Broken Homes

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Contents

Message from the President of the Nova Scotia Nurses' Union

Janet Hazelton, BScN, RN, MPA

Research can become the impetus for change and, potentially, success, but it can also unearth profound and uncomfortable truths about the institutions we rely on for support.

Such is the case with the Nova Scotia Nurses' Union (NSNU) report on long-term care, *Broken Homes – Nurses speak out on the state of long-term care and chart a course for a sustainable future.* The Nurses' Union has repeatedly heard from its members about difficulties in long-term care – difficulties that are systemic, cultural, chronic and demoralizing. Long-term care (LTC) is in desperate need of resuscitation in order to prepare for the imminent and expansive growth in our seniors population. Our system is dangerously out of step with the times, desperately trying to keep pace but suffering from widespread malaise and neglect. An immediate, multi-pronged approach is required to remedy the litany of current and critical ailments within the sector.

Shortly after I was elected as the President of NSNU in 2002, I met with government and representatives from the Department of Health to express the Union's concerns about long-term care, and to ask for a revised *Homes for Special Care Act* to reflect the then

current realities of LTC, not as they were in 1977 (the year many of the *Act's* regulations were developed). It is truly lamentable that today, all these years later, and many governments later, we are still asking for the same thing.

As advocates for nurses and patients alike, the NSNU feels compelled to expose the current state of long-term care in Nova Scotia by examining the key factors that contribute to both the quality of resident care and the quality of working conditions. We feel ethically and morally bound to ensure that residents are provided with a place they can call home, without hesitation. Let's be clear – residents are in nursing homes because they require health care, and the care they receive there should meet the same standards as the care provided in our hospitals. As a bargaining agent for nurses in long-term care, we also owe it to our members to ensure that they have a respectful and safe work environment with manageable workloads.

Unfortunately, our research over several years confirmed what we heard from our nurses – the LTC sector suffers from understaffing, excessive workloads, demoralized workers, unsafe work environments and workplace violence.

Tragically, several deaths have occurred in long-term care within the past few years. Resident-to-resident violence and resident-to-health care provider assaults have both become more prevalent. Clearly, violence in the workplace, regardless of the perpetrators' ability to control their actions, is unacceptable. It should never be considered a part of the job and every precaution must be taken to prevent violence, including verbal threats and harassment.

The acuity of residents now living in long-term care has reached a level not reflected in staffing plans and this leads to a myriad of problems, frustrations and dilemmas for care providers. LTC nurses require a high degree of training and autonomy. Their responsibilities are daunting on a good day, completely overwhelming on a bad day, and yet they feel undervalued. Nurses and Continuing Care Assistants are keeping the LTC sector alive despite growing demands and a sense of feeling invisible. They can only prop it up for so long under such formidable pressure.

The NSNU entered into this project with an eye to improving the work lives of nurses and the quality of care for residents. Our hope is to work with other stakeholders to implement solutions that address retention and recruitment in this sector in order for it to be sustainable. We must abandon antiquated notions, policies and practices that no longer

apply to current realities in long-term care. We must create reliable and robust mechanisms for transparency and accountability so that we know where we have been and where we want to go. We must work together and forge a new path that allows for a dignified work-life for workers and a dignified place for seniors and other loved ones to live.

This report is not a condemnation of those who administer care or manage the system but an invitation to be part of the restoration. The NSNU, for its part, is ready to examine what we, as partners in this community