challenging complex care needs.

Admission requirements for residential care, previously called long-term care (LTC), used to categorize residents' care needs as Personal Care 1 (PC1), Intermediate Care 2 or 3 (IC2 or IC3), or Extended Care. However, the care needs of residents currently living in B.C.'s RCFs have shifted "from 90 per cent 'Personal Care 1'... to almost 100 per cent 'Intermediate Care 3' and 'Extended Care' today."¹

As a result, today's residents are often sicker and more likely to have dementia and/or numerous chronic diseases treated with multiple medications.² "Residents' physical and psychosocial care needs have become so complex that residential care facilities are like "mini-hospitals."³

Most of this dramatic change in resident acuity has occurred since 2002, when the B.C. Ministry of Health Services argued that: "many residents assessed at IC1 and 2 and even some at higher levels do not need to live in residential care"; these residents would be more suitably accommodated in either "supportive housing" or "assisted living" housing; and only "those who need access to *constant* professional care will continue to be accommodated in residential care facilities. This level of need is called 'complex care.'⁴

In addition, as the B.C. Care Providers Association notes, health authorities are increasingly admitting people with sub-acute and palliative care needs into residential care, but without "allowing comparable increases in funding to pay for specialized staff and equipment to effectively deliver these services."⁵

Despite residential care facilities in B.C. now admitting only residents with multiple complex health care needs, the staffing levels required to appropriately care for these "complex care" residents has not been provided. Staffing levels are still based on funding formulas established in the late 1970s and they were not adjusted upward with the shift to complex care in 2002.⁶

Concurrently, the B.C. Ministry of Health reduced the number of residential care facilities to the point where B.C. now lags behind the rest of the country – with the possible exception of New Brunswick – and has the **lowest** number of residential care beds in Canada. This is in stark contrast to 2001 when B.C. was very close to the national average in terms of the number of RCF beds per 1,000 population aged 75 and over.⁷

There's been considerable controversy over the provincial government's failed

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promise to build 5,000 new, non-profit, long-term care beds by 2005. More than 2,500 – mostly non-profit, long-term care beds – were closed between 2002 and 2004, with additional closures since that time.⁸ Most new residential services are assisted living (AL) or supportive living (SL) housing services, which provide much lower levels of care.⁹ While some private-for-profit complex care facilities have been opened as well, this number is still less than the number of not-for-profit facilities that have been closed.¹⁰

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In addition, care is now contracted out in 39 facilities (14 per cent of all RCFs) and 107 facilities (37 per cent of all RCFs) have contracted out support services such as dietary, laundry and/or cleaning services. [see *Appendix III*]. As a result, there's been a clear shift from not-for-profit to for-profit, private delivery.¹¹

All these changes have created significant challenges for frail seniors requiring access to affordable and appropriate residential services and for our members who deliver these services.

This report begins with a review of HEU's efforts, over the years, to advocate for improved working and caring conditions in residential care. It's followed by a summary of our members' concerns with respect to the current situation for both the staff and residents in B.C.'s licensed residential care facilities. These sections set the stage for the discussion and recommendations that follow on staffing, the work environment, ownership, access, licensing, and models of care.

HEU's history advocating for improved quality of care

The Hospital Employees' Union (HEU) has a long history advocating for improved care standards in residential care facilities. Approximately 90 per cent of the licensed residential care facilities are organized by HEU, and the union represents about 90 per cent of the staff working in these facilities. This includes licensed practical nurses (LPNs), resident care attendants (RCAs), activity workers, rehabilitation assistants, dietary workers, and housekeeping staff – everyone other than registered nurses (RNs) and rehabilitation/recreation therapists.

In all, HEU has approximately 20,000 members working in seniors' care across the province. The union's role in advocating for improved care standards in residential care dates back to the 1970s when HEU first organized staff in the private nursing home (i.e. residential care facility) sector in B.C.

During that organizing drive, the union brought to light issues related to resident neglect and low-staffing levels, demonstrating the clear link between poor working conditions for staff and poor caring conditions for residents in the private nursing homes.¹² The success of this organizing drive and public support for the connection between caring and working conditions were critical in pushing the provincial government of the day to establish a legislative and funding framework that would improve quality care standards in B.C.'s long-term care sector.¹³ This included the passage of the 1978 *Long-term Care Act*, the development of funding guidelines for staffing (i.e. the Ministry of Health's 1979 *Staffing Funding Guidelines*), and the provision of financial and expert assistance to support not-for-profit community organizations to build long-term care residential facilities.¹⁴

Over the years, the union has continued to advocate for improved working and caring conditions. HEU's submission to the 1997 Community Care Licensing Review pointed out that the minimum staffing levels set out in the regulations for intermediate care facilities was one hour of individual personal care a day and 15 minutes of professional care. This was lower than the funding guidelines for staffing established in the late 1970s – 1.8 hours per day for Intermediate Care level two and 2.8 for Intermediate Care level three.

In March 2001 – in response to growing concerns from our members working in long-term care about their capacity to provide appropriate, compassionate care to residents with rising levels of acuity – the union made increased staffing levels a priority bargaining issue. The union worked in coalition with community and seniors groups to advocate for better staffing levels and negotiated an agreement with the provincial government to add 300 new RCA positions in long-term care.

Shortly after taking office in 2001, the newly-elected government passed the *Health and Social Services Delivery Improvement Act, Bill 29*, which made it easier for government to close long-term care facilities and contract out both care and support services. These changes had a profoundly negative impact on HEU members, many of whom lost their jobs, as well as on the frail seniors who had to move and/or were no longer eligible for residential care.

Despite these difficulties and setbacks, however, the union continues to advocate for improved care and works with government whenever possible.

In July 2002, when government announced it would introduce new provincial licensing legislation, the *Community Care and Assisted Living Act*¹⁵, HEU submitted suggestions on the importance of improved monitoring of quality of care in both assisted living and residential care facilities.¹⁶ Then, in 2004, HEU organized two focus groups of RCAs and LPNs to provide input into the regulations under the new Act.

In addition, between 2001 and 2003, HEU partnered with B.C.'s Occupational

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Health and Safety Agency for Healthcare (OHSAH) and the University of British Columbia (UBC) on a study funded by B.C.'s Workers' Compensation Board. This study provides some very important insights into facility level factors that contribute to improved quality care and on the relationship between injury rates, working environment, and staffing levels.¹⁷

HEU has also been an active member of the British Columbia Ministry of Health Service's Nursing Directorate. In 2005, the union undertook a project funded by the Nursing Directorate to support the implementation of B.C.'s priority recommendations in the 2005 *Canadian Nursing Advisory Committee Report*. An exhaustive review of the literature was conducted by researcher Dr. Janice Murphy, on behalf of HEU, with an advisory committee of nursing and physician experts from around the province. The goal of the review was to increase knowledge of nurse-to-resident ratios (nursing in this review included RNs, registered psychiatric nurses, LPNs, and RCAs), and the impact of these ratios on resident outcomes.¹⁸

The review found that the research clearly establishes a relationship between staffing levels and quality of residential care and points to the need for minimum levels of RCA, LPN and RN staffing to avoid adverse outcomes and improve quality of care. (This review is also referenced in the section of this report: *Personal and nursing staffing levels necessary to avoid poor health outcomes and to improve quality of life.*)

In addition, in the lead up to the 2006 round of public sector bargaining, HEU approached the Ministry of Health with a request to establish two policy tables. One focused on strategies for improving the utilization of and training opportunities for RCAs and LPNs, in the face of the nursing shortage. The other focused on training standards, staffing and quality care issues in residential care. Government agreed to both tables and established the *Resident Care Aide/Licensed Practical Nurse (RCA/LPN) Utilization Committee and the Residential Care Policy Committee*.¹⁹

These policy tables have provided union members with an important opportunity to work in collaboration with the Ministry of Health and their health authorities to address both the nursing shortage and quality of care issues in residential care. And while some significant progress has been made in moving forward the policy commitments for the RCA/LPN Utilization Committee, progress on the Residential Care Policy Committee (RCPC) has been slower and more uncertain. The problems encountered in addressing the issues raised in the RCPC are discussed in more depth in the sections of this report on staffing, work environment, and training standards.

Being able to provide quality care to our frail elderly residents is very important to our members. While the union's history in advocating for care has been

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chronologically catalogued by key events, HEU members continue fighting for the ability to do their jobs well: that is, providing quality care to an increasingly frail and diverse population. Unfortunately, this has become more and more difficult in the face of inadequate staffing, increasing workload, contracting out, and the privatization of residential care facilities.

In response the Ombudsman request for input into the systemic problems affecting seniors' care in B.C., HEU members have raised the following concerns in focus groups and in written submissions:

1. Staffing and quality of care

First and foremost, HEU members are concerned about the increasing care needs and acuity of residents, and their inability to provide quality care because of inadequate staffing levels. They have provided the union with many examples about how low-staffing levels impact care:

- care aides reported that they often did not have time to turn residents, which results in more people ending up with beds sores;
- others noted that they didn't have enough time to properly feed residents who required extra assistance and encouragement with their meals and fluids; and
- still others talked about lack of activities and no rehabilitation staff to mobilize and work with residents who had just come back from acute care, following a stroke or fall.

These stories highlight some of the issues that arise when staffing levels are insufficient for residents' care needs.

The first section of this report provides empirical evidence on the link between staffing and quality of care, and on efforts in a number of jurisdictions to increase staffing and/or legislate minimum staffing standards.

Work environment and quality of care

HEU members have long recognized and experienced the impact of the work environment on their ability to provide quality care. While the concept of "team work" is lauded, in practice it takes a strong, stable leadership – and the inclusion of **all** health care workers (RCAs and other support staff) to achieve this.

In focus groups, RCAs shared how, in some facilities, they are not consulted on residents' care plans; care plans are not updated; and decisions are made without involving the RCA who works directly with the resident.

Research shows that if direct care staff are encouraged to provide input and are supported to provide quality care, they will be more successful in providing residents with the individualized care they require.

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Educational standards and continuing professional development needed for quality care

Health care employees are calling for government to mandate the training needed to deal with new types of complex care residents. With contracting out, HEU members have experienced a drop in the training and education required for the job, and provided by the employer.

Privatization and contracting out has repeatedly been linked to poor health outcomes. The flipping of contracts in B.C. facilities is further contributing to the lack of continuity of care and a decline in quality of care.

HEU members are also concerned about the differences in training standards for Resident Care Attendants (RCAs)/ Community Health Workers (CHW) programs in private and public educational institutions. As noted in the discussion of the policy tables above, HEU has been working to increase training opportunities and to establish standardized education requirements for RCAs/CHWs whether they attend a public or private training institution. Our members believe that provincial regulations and policies are required to mandate the new provincial curriculum as the standard across the province.

2. For-profit status and quality of care

HEU members have directly experienced the impact of contracting out on quality of care. Their experience is echoed in the research on privatization and the change in quality of care when ownership shifts to private-for-profit RCFs.

Privatization and contracting out has repeatedly been linked to poor resident health outcomes. The flipping of contracts in our B.C. facilities is further contributing to the lack of continuity of care and a decline in quality of care.

3. Increasing access to not-for-profit residential care

HEU members believe that the substitution of Assisted Living (AL) for licensed residential care beds has not been an effective policy direction. While they recognize the benefit of AL for people with limited care needs, they are concerned about the lack of an adequate number of publicly-funded, licensed residential care beds.

Because people are waiting much longer in the community and in acute care before being placed in a licensed RCF, they're often coming into a facility in a less stable condition, are very frail, and are more likely to die shortly after coming into care. Our members see the need to significantly increase access to the licensed residential care sector, and in particular to not-for-profit RCFs.

4. Improving quality of care in residential care facilities: new models of care

Over the years, HEU members have participated in various initiatives, such as resident-focused care. But without sufficient resources, these initiatives have not

been maintained. Adequate staff and resources, provision of education, and strong leadership are needed for these models to succeed.

In other words, there's a need not only for more care, but for better integrated care provided by a broader multi-disciplinary team. Efforts to integrate care have met with good outcomes, but these initiatives need support to be systemically applied throughout all RCFs.

5. Improved oversight to protect B.C.'s long-term care residents

HEU members believe that residential care facility legislation and enforcement needs to be strengthened. Among other things, information on staffing levels, the complaints process, and investigations into licensing complaints should be publicly available.

Staffing and quality of care

The evidence linking higher levels of direct care staffing to improved outcomes for residents is substantial.²⁰ In addition, many studies show that a positive work environment is associated with improved job satisfaction, reduced staffing turnover, and higher levels of quality.

Many of these studies examined the direct care staffing levels needed to avoid residents suffering from preventable adverse outcomes such as falls, fractures, infections, weight loss, dehydration, pressure ulcers, incontinence, agitated behaviour, and hospitalizations.

In recent years, many Canadian provinces have increased staffing levels in residential care; and in the U.S., many states have legislated minimum staffing levels.

Personal care and nurse staffing levels are necessary to avoid poor health outcomes and to improve quality of life

A comprehensive review of the research literature on the relationship between personal and nurse staffing and quality of care by Janice Murphy (prepared on behalf of HEU) found that staffing levels are positively related to residents' quality of care, and that all levels of direct care staffing – RNs, LPNs and RCAs – contribute to quality care.²¹ A review of 34 research studies from Canada, the United States, England, Australia, New Zealand and Hong Kong, provided evidence of a clear link between inadequate direct care staffing and higher rates of adverse outcomes for residents, and the levels of staffing required to avoid poor health outcomes and improve quality of life.

Many of these studies examined the direct care staffing levels needed to avoid residents suffering from preventable adverse outcomes such as falls, fractures, infections, weight loss, dehydration, pressure ulcers, incontinence, agitated behaviour, and hospitalizations.

- One study found that residents who received **45 minutes or more of direct care from LPNs** were 42 per cent less likely to develop pressure ulcers.²²
- Another study concluded that for four of five quality measurements – electrolyte imbalance, respiratory infection, UTIs, and sepsis – **nurse aide staffing below 2.04 to 2.06** hours per resident per day (hprd) was associated with a quadruple increase in the likelihood of high hospitalization rates.²³
- A very large national study commissioned by the U.S. Congress found that minimum staffing levels of **4.1 hprd** (hours of direct care per resident per day) – including **2.8 nursing assistant hprd** and **1.3 licensed hours**, of which 0.75 are RN hours – are required to avoid jeopardizing the health and safety of residents.²⁴ This 4.1 hour staffing level has been supported by numerous

studies published since the CMS (2001) report.²⁵ (Note: the 4.1 hprd is for worked hours, not paid hours. Paid hours include benefits, holidays, sick time, etc. and increases the hours from 15 to 30 per cent. The 4.1 hours also includes a small number of hours for nursing administration.)

- The U.S. study, led by Dr. Schnelle in 2004, recommended staffing levels that allowed about **4.5 hours** of direct care per resident per day in order to **improve quality** of care.²⁶ A panel of interdisciplinary health care experts (the Hartford Panel) similarly called for substantial increases in funding for U.S. RCFs and new staffing standards requiring a minimum of **4.55 hprd**, and that these standards should not be subject to waivers.²⁷

Other studies have looked at quality of care factors such as the amount of time nurse aides require to appropriately assist residents who need help eating. One such examination found that adequate staffing allows RCAs to help feed **no more than two to three residents** at one mealtime, which is essential to good nutrition and hydration. Interestingly, another study showed that residents receiving **three or more hours of RCA care** per resident per day had a 17 per cent lower risk of weight loss compared to those who received less.²⁸

Other studies focused on quality of life indicators such as frequency of meaningful activities, quality of social engagement, and opportunities for choice. These studies found that residents in higher-staffed care facilities spent less time in bed, experienced more social engagement, and consumed more food and fluids.²⁹

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Adequate staffing key to reducing abuse and neglect in residential care facilities

Abuse and neglect of frail, elderly residents is increasingly being recognized as a serious health and social problem by health care providers and advocates across Canada.³⁰ Much of the abuse prevention work that has been done at the institutional level has focused on the actions of individual workers. More recently, however, there's been greater recognition of the need to "consider abuse and neglect in the context of systemic issues such as staffing levels and types of training staff are receiving."³¹

Participants at regional forums on preventing abuse and neglect from across Canada identified "a care gap in the long-term care system where the number of residents and the complexity of their needs is increasing while the number of appropriately trained care providers is decreasing."³²

Professor Catherine Hawes (2002) stated in her testimony before the U.S. Senate Committee on Finance, "there is a remarkable consensus across diverse studies and

surveys of stakeholders” as to the causes and factors that contribute to abuse and neglect in nursing homes.³³ They are:

- staffing shortages that cause neglect and create stressful working conditions in which abuse is more likely to occur;
- staff burnout, often a product of staffing shortages, mandatory overtime and the fact that many staff must work two jobs to survive financially, and
- poor staff training, particularly on the impact of dementia, and how to interpret and manage challenging behaviours among residents.³⁴

Similar issues were identified in two Health Canada projects conducted in the late 1990s on abuse prevention in long-term care.^{35,36} The researchers report that in every province long-term care residents, staff (both clinical and administrative), volunteers, and family members raised concerns about the reduction in direct care staffing:

Health care workers, families and residents expressed increasing anger at the continuing decline in appropriate care funding and their frustration at being unable to affect changes or have an impact on policy development.³⁷

These conclusions were supported in a recent, very comprehensive cross-Canada study on abuse prevention, “A Way Forward: Promising Approaches to Abuse Prevention in Institutional Settings.”³⁸ In the key finding section of the report, the authors note that “official figures severely under-represent the extent of the issue and ignore its systemic basis.”³⁹ The study links the increased risk of abuse and neglect with the growing “care gap” in Canadian long-term care facilities:

The average care needs of residents across the range of care facilities have become heavier and significantly complex over the past 15 years... There is often fewer staff with less training and education to meet the needs of residents with multiple complex conditions. Moreover, staff often did not have the time, the training or the day to day support to be able to understand and appropriately respond to the needs or behaviours of residents.⁴⁰

Based on the research evidence, it is clear that strategies on abuse prevention and improving the staffing levels in long-term care settings are intricately linked.

Similarly, researchers at York University identified “...chronic short-staffing as a key contributor to workplace violence. Governments need to address short-staffing by legislating adequate care standards and by providing the funding to meet these standards.”⁴¹ In like manner, the Ontario Nurses’ Association (ONA) argues that “legislating minimum staffing standards and levels of resident care is fundamental to ensure that resident daily nursing and personal care needs are met.”⁴²

Minimum nurse and personal care staffing standards

In 2001, researchers found that British Columbia staffing levels in residential care facilities ranged from 2.3 hprd to 3.4 hprd.⁴³ The staffing level varied depending on the care level of the residents and the for-profit/not-for-profit status of the facility. Since 2002 – and the policy that only complex care clients (previously IC3 or Extended Care level) could be admitted to residential care facilities – staffing levels in B.C. have not been adjusted to reflect the increase in care intensity.

Currently, although newly constructed facilities are required to provide **2.8 hours** per resident per day (hprd) of direct care, a B.C. Care Providers survey found that the average hours of direct care provided in 2006 was **2.44 hprd** with a range from 2.0 to 3.2 hprd and an average of 2.6 hprd.⁴⁴ A recent Freedom of Information (FOI) request from the HEU found that the average hours of nurse and personal care provided in facilities in the Fraser Health Authority is **2.7 hprd** – with 3.1 hours of direct care provided in facilities run directly by the health authority as compared to 2.5 hprd provided in FHA's contracted facilities.

These levels are far below the **minimum 4.1 hprd** recommended by experts and researchers. They also point to significant differences in staffing levels within B.C. licensed residential care facilities, despite the fact that all of these facilities are now expected to provide services for residents with complex needs.

These differences reflect the historical discrepancy in funding levels, and disparity in funding, between extended and intermediate care facilities. For example, an FOI request from the HEU in 2007 found that Fraser Health Authority per diem levels for licensed residential care went from a low of \$114.06 to a high of \$174.87. And in the Interior Health Authority the lowest rate was \$128.64 and the highest \$160.00. These per diem levels were not adjusted after 2002 to reflect the level of staffing appropriate for residents with complex care and/or sub-acute or palliative care needs. In fact, the funding formula that is used by the provincial Ministry of Health is almost 30 years old.

An FOI request from the HEU in 2007 found that Fraser Health Authority per diem levels for licensed residential care went from a low of \$114.06 to a high of \$174.87.

In response to similar concerns about the standards of care with rising acuity levels and residents' care needs five provincial governments – Ontario, Alberta, Manitoba, Nova Scotia, and New Brunswick – have committed to increasing funding for front-line staffing (*see Appendix II*).

Ontario, for example, is increasing funding for personal care and nursing by 0.405 hprd within four years; Alberta has set a target of **3.8 paid hprd**; and Manitoba recently set as policy **3.6 paid hprd** of personal and nursing care. In New Brunswick, the government promised in 2006 to increase nurse staffing from 3.2 to **3.5 paid hours** per day per resident, and they are still working toward that goal.

At the same time, it's important to note that these targets are for funded hours (i.e. inclusive of benefits) not worked hours. The research pointing to 4.1 hprd as the minimum necessary to avoid adverse outcomes, is based on hours worked. This suggests that to meet the minimum of 4.1 hprd, the funded hours must be higher still.

Ontario care providers and advocates are calling for minimum standards of care of at least 3.5 paid hours per resident per day.

In addition, no Canadian province has mandated meaningful minimum staffing levels. Provinces have either established target levels, which are unenforceable, or their legislated levels have become so outdated that they're virtually meaningless (*see Appendix II*).

In 1996, Ontario repealed its standard of 2.25 hours of personal and nursing care per resident per day. And Saskatchewan – the only province still with a minimum standard – has set the standard so low, at **two hprd** of personal and nursing care, that it is meaningless.

In her 2008 review of standards of care in Ontario facilities, S. Sharkey rejects the idea of establishing a minimum staffing standard, although she does recommend that the provincial government support a target of **four hours of care per resident per day**.⁴⁵ Ironically, to support her claim that she cannot recommend a minimum staffing standard, Sharkey cites Murphy's review (commissioned by HEU and for the Nursing Directorate), arguing that there is no consensus on the link between staffing ratios and quality of care.⁴⁶ Contradictorily, in her Appendix, Sharkey provides findings from Murphy's exhaustive literature review that plainly shows the impact of staffing on quality care.

Indeed, based on her review of the research, Murphy clearly states that "the research shows that minimum staffing levels for all types of workers (i.e. RNs, LPNs and Care Aides) contributes to the avoidance of adverse care outcomes amongst residents and that added staffing can improve quality care."⁴⁷ Ontario care providers and advocates are calling for minimum standards of care of at least 3.5 paid hours per resident per day and are very concerned about the lack of a minimum level in Sharkey's report.⁴⁸

U.S. staffing levels and regulations

Many U.S. states have established minimum nurse staffing standards as a way of addressing inadequate staffing in their nursing home sector. A report published in 2003 on minimum nursing staff ratios found that 36 states had established ratios: the majority expressed their minimum nurse staffing ratio standard as hprd, whereas others used a ratio of staff-to-resident or staff-to-bed, or in some cases, a mixture of both.⁴⁹

The remaining 14 states used either the federal nursing staff requirements or had a similar state professional coverage standard for nursing home licensure. Other variations occurred across personnel groups (i.e. licensed nurse, nurse aide, etc.). In some states, minimum staffing standards also varied by facility size or type (i.e. intermediate care versus a skilled nursing facility – which is similar to B.C.'s RCFs).

And by 2003, 16 states had increased their staffing requirements. For example, beginning January 2007, **Florida has legislated minimum direct care/nurse assistant staffing levels of 2.9 hprd plus 1.0 hours of licensed nursing per day, for a total of 3.9 hprd.**⁵⁰

In the U.S., residential care facilities are also required to post their staffing data. In December 2005, the U.S. Centers for Medicare and Medicaid Services (CMS) issued a final rule for nursing facilities to post individual shift data and the total hours worked each day by licensed and unlicensed nursing staff. The requirement, legislated by Congress in 2000, has been in effect since January 1, 2003, but CMS has taken longer to specify reporting guidelines. The final rule was published in the Federal Register on October 31, 2005, to take effect December 27, 2005.⁵¹

In a more recent 2007 survey of nursing home staffing regulations in the U.S., 32 American states had minimum total staffing standards and 16 more states had minimum licensed nurse staffing standards.⁵² Also in 2007, Harrington used the federal OSCAR data to track the actual direct care staffing hours. She found that the average U.S. facility has 3.7 hprd of nurse staffing (i.e. combined licensed and personal care hours).⁵³ Only five per cent of facilities in the U.S. meet the 4.1 hours per resident per day (hprd) standard, but Harrington argues this is a minimum for long-stay residents, which make up the vast majority of all U.S. nursing home residents.

Caution is needed, however, when making comparisons between Canadian and American nurse and personal care staffing levels. The education and training requirements for resident care attendants in the U.S. varies widely. In 2000, 27 American states required 100 hours or less of training for its certified nursing assistants (and 18 of these states only required 75 hours of training).⁵⁴ Only three U.S. states required 150 hours of training and five required 120 hours of training.

In comparison, B.C. resident care attendants attending **public post-secondary institutions** are highly trained: the B.C. Home Support Resident Care Attendant (HSRCA) citation is 27 weeks long and requires 291 hours of lecture, 60 hours of lab work, and 312 hours of clinical practice.⁵⁵

Need for staffing standards and adequate funding in residential care

To affect increased staffing levels in B.C., funding for residential care needs to be substantially increased. The impact of inadequate funding was highlighted in a recent release by the B.C. Care Providers Association.⁵⁶ The Association announced that Zion Park Manor would be closing 71 beds because of chronic under-funding of staff and benefit costs. The Manor, owned by a non-profit society, can no longer sustain

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subsidizing the facility at \$400,000 per year. According to the B.C. Care Providers Association, many other facilities are also in a deficit position with a shortfall in operating grants, across the sector, of six per cent or \$81 million.⁵⁷

However, as the B.C. Care Providers Association's news release demonstrates, without firm staffing standards money ostensibly allocated to increase direct care staffing may be used instead to reduce deficits.⁵⁸ Similarly, in the U.S., Harrington expressed her concerns about the initiation of California's 2004 payment system without accompanying staffing standards, arguing that "without attaching more specific minimum requirements for staffing levels and penalties for poor quality of care, the new payment system appears unlikely to achieve its goals."⁵⁹

According to the B.C. Care Providers Association, many other facilities are also in a deficit position with a shortfall in operating grants, across the sector, of six per cent or \$81 million.

Indeed, after the enactment of the new statute, nursing facility revenues increased, but the level of direct care spending decreased as a portion of total spending (by 3.7%), while administrative expenses grew by 37 per cent, and overall, all types of facilities reported improved net income margins on health care revenues.⁶⁰

Likewise, in their submission to the Alberta MLA Task Force on *Continuing Care Health Service and Accommodation Standards*, The Bethany Care Society expressed their concerns that standards need to quantify "staffing mix and service levels in terms that ... [are] meaningful and straightforward for those receiving and providing service." A standard of "average hours of care per resident per day" is too ambiguous, "given the range of care services and diversity of staff such a standard encompasses."⁶¹

In 2007, the Vancouver Island Health Authority (VIHA) announced a new funding model with a target of 3.24 hprd, including activities and rehabilitation. They did not, however, provide adequate funding to meet this target. The B.C. Care Providers Association has since come out in support of the ratio of a **minimum of 3.2 hprd**, but in addition, they recommended that the "actual wage and benefit cost be fully funded and other non-direct care costs be fairly compensated."⁶² We would concur. Establishing 3.2 hprd as a minimum would be a positive first step provided that:

- the 3.2 hprd is the minimum and not the average;
- it is fully funded and mandated in regulations;
- it includes only direct care (RCAs, LPNs, and RNs) with additional funding for activities and rehabilitation.

At the same time, our goal over time is to achieve the **minimum of 4.1 hours** of personal and nursing staff per resident per day indicated in the research, including the requirement that this level should be indexed to rise with resident care needs.

Work and organizational factors affecting quality of care

Research shows that organizational and managerial practices influence job satisfaction, staff turnover and retention, and quality of care.⁶³ For example, negative outcomes to residents decrease when organizations emphasize employee job satisfaction, in large measure because job satisfaction reduces staff turnover and improves the continuity of care.⁶⁴

Managerial practices such as open communication, engaging staff in decision-making, and relationship-oriented leadership have been associated with lower rates in the following resident outcomes: aggressive behaviour, restraint use, immobility complications, and fractures. The following are some specific examples from the research literature of the ways in which organizational factors can positively influence care outcomes.

- Greater levels of RN participation in decision-making explained a lower prevalence of behavioural problems among residents.⁶⁵
- Greater relationship-oriented leadership – defined as “helping staff resolve conflict and generating trust” – was related to decreased prevalence of fractures and immobility complications among residents, while greater communication openness (being able to say what you mean without fear of retribution) was related to lower use of resident restraints.⁶⁶
- Similarly, in situations where management empowered care aides, there was a lower incidence in pressure ulcers, and when care aides had more influence in resident care decision, residents’ quality of life improved (as measured by higher aggregate resident social engagement scores).⁶⁷

These examples suggest that RCFs need to have clear organizational policies that foster a positive and respectful work environment, encourage staff input, and provide opportunities for personal growth and professional development. Recent research in B.C. by Boothman reinforces these findings.⁶⁸ Boothman interviewed 568 front-line workers (RCAs, LPNs and RNs) and managers from over 60 RCFs in B.C., and found that health care workers are better able to give the individualized care that residents require if they are provided with support, access to information, resources and education, including the opportunity to apply what they have learned.⁶⁹

However, Boothman found that in many facilities worker access to support was lacking. In particular, RCAs, who provide most of the direct care, were less likely than RNs and LPNs to have access to training or educational opportunities, to have input into ward decisions, or to receive recognition or rewards for a job well done.

In situations where management empowered care aides, there was a lower incidence in pressure ulcers, and when care aides had more influence in resident care decision, residents’ quality of life improved.

Compounding the problem, it appeared that most rewards given tended to be for performance, based on the medical model, not individualized person-centred care. The lack of support hindered care providers' ability to provide quality, individualized care to residents, a finding echoed by the RCAs and LPNs in HEU focus groups.

All of which points to the importance of organizational policies and practices in creating a positive work environment for staff, so that they in turn can provide residents with a quality living environment. A study conducted jointly by B.C.'s

Occupational Health & Safety Agency for Healthcare (OHSAH), University of British Columbia (U.B.C.) and HEU⁷⁰ identified the organizational characteristics needed to support front-line staff to do their "best work" including an engaged environment, a substantive philosophy of care, and concrete policies and procedures to support this philosophy of care. This research, along with the study by Boothman, could be used in developing effective systems-level interventions and strategies to support a more positive work environment in B.C.'s licensed RCFs. In other words, in addition to establishing minimum staffing standards, provincial level initiatives are required to support positive changes in organizational and managerial practices.

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Provincial educational standards and continuing professional development

Resident Care Aides (RCAs) and Community Health Workers (CHWs) provide the majority of hands on care to seniors living at home, in residential care and now increasingly in acute care. More and more, RCAs and CHWs are expected to provide care to people who are very frail, have complex physical and emotional health problems, and/or who are in the final stages of their lives. One of the strengths of the B.C. health care system has been the extensive training required for qualification as an RCA/CHW; but this is being jeopardized by the lack of regulations regarding the RCA/CHW curriculum content, hours of training, and instructor qualifications. In British Columbia, a considerable difference is emerging between care aide/home support workers training offered for certification by public versus private educational institutions.

This issue was raised during the 2006 policy discussions between the unions (i.e. HEU, BCGEU and IOUE), the Ministry of Health, B.C.'s health authorities, and HEABC (*see also the section in this report on "HEU's history advocating for improved quality of care"*). At the time, health care workers, employers, and unions were in agreement that graduates from some private schools were not receiving the standard of training expected and desired by employers. Concerns were raised regarding the length of the programs, the level of English competency of new graduates, the qualification of instructors and "no fail" policies in some private training schools.

One of the key deliverables for the Residential Care Policy Committee (RCPC), identified during these discussions, was the development of a mechanism for ensuring a common training standard for graduates of RCA and CHW educational programs, whether delivered by public or private training institutions.

In 2007, the Ministry of Health initiated “The Care Aide Competency Project.” Based on these competencies, a new provincial curriculum and standards for training RCA/CHWs were developed.⁷¹ There remains the need, however, to ensure that curriculum and training standards are in place in all educational institutions, private or public. Unfortunately, under current legislation, the private career training schools cannot be regulated directly by government. The government created Private Career Training Institutions Agency of British Columbia (PCTIA) as an industry body, at arm’s length from government, with the responsibility for governing its own members.

And while the RCPC may make some progress on issues through voluntary processes developed in co-operation with the PCTIA, there are limitations to what can be accomplished on a voluntary basis. There is, in addition, a need for the development of appropriate policies and regulations for an independent body to monitor and ensure the implementation of the new curriculum and training standards in all institutions offering the RCA/CHW programs.

There is also the need for additional provincial resources to support increased professional development opportunities, specifically for RCAs and CHWs. This issue is raised in the previous section on organizational practices. When the new RCA/CHW curriculum was developed, an advisory committee drawn from the health authorities, the employers, and unions⁷² worked with the consultants to review the curriculum and recommended a new post-basic certificate program in mental health and palliative care. To develop and deliver these programs, additional targeted funding from the provincial government will be required.

There remains the need, however, to ensure that curriculum and training standards are in place in all educational institutions, private or public. Unfortunately, under current legislation, the private career training schools cannot be regulated directly by government.

Ownership matters: the troublesome shift in British Columbia to private-for-profit RCFs

The shift in British Columbia to an RFP (request for proposals) process for construction of new RCFs has favoured large, private-sector organizations over small non-profit organizations.⁷³ Since 2001, more than 90 per cent of the net residential bed closures have been in the not-for-profit sector, while the new residential care and assisted living bed openings have been predominantly in the for-profit sector. It can be argued that so many of the not-for-profit facilities were closed because they were older and requiring replacement, but this does not explain the shift to creating new for-profit facilities.

Residential care facilities may achieve improved financial performance, but by reducing staffing and expenditures and at the cost of negatively affecting the quality of care.

This shift to more for-profit RCFs is problematic because there is considerable evidence of poor quality care in the for-profit sector – in an extensive review of the research Hillmer and colleagues found that 33 studies indicated that quality of care in for-profit facilities was worse.⁷⁴ Residential care facilities may achieve improved financial performance, but by reducing staffing and expenditures and at the cost of negatively affecting the quality of care.^{75 76} Residential care facilities are labour intensive and thus staffing costs account for a significant portion of RCFs' expenditures; and in B.C., facilities are free to choose how to apportion their funding.⁷⁷

Numerous studies have demonstrated that facility characteristics (i.e. ownership) are primary predictors of staffing levels. For-profit RCFs try to make money by keeping nurse staffing levels and wages low, compared to non-profit facilities that provide higher staffing levels, higher quality of care, and a more transparent, trustworthy management.⁷⁸ High staff turnover, which is linked to low-staffing levels and poor wages, has been found to be related to low-quality in for-profit, large facilities.^{79 80}

For-profit RCFs: lower quality of care

In the U.S., researchers analyzed all state inspection surveys conducted during 1998, across all states, in 13,693 long-term residential care facilities. They found that investor-owned, for-profit facilities averaged 5.89 deficiencies per home, which were 46.5 per cent higher than non-profit facilities and 43 per cent higher than public facilities.⁸¹ In the multivariate analysis, investor-owned facilities averaged 0.68 more deficiencies, and chain ownership was associated with an additional 0.63 more deficiencies. Severe deficiencies (which make up one quarter of all deficiencies) occurred at a rate of 40.5 per cent higher at for-profit RCFs than non-profit RCFs, and 35.8 per cent higher than public RCFs.⁸²

These findings were confirmed by a recent study that measured how divestment of public facilities to the for-profit sector influences the number of regulatory violations. Facilities that changed ownership from public to for-profit had 46 per cent more deficiencies on the total quality score and more violations pertaining to quality of life than non-divested, county-owned facilities. The for-profit comparison group also had more deficiencies (28 per cent) than non-profit and public facilities.⁸³

Similarly, in Canada, a 1995 Manitoba study of residential care facilities' performances found that compared with non-profit facilities, residents living in for-profit RCFs had a significantly higher adjusted risk of being hospitalized for dehydration, pneumonia, falls and fractures.⁸⁴

More recently, a B.C. study of staffing levels in RCFs, between 1996 and 2000, found that compared to non-profit RCFs, for-profit facilities had demonstrably higher adjusted hospitalization rates for anaemia (adjusted odds ratio [AOR] = 1.18), pneumonia (AOR = 1.09), and dehydration (AOR = 1.24).⁸⁵ In comparison to for-profit facilities, non-profit hospital-attached facilities had superior performance measured by dramatically lower adjusted hospitalization rates for all outcomes. The researchers suggest that by being part of a hospital, these facilities were likely to have improved and more timely access to diagnostic services, other specialized services, and nursing and physician professionals.⁸⁶

Facilities that changed ownership from public to for-profit had 46 per cent more deficiencies on the total quality score and more violations pertaining to quality of life.

For-profit RCFs: lower staffing levels

In 2001, U.S. researchers found that nurse staffing, for each occupational category, was lower in for-profit, long-term residential care facilities.⁸⁷ Licensed nurse staffing hprd were 31.7 per cent lower, and nursing aide hours were 11.9 per cent lower than at non-profit facilities. Compared to public facilities, licensed nurse staffing was 22.8 per cent lower and nursing aide hours were 16 per cent lower. Within the for-profit sector, corporate chain facilities had the highest violation rates.⁸⁸

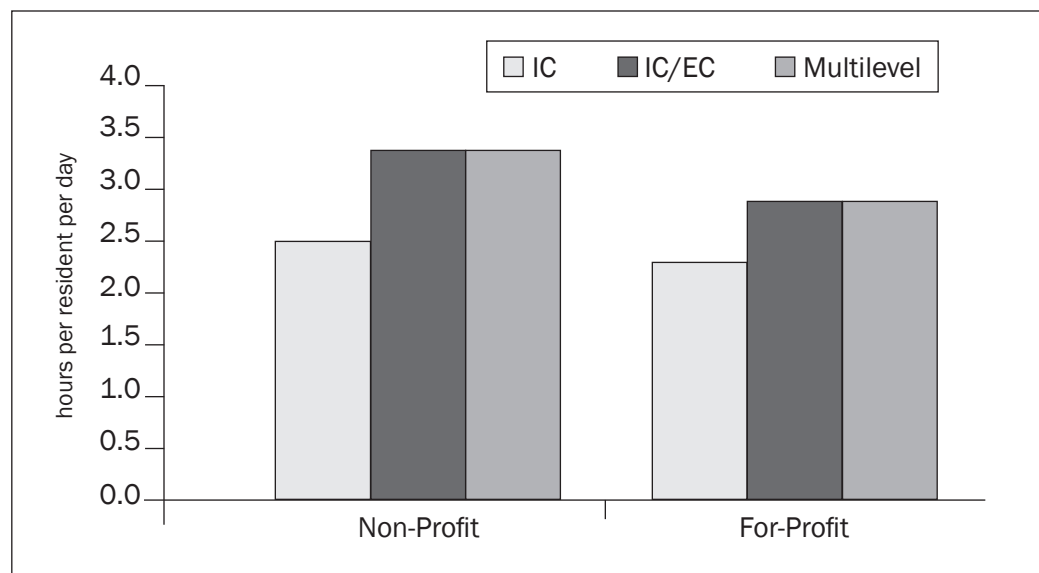
In the U.S. in 2007, nurse staffing in public LTC residential facilities were 4.15 hours per resident per day (0.78 RN), and 4.13 hprd in non-profit facilities (0.84 RN). In comparison, nurse staffing hours in privately owned and operated facilities were 3.54 hprd (0.53 RN); 15 per cent lower than that provided in public facilities.⁸⁹ Similarly, in Ontario, government-operated RCFs provided a higher level of staffing than for-profit facilities, although the public-sector facilities also cared for residents with higher intensity care needs.⁹⁰

In 2001, researchers found that in British Columbia residential care facilities' staffing levels for front-line care was considerably lower in for-profit facilities, despite the fact that the same government funding applied.⁹¹ For-profit facilities had lower nurse and

personal care staff across all care levels, ranging from 17 per cent less in IC/EC and multilevel facilities, to 26 per cent less in IC facilities alone.

Figure 1.

2001 B.C. Average Nursing Hours per Resident Day by Ownership and Facility Level of Care



Notes:

1. IC, EC and Multilevel denote the level of care provided based on the residents' assessed care needs. IC=Intermediate Care; EC=Extended Care; Multilevel facilities provide care at the full-range of care levels.
2. The nursing hours include RN, RPN, LPN and RCA care hours.

An additional problem with the privatization of RCFs, is that unlike contracting out, which can be followed by contracting back in, once residential care facilities are divested to for-profit providers, it is harder to reverse this privatization because of the significant capital costs involved.⁹² More recently, researchers have also identified the high risks associated with contracting out and privatization in poor economic times as private companies and corporations file bankruptcy and/or close facilities.⁹³ ⁹⁴ For example, five of the largest chains in the U.S. operated under bankruptcy protection in 2000, involving 1,800 RCFs.⁹⁵ For-profit RCF chains have an even more worrisome track record with lower staffing than for-profit, independent facilities and non-profit chains. In the U.S., private ownership of RCFs has become so convoluted and complex that it has become increasingly difficult to determine who has responsibility for the management and operation of the RCF, making regulation and oversight by the state problematic.⁹⁶

This evidence calls for increased capacity in government and/or the health authorities to support the development of new, not-for-profit, residential care facilities. In the past, the provincial Ministry of Health worked with non-profit

societies to support them to design, finance and build new facilities, much as B.C. Housing now provides support to non-profit societies to build Assisted Living housing units.

Costs transferred to residents in private-for-profit facilities

The increasing amount and number of costs being passed onto residents in for-profit facilities is another concern – especially for those seniors on a limited fixed income. Most recently, on Vancouver Island, residents who were moved from Cowichan Lodge (a public RCF that was closed) to Sunridge Place (the new, private RCF) have been billed for hundreds of dollars in extra charges for over-the-counter medications, cablevision, etcetera, which they had never been billed for in their previous residence. This is despite the assurances they received that the public-private partnership (P3) would deliver identical care at no extra charge. “Ms. Condon said Sunridge Place’s contract with VIHA requires it to provide ‘hospitality services and basic medical care,’ which doesn’t include specialty medical items such as wheelchairs.”⁹⁷

A recently completed B.C. study by Baumbusch corroborates these findings.⁹⁸ For example, at the non-profit RCF, all of the rooms were private; however, at the for-profit where there was a mix of four-bed, semi-private and private rooms, there was a long waitlist for semi-private and private rooms and an additional daily charge for these rooms. There were also differences in fees for services such as rehabilitation therapy. Whereas the non-profit RCF had rehabilitation therapists as core staff available to all residents, there was no rehabilitation therapist on staff at the for-profit RCF, and the residents had to pay for this service.

Residents and their families were expected to pay these additional fees out-of-pocket. Low-income residents, who may not have access to a private pension or have family able and/or willing to pay extra fees, are obviously the most vulnerable in this system.⁹⁹

The increasing amount and number of costs being passed onto residents in for-profit facilities is another concern – especially for those seniors on a limited fixed income.

Contracting out leads to poor resident health outcomes

On January 28, 2002, the B.C. government introduced *Bill 29, the Health and Social Services Delivery Improvement Act*, legislation that resulted in the layoff of more than 9,000 HEU members, and disrupted the lives of many more frail, elderly seniors living in residential care facilities.¹⁰⁰ *Bill 29* also resulted in the closure of more than 50 health facilities, including hospitals and long-term care facilities. In addition, residential care facilities' laundry, maintenance, housekeeping, security, and dietary services were contracted out in numerous RCFs in the Vancouver Coastal Health

Authority (VCHA), the Fraser Health Authority (FHA), and the Vancouver Island Health Authority (VIHA).¹⁰¹

In 2003, *Bill 94, the Health Sector Partnership Agreement Act*, was passed. It covers employers who are not part of the health authority structures (i.e. non-profit societies and for-profit RCFs). It provides them with the unrestricted ability, which many utilized, to contract out the work of RCAs, LPNs, and recreation aides.¹⁰²

Today, care is contracted out in 39 facilities or 14 per cent of all RCFs. Support services (i.e. dietary, laundry and/or cleaning services) is contracted out in 107 facilities or 37 per cent of all RCFs. (*see Appendix III*).

A residential care facility is home to the senior who resides there. Often, the staff who work in the facility are like their family. Many studies have shown that high rates of turnover among care staff have negative effects on the quality of care and residents' health status (or patient outcomes). The kinds of outcomes discussed in the literature are: increased incidence of pressure ulcers, increased dehydration, increased rates of hospitalization, and the decreased ability of residents to engage in the activities of daily living (dressing, grooming, etc).¹⁰³

Given that RCAs and LPNs are the primary care providers for seniors living in RCFs, the continuity and quality of those relationships is particularly important to the quality of health and life residents' experience. This continuity was destroyed with contracting out. The contracting out of support services in residential care has created significant challenges in terms of the reduced quality of cleaning and food services, high turnover rates, and short-staffing of these services.

However, despite the research evidence and concerns raised by residents and their families, a number of private, for-profit RCF employers are continuing to take advantage of the legislation, which allows them to terminate contracts with private care providers with 60 days' notice, lay off the staff, and hire another contractor with an entirely new group of employees (often to avoid paying negotiated wage increases). At the **Nanaimo Seniors Village** on Vancouver Island, for example,

Today, care is contracted out in 39 facilities or 14 per cent of all RCFs. Support services are contracted out in 107 facilities or 37 per cent of all RCFs.

RCA and LPNs were contracted out to Wellbeing in January 2004.¹⁰⁴ Then, later that same year, the contract was cancelled and the RCAs and LPNs were contracted out to Caresource.¹⁰⁵ Most recently, 168 health care workers at Nanaimo Seniors Village were terminated in early May 2007 by CareSource, and their work has been contracted out to Abbey Therapeutic Services Inc.¹⁰⁶

This scenario has been repeated at **Windermere Care Centre** in Vancouver where 77 LPNs, RCAs and recreation aides lost their jobs to contracting out (for the third time since 2004);¹⁰⁷ and at **Dufferin Care Centre** in Vancouver, where the contract has flipped three times since 2003, and 72 support staff have again lost their jobs.¹⁰⁸ A similar situation has occurred at the **West Vancouver Care Centre**, **Dania Home** in Burnaby, **MSA Manor** in Abbotsford, and at **Normanna Care Home** in Burnaby.

A major 2006 research report on the health of Canadian seniors by Statistics Canada noted that according to *National Population Health Survey* (NPHS) data, “seniors in institutions who were close to at least one staff member and those with at least one close friend in the institution tended to have positive self-perceived health.”¹⁰⁹ Support staff, RCAs and LPNs are the staff most likely to identify changes in the behaviour or health status of a resident – such changes may appear subtle but can indicate a serious problem. Residents who have developed a relationship with their caregiver are also less likely to resist care.¹¹⁰ A U.S. study noted that “well-trained and supervised nursing home staff are more likely to identify early symptoms such as confusion, agitation, or non-specific complaints” thereby increasing the chances of addressing a health problem sooner, and preventing further deterioration or a hospital admission which saves money.¹¹¹

As long as *Bill 94* is in place, contracting out in this sector will continue. To ensure continuity of care, the work force needs to be stabilized. This could be achieved through successorship rights for the workers so that when an employer decides to terminate a commercial contract, the staff remains in place and is transferred to the new contractor. This is common practice in many jurisdictions.

Support staff, RCAs and LPNs are the staff most likely to identify changes in the behaviour or health status of a resident – such changes may appear subtle but can indicate a serious problem.

Improving access to, and quality of care in, B.C.'s residential care facilities: challenges and opportunities

The B.C. Ministry of Health's reduction in residential care facilities has brought us to the point where B.C. now lags behind the rest of the country – with the possible exception of New Brunswick – with the **lowest** number of residential care beds.¹¹² This is in stark contrast to 2001 when B.C. was very close to the national average in terms of the number of RCF beds per 1,000 population aged 75 and over.¹¹³ More than 2,500, mostly non-profit, long-term care beds were closed between 2002 and 2004 with additional closures since that time.¹¹⁴

The level of care services provided in AL and SL facilities are not an equivalent substitute for IC level care – indeed, they offer 40 to 97 per cent less services.

Since then, most new residential services developed are assisted living (AL) or supportive living (SL) housing services,¹¹⁵ both of which provide much lower levels of care. The B.C. Ministry of Health defends this shift in service with the argument that residents with Intermediate Care (IC) needs do not require residential care, and would be better accommodated in AL or SL housing.¹¹⁶ However, the level of care services provided in AL and SL facilities are not an equivalent substitute for IC level care – indeed, they offer 40 to 97 per cent less services. For example, in 2001, B.C. researchers identified that the average direct nursing and personal care hours provided in Intermediate Care facilities was 2.3 hprd (in for-profit facilities) to 2.5 hprd (non-profit facilities);¹¹⁷ in comparison, the current direct care hours in AL facilities is 1.5 hprd and in SL facilities is 0.7 hprd.¹¹⁸

In 2003, the provincial government developed their Continuing Care Renewal Plan, nine months *after* these residential care bed cuts.¹¹⁹ These changes were made with a plan that had significant limitations in that it did not consider the impact of changes in frail seniors' health status, their income level, or the differences in service availability in rural versus urban areas.^{120 121} The Ministry's report acknowledged these limitations of the model, but nonetheless proceeded to direct the health authorities to drastically cut their residential care beds and substitute them with assisted living/supportive housing.

The shortfalls in planning are highlighted in Auditor General Doyle's 2008 review of *B.C.'s Home and Community Care Services*. Auditor General Doyle concluded that the Ministry of Health was not adequately managing the home and community care system; it still did not have a capacity plan specific to the home and community care program, and "the capacity indicators used to monitor the system [were] not comprehensive enough to identify critical system pressures or issues across all core services."¹²² In addition, the Auditor General identified that the home and community care program's planning efforts were not finished or integrated with

the ministry-wide planning process, and that the Ministry needed to ensure this integration occurred. The Auditor General concludes that:

The Ministry of Health Services is not adequately fulfilling its stewardship role in helping to ensure that the home and community care system has the capacity to meet the needs of the population. [The ministry needs to] more effectively incorporate information on population health trends, systems costs and accessibility of services in planning for system capacity.¹²³

The system-wide changes implemented by the B.C. Ministry of Health have made accessing residential care, as well as other home and community care services, very difficult and time-consuming.¹²⁴ Access is limited by the very restrictive eligibility criteria and the fact that there's not enough licensed residential care beds. To ensure that the B.C. government can meet the needs of its population, the BC Medical Association argues that the government should build 5,000 new licensed residential care beds, as promised, and significantly expand the home care and home support systems.¹²⁵ Additionally, the BCMA calls for new ways of providing home and community care services, including residential care, stating that the system needs to be better integrated and provide care in a flexible, individualized manner.

Old models of care: revisiting resident-centred care

Health care providers have spoken for many years about the changes needed in residential care to better meet the needs of increasing numbers of residents with dementia and/or multiple complex, chronic health conditions. Resident-centred or “relational” care requires change from an institutional hierarchical model to a social model of care, which empowers staff to support and care for residents in a flexible manner that best meets their individual needs.

In the early-1990s, the B.C. Ministry of Health adopted a version of the social, resident-centred model of care.¹²⁶ The fundamental elements of this model of care were:

- a work culture that values the residents first;
- flexibility of residents' schedule and care;
- multi-skilled or multi-tasked workers;
- permanent assignments for front-line staff (little or no rotation);
- Care Aides' and LPNs' involvement in care planning;
- a respectful management philosophy; and small clusters of residents.¹²⁷

Resident-centred or “relational” care empowers staff to support and care for residents in a flexible manner that best meets their individual needs.

However, by 2000, the residential care system still had not changed to a more resident-centred model of care. Interviewing nurse practice leaders and front-line staff, Gnaedinger identified the barriers to implementing resident-centred care in

the B.C. residential care system as being: the increasing acuity of residents requiring more intensive care; inadequate staff-to-resident ratios; extensive use of casual workers (i.e. limited consistency of caregivers); administrators who were responsible for several facilities (and challenged to provide needed leadership); outdated hospital-like facilities; and resistance to change at all levels.¹²⁸

In her recent research, Boothman found that the B.C. residential care system still continues to largely provide care based on a hierarchical model, despite the system's stated intent to provide individualized care to residents.¹²⁹ There continues to be a large gap between the residential care system's goal of providing individualized care, and reality. The lessons and recommendations from 2000 still apply – in order to implement a resident-centred, relational model of care, we need:

- higher staff-to-resident ratios;
- enhanced leadership skills among Directors of Care;
- formal involvement of front-line care staff in decision-making;
- increased team work and communication with co-workers, and
- education in dementias, and training in dementia care, for providers at all levels...¹³⁰

New models of care: integrated interdisciplinary care and primary care

On-site treatment for pneumonia successfully reduced emergency transfers to acute care, hospital admissions, lengths of stay, and overall cost of care.

As the level of acuity and complexity of residents' care needs increases, residential care could also benefit from better integration with primary care. The cost-effectiveness of reforming residential care practice was shown by research from Ontario where on-site treatment for pneumonia successfully reduced emergency transfers to acute care, hospital admissions, lengths of stay, and overall cost of care.¹³¹

The leading work in this area is from the Netherlands. Dutch nursing homes (similar to our residential care facilities) report far lower hospitalization rates for residents: only eight per cent of nursing home residents were admitted to a hospital at least once in the past year. Researchers argue that this low hospitalization rate can be attributed to enhanced staffing, and the presence of a specialist physician working within the nursing home with a multi-disciplinary health care team.^{132 133} Improved communication results from the continuous presence of the nursing home physician, which contributes to better decisions and care planning.

Interestingly, recently published B.C. research found that residential care facilities attached to a hospital had significantly lower hospitalization rates for pneumonia,

urinary tract infections, falls, anaemia, and pressure ulcers than other residential care facilities.¹³⁴ While the precise reason for the lower hospitalization rates were not identified, higher staff levels and access to hospital resources – both more specialized staff and diagnostic services – may be significant.

To date, there are a few places in B.C. where primary care (i.e. either a nurse practitioner or primary care physician) has been more fully integrated into the delivery of residential care services. Two examples of where this has occurred are five residential care facilities at Providence Health Care in Vancouver, and three Northern Health residential care facilities in Prince George. These initiatives have shown promising results.

Prince George was experiencing an increasing rate of residents being sent to the hospital for treatments that could potentially have been better provided in the residential care facility – if staff and resources were available. The *Long-term Care Physician Project* was implemented in three facilities in February 2007 with the aim of attracting more physicians to residential care, thereby enhancing residents' care and reducing transfers to acute care.¹³⁵ Similar to the Dutch house physician model, a larger number of residents (i.e. 10 to 20) were consolidated under the care of one physician. The 10 “project physicians” take turns being on-call (a week at a time) to respond to emergencies that arise for any of the residents.

Similarly, if a project physician is on-site and another physician's resident needs immediate attention, the doctors cover for each other, resulting in quicker medical attention for the resident and more effective use of the physicians' time. Because of the on-call service and comprehensive coverage, many residents who would otherwise go to the emergency department are seen and treated in the facility, thus decreasing admissions to the emergency department. Subsequently, the RCFs have experienced fewer numbers of residents having to go to the emergency department because of physicians attending to calls.

Leadership, administration and financial support have been instrumental in the implementation and success of this project. In addition to the new MSP billing schedule that allows physicians to bill for attendance at case conferences, physicians have been provided with additional “sessional” time (from the Northern Health Authority) to conduct comprehensive assessments and evaluations of their new patients. As a result, the physicians' visits to the residential care facility are more regular, which improves communications and relations with residential care staff. To date, nursing staff and residential care managers are very positive about the project.¹³⁶

The discussion in this section points to the evidence showing that the delivery of long-term residential care can be improved if we move to an integrated system that provides care in a flexible, individualized and resident-centred manner, and integrates primary care as a part of residential care. However, to move effectively in this direction, provincial leadership is required.

Many residents who would otherwise go to the emergency department are seen and treated in the facility, thus decreasing admissions to the emergency department.

Need for improved oversight of Residential Care

One of the key mechanisms available to the government for tackling care and abuse issues is effective oversight and enforcement of provincial licensing requirements for residential care facilities. In B.C., the licensing requirements for residential care are set out in 2002 *Community Care and Assisted Living Act* and regulations.¹³⁷ Unfortunately, not all residential facilities are covered by this legislation; some are covered under the *Hospital's Act*. This creates differences in how similar facilities are treated.¹³⁸ And while this legislation includes a number of positive features – an inclusive definition of abuse, whistle-blower protection for staff and residents, mandatory reporting of abuse, and mandated abuse prevention policies – there are, at the same time, some very glaring weaknesses.

In the risk management tools document 20 risk factors are outlined, none of which focuses on the risk of inadequate levels of staff, whether it be nursing, personal care, recreation, rehabilitation, or support.

For example, there are no minimum staffing levels or training requirements. And while there are regulations related to quality care issues, such as residents' right to proper nutrition and access to recreational activities (including outdoor activities) and social programs, it's not clear that there is appropriate monitoring (i.e. indicators or measures) or enforcement of these regulations by licensing officers. In the risk management tools document – developed by the Ministry of Health to support licensing inspectors – 20 risk factors are outlined, none of which focuses on the risk of inadequate levels of staff, whether it be nursing, personal care, recreation, rehabilitation, or support.¹³⁹ There is some recognition in the document of the risks associated with staff and management turnover, inadequate training, qualifications and supervision, but nothing on staffing levels. In addition, until mid-November 2008, there was no requirement for public reporting on licensing violations and substantiated complaints. Prior to November, access to information on the results of complaints investigations and inspections in B.C. could only be obtained through a *Freedom of Information* (FOI) request.

In October 2007, extensive province-wide media coverage of the findings from an FOI request (i.e. on Beacon Hill, a Victoria-based RCF owned by Retirement Concepts corporation), revealed a pattern of substandard care and neglect over three years, including one case of neglect that led to the death of the resident.¹⁴⁰ This story was followed by a series of media reports from family members across the province concerned about issues of neglect due, in many cases, to inadequate staffing.

In the spring of 2008, in response to concerns raised about the lack of public reporting of inspection reports, the Ministry of Health announced that they would publicly report the inspection results. However, while they are doing this, it is

important to note that only the most recent licensing violations and substantiated complaints are being reported. Information about whether a facility is classified as low, medium or high risk will not be put online, nor will any details on its history of serious incidents.¹⁴¹ This makes it very difficult for seniors and their families to know if a facility has a history of licensing violations or if this is a one-time only occurrence.

Strengthening legislation to protect residents in B.C.'s RCFs

Long-term care in B.C. must be recognized as an essential health service and become a national priority.¹⁴²

The major areas of oversight that need to be addressed by the provincial government are (1) provision and funding of adequate nurse and personal care staffing levels in residential care facilities; (2) regulation of education and continuing professional development of health care workers; (3) improvements in the work environment and culture; (4) transparency, responsibility, and accountability, and (5) inspection and enforcement of regulations.^{143 144 145 146}

B.C. needs similar legislated changes to improve the complaints process in residential care, as well as establishing a more accountable, transparent process. To increase transparency, responsibility and accountability, the legislation should be redrafted to focus more clearly and forcefully on issues related to quality of care including:

- Minimum staffing levels for direct care staffing, activities and rehabilitation;
- Information readily available, upon admission, to residents and their family members about how to contact a Licensing Officer and engage in the complaints process (in the 2006 *Ontario Long-term Care Act*);
- Requiring facilities to post accurate staffing ratios for all types of care and support staff for each shift on a daily basis. These should be regularly submitted for inspection (i.e. quarterly), using a standard electronic format;
- Reporting publicly on staff turnover and retention rates (i.e. from payroll data);
- Recognition of the role of family councils as advocates and their right to access facility documents process (in the 2006 *Ontario Long-term Care Act*);
- Mandating the provincial curriculum and training standards for the Health Care Assistant Program as the minimum standard to work as a care aide in a licensed residential care or assisted living facility;

To increase transparency, responsibility and accountability, the legislation should be redrafted to focus more clearly and forcefully on issues related to quality of care.

- Ensuring that employers are promoting and providing continuing education and training that supports and empowers staff to do their jobs well;
- Unannounced inspections at all facilities at least once a year and posting of annual inspection reports in facilities and on the health authority website process (in the 2006 *Ontario Long-term Care Act*);
- Solicitation of input from staff on work environment issues, during annual inspections through confidential processes.

Conclusion

To improve long-term residential care quality, we need to address the problems inherent in the current residential care system. We need increased numbers of residential care beds; increased nurse and personal care staffing levels; education and training; publicly-owned and provided residential care services, and improved regulation and oversight of residential care services.

In addition, there is a need to review and change our approach to providing residential care so that we can better meet the needs of residents with complex care needs, of which an increasing proportion has dementia. Health care practitioners and researchers in Canada and internationally have identified that the way we provide long-term residential care can be improved by moving to an integrated system that provides care in a flexible, individualized and resident-centred manner, and integrates primary care as a part of residential care.

Recommendations

More specifically, we call for the following changes to B.C.'s residential care system:

1. As a first step, establish 3.2 hours per resident per day (hprd) of direct nurse and personal care staffing as a minimum provided that:

- the 3.2 hprd is the minimum and not the average;
- it is fully funded and mandated in regulations, and
- it includes only direct care (care aides, licensed practical nurses and registered nurses) with additional funding for activities and rehabilitation.

Over time, the goal is to achieve the **minimum of 4.1 hours** of personal and nursing staff per resident per day indicated in the research, including the requirement that this level should be indexed to rise with resident care needs.

2. Develop an effective, provincial level system of interventions and strategies that support a more positive work environment for staff so that they, in turn, can provide residents with the quality of care they require including:

- staff participation and engagement in decision-making;
- a substantive philosophy of relational care and concrete policies and procedures to support this philosophy of care, and
- increased professional development opportunities specifically for front-line care staff (i.e. in mental health, dementia, and palliative care).

3. Develop an independent body at the provincial level to monitor and ensure the implementation of the new curriculum and training standards in all institutions offering the RCA/CHW programs.

4. To ensure that B.C. can meet the needs of its population, the provincial government should relook at the target of building 5,000 additional not-for-profit, licensed, residential care beds by 2006, and factor in the additional beds needed for 2009 and beyond.

5. Increase the capacity in the provincial Ministry of Health, or an agency such as B.C. Housing, to support non-profit societies to design, finance and build new RCFs.

6. To ensure continuity of care, the provincial government should require employers in RCFs who receive public funds to provide the staff with successorship rights when they are terminating a commercial contract and transferring to a new contractor.

7. To increase transparency, responsibility and accountability, the legislation should be redrafted to focus more clearly and forcefully on issues related to quality of care, including the points outlined in the section *Strengthening Legislation to Protect Residents in B.C.'s RCFs*.

Appendix I. Terminology and acronyms

RCA	LTC
Resident Care Aide or Attendant	Long-term Care (also known as “residential care facility”)
LPN	LN
Licensed Practical Nurse (in Ontario, they are called Registered Practical Nurse)	licensed nurse (RN, RPN or LPN)
RPN	NH
Registered Psychiatric Nurse	nursing home
RN	hprd
Registered Nurse	hours per resident per day
HEU	<i>The term “care aide” is used to refer to Resident Care Aides (RCAs); Patient Care Aides or Personal Care Attendants (PCAs); Nurse Aides and Nurse Attendants (NAs)</i>
RCF	
Residential Care Facility (also known as “nursing home”)	

Appendix II. Personal and nursing care staffing levels in RCFs

Provincial reports on resident/staff ratios interpret “nursing staff” and “hours of care per patient/resident” in various ways. Most reports are based on worked hours versus paid hours (paid hours include benefits, holidays, sick time, etc. and the actual worked hours reflected are about 25 per cent less than the paid hours reported). The mix of staff providing nursing care (i.e. the ratio of RNs and LPNs to RCAs) also varies by jurisdiction and some reports include the time of clerical staff, rehabilitation staff, and/or management staff.

A comparison of staffing levels is further complicated by the different methods provinces use to classify residents’ care acuity into levels of care and the mix of care needs of residents (i.e. care acuity) living in a facility.¹⁴⁷ Based on calculating case mix measures, patients at a level three or four are at the maximum level of dependency on nursing time for bathing and dressing, feeding, treatments, ambulation, elimination, etc. and require 3.5 or more hours of nursing care per day.

Ideally, reports on staffing hours would differentiate between time spent on “direct care” versus “indirect care.” Resident/staff ratio “**direct care**” reflects worked hours providing hands-on care or time spent discussing resident issues with caregivers and others and includes the following:¹⁴⁸

Personal Care: assistance with activities of daily living (i.e. feeding, bathing, dressing, toiletry, lifting, moving, charting) and instrumental activities of daily living (i.e. transportation), assistance with activities where supervision or hands-on help is provided to assist the resident with a task, or to perform the task for the resident; includes assistance by resident care attendants (RCAs), licensed practical nurses (LPNs), and/or registered nurses (RNs).

Nursing Care: any and all activities that form part of a whole nursing intervention for a specific resident, from assessment to evaluation (i.e. treatment, medications, care planning, charting, and supervision of care staff); includes nursing care provided by RNs, LPNs and RCAs.

Indirect Care: refers to time spent on non-patient specific activities, such as attending general staff meetings.¹⁴⁹

For the purposes of this report, the commonly used “paid,” and where available, “worked” hours of nursing care per patient/resident per day are compared. Where provinces report differently, a footnote explaining their method of reporting is included.

Figure 1.

Total nurse staffing levels across Canada comparison

(comparison of worked or paid hours of nursing staff including RCAs, LPNs and RNs)

Province	2008 average worked hours	2008 average paid hours	Target hprd
British Columbia¹	2.6 – 2.7	3.1	
Alberta ²	n/a	n/a	3.8
Saskatchewan ³	n/a	3.0	
Manitoba ⁴	n/a	3.3	3.6
Ontario ⁵	2.6	2.85	3.26
Quebec ⁶	n/a	n/a	n/a
Nova Scotia ⁷	n/a	n/a	3.25
New Brunswick ⁸	n/a	2.6	3.5
Prince Edward Island ⁹	n/a	3.4	n/a
NFLD & Labrador ¹⁰	n/a	3.0	n/a

*Quebec’s data is not included because the data available is from 1997.

n/a = not available

1) British Columbia

In a *Freedom of Information* request, HEU found that in the FHA, the average worked hours of direct nursing and personal care per day is 2.70 hours. The B.C. Care Providers survey found an average of 2.6 hours a day with staff varying 2.1 to 3.2 hours per resident day.^{150 151}

2) Alberta

1985 – 1.9 paid hours (1985 *Nursing Home Act* regulations)

2000 – 2.8 paid hours (*Alberta Continuing Care Watch*. Commentary on the Auditor General Reports on Seniors' Care and Services, April 2008, page 4)

2004-2005 – 3.1 paid hours (target)

2006-2007 – 3.6 paid hours (target)

2007-2008 – 3.8 paid hours (target)

In Alberta, hours of care does not mean hours spent providing care to a RCF resident; it refers to the number of paid hours of staffing. Paid hours include vacation time, sick leave time, lunch and coffee breaks, and any other absence during which a staff member is paid. It also includes indirect care time spent on administrative duties, staff meetings, daily housekeeping, and anything else which staff assigned to a care unit are asked to do

Alberta has a minimum staffing standard, regulated in the *Nursing Homes Act*, of 1.9 paid hours of combined nursing and personal care per resident per day. Of this, 1.9 hours (22 per cent of the hours) “should” be provided by nurses.

In 2005, the Alberta government targeted to increase staffing levels from 1.9 paid hours to 3.4 paid hours per resident day (*Edmonton Journal*).¹⁵² The Alberta Budget¹⁵³ 2006-07 notes plans to provide additional funding to increase staffing from 3.1 paid hours in 2004-05 to 3.6 paid hours in 2006-07. The Calgary Health Region set a goal of increasing the average paid hours in LTC from 3.4 to 3.8 to 4.1 by 2007.¹⁵⁴ In the following year's plan, the final target was readjusted for 4.0 paid hours of personal and nursing care per resident per day.¹⁵⁵

The Ontario Health Coalition (OHC) briefing note¹⁵⁶ states that in the *Capital Health Authority and Public Interest* report, staffing is at 3.6 paid hours in 2007. However, the current 3.6 hours of care is a **target** for the Regional Health Authorities to provide – it is not mandated in legislation or regulations, but is part of the performance expectations issued by the Minister of Health and Wellness; and it has not been accompanied by a sufficient increase in funding to achieve. It also does not speak to the competencies of staff required to deliver this care. In addition, the level of staffing varies by RHA. For example, in 2005-06, the NLHA was funded at a rate that was 36 per cent less than the provincial average.¹⁵⁷

In the February 2008 issue of the Alberta Continuing Care Association (ACCA) newsletter, continuing care facility operators reported that their most critical issue at this time is to attract enough staff to fill all the available positions. The province currently needs over 2,000 health care aides just to fill the vacant jobs. Current staff are working short or working overtime on a regular basis to ensure good resident care. ACCA members employ over 15,000 continuing care employees throughout the province; 80 per cent of these employees are health care aides.

The 2007/10 Accountability Guide for Alberta RHAs provides a measure of an average of 3.8 paid hours for personal care per resident per day in LTC facilities in 2007/08.¹⁵⁸

3) Saskatchewan

1997-1998¹⁵⁹ – 3.06 total paid hours (0.59 RN hours) (PriceWaterhouseCooper, 2001)

2008 – 3.00 paid hours (Saskatchewan Ministry of Health; see note below)

The Saskatchewan Ministry of Health reports, “There is no current change in Saskatchewan’s regulations regarding hours of direct care per resident per day. ‘The Housing and Special-care Homes Regulations’ states ‘at least 2 hours of personal or nursing care per guest per day with nursing staff ratio of one registered nurse or one registered psychiatric nurse to seven ancillary nursing staff such as nursing aides and orderlies, etc.’ However it is important to note these are Saskatchewan’s minimum requirements in regulation for providing care and doesn’t provide an accurate picture of what the actual paid hours of care per resident are. The regulations do not take into account heavier care residents such as level 4 as heavier care has been recognized at about 3 hours of direct care per day.”^{160 161}

4) Manitoba

1999¹⁶² – 2.44 total paid hours (0.4 RN hours) (PriceWaterhouseCooper, 2001)

2003-2004¹⁶³ – 3.3 paid hours per resident per day (Manitoba Centre for Health Policy)

2008-2012¹⁶⁴ – 3.6 target paid hours (Province of Manitoba)

The Province of Manitoba announced that the \$40 million funding would be used to add an additional 250 nurses, 100 care aides and 50 allied health (i.e. dieticians, occupational therapists, physiotherapists). While the announcement includes that the Province of Manitoba has set as policy that 3.6 hours of personal and nursing care per resident per day will be provided by April 2011, it is not clear if this is including the increase in allied health staff.¹⁶⁵

Of concern, is that RCFs, particularly private for-profit RCFs, do not replace sick staff and so the paid hours of staff do not reflect the care provided.¹⁶⁶

In personal care homes with more than 80 beds, 30 per cent of the time “should” be provided by licensed nurses, and the remaining 70 per cent by RCAs. In NHs with less than 80 beds, the ratio of RNs increases to 35 per cent and the proportion of RCAs to 65 per cent. (Sharkey)

5) Ontario

1999¹⁶⁷ – 2.04 total hours (0.23 RN hours) in LTC; and 3.25 total hours (0.9 RN hours) in chronic convalescent care (short-term care) facilities (PriceWaterhouseCooper, 2001)

2008¹⁶⁸ – 2.85 LTC **paid** hours (MOHLTC) (includes only nursing and personal care staff)

2008¹⁶⁹ – 2.6 LTC **worked** hours (Ontario Long-term Care Association)

There is no provincial staffing standard for LTC homes in Ontario. In 1996, the standard of 2.25 hours of personal and nursing care per resident per day was repealed (Sharkey, 2008, p. 13). A recent review of LTC staffing identified a wide variability in the level and type of staffing at each home from an average of 1.9 to 5.1 paid hours of nursing and personal care per resident per day.¹⁷⁰

According to the Ontario LTC Association, the current 2.6 hours of care reflects “worked hours” not paid hours. These “worked hours” include nursing staff time on duty, that is, the hours of the nursing staff members shift. Thus, this “worked time” does not reflect any specific “direct” or “non-direct” care process, but includes all activities from direct care to staff meetings to paid coffee breaks. The 2.85 reported by the government reflects “paid hours.” The Ontario LTC Association is lobbying the government for a minimum standard of three worked hours per resident per day; this is the equivalent of 3.5 paid hours.¹⁷¹

In the 2008 budget, the Ontario government has stated that its goal, over the next four years, is to increase LTC

staffing hours by 0.405 average paid hours per resident (this includes 0.085 licensed practical nurse hours; 0.178 personal care worker hours; and 0.142 RN hours).¹⁷²

6) Québec

1997 – 2.15 hprd

The only data found on Québec staffing levels is from a 1997 study that reports notes that the mean number of hours of nursing care provided to residents per day in long-term care institutions in Québec was 2.15 hprd, although the report indicates that 2.25 hours was required.¹⁷³ Hours of care varied between institutions. In LTC units in acute care hospitals, 3.11 hprd were provided while 3.19 hours per day were required.

7) Nova Scotia

prior to 2008 – 2.25 hrs

2008 – 3.25 pd hrs (target)

The OHC briefing notes states that the guidelines for direct care staffing are increasing from 2.25 to 3.25.¹⁷⁴ CUPE negotiated increases in care aide staffing from current rate in 2008 of 2.2 hprd, to 2.3 hprd in 2009, and to 2.45 hprd in 2010.

8) New Brunswick

2001-2005 – 2.5

2006- 2008 – 3.0 (increase due to addition of ward clerks)

2008- 2009 – 3.1 (increase due to addition of resident care attendants)

2009 – 3.5 (target)

In the table, New Brunswick is noted as currently having 2.6 paid hours – this includes the original 2.5 hours plus the 0.1 increase in 2008 due to the addition of resident care attendants. The 0.5 increase due to the addition of ward clerks is not included because they do not provide personal or nursing care.

The current government promised to increase nurse staffing to 3.5 hours per day per resident during their 2006 election campaign. When the government took office in October 2006, they immediately increased the staffing ratio to 3.0 from 2.5 hours per day. This was accomplished by adding clerical staff (i.e. ward clerks) to RCFs in an attempt to reduce the amount of paper work nursing staff had to do, with the intent of giving nursing staff more time for direct care.

In April 2008, the staffing ratio increased to 3.1 hours per resident per day with the addition of 93 resident care attendant positions. The government is moving toward increasing the ratio to 3.5 hours and hopes to reach this target by spring 2009. So far, the cost of increasing staffing by over 180 FTE has been \$20 million (approximately 90 FTE of clerical staff were added at a cost of \$7 million, and then 93 RCA FTE at a cost of \$5 million).¹⁷⁵ The government has announced it expects the cost of bringing the staffing ratio up to 3.5 hours per resident per day will cost another \$30 million.¹⁷⁶ The staff mix ratio continues to be 20 per cent for RN; 40 per cent for LPN, and 40 per cent for RCAs.¹⁷⁷

9) Prince Edward Island

2008 – 3.4 paid hours¹⁷⁸

Sharkey reports that the average staffing ratio in PEI is 3.4 paid hours of personal and nursing care per resident per day.¹⁷⁹ The staff mix is 18 per cent for RNs, 30 per cent for LPNs and 52 per cent for RCAs.

10) Newfoundland

2008 – 3.0 paid hours¹⁸⁰

For residents assessed at a level four – the highest care need – the staffing standard is 3.0 paid hours of care per resident per day. The recommended staffing mix is 20 per cent for RNs, 40 per cent for LPNs and 20 per cent for RCAs.¹⁸¹

Appendix III: Contracting out in unionized residential care

Appendix III Contracting Out in Unionized Residential Care (to September 30, 2008)

CARE SERVICES

Health Authority	Number of Care Facilities		TOTAL	Percentage WITH C/O CARE
	WITH Contracted Care	NO Contracted Care		
FHA	15	51	66	23%
NHA	1	24	25	4%
IHA	7	53	60	12%
VCH	10	55	64	15%
VIHA	5	49	54	9%
All Regions	39	232	271	14%

SUPPORT SERVICES

Health Authority	Number of Care Facilities		TOTAL	Percentage WITH C/O SUPPORT*
	WITH Contracted Support*	NO Contracted Support*		
FHA	37	29	66	56%
NHA	1	24	25	4%
IHA	5	55	60	8%
VCH	35	29	64	55%
VIHA	21	33	54	39%
All Regions	101	170	271	37%

* Support refers to the three main support services: Dietary, Housekeeping and Laundry

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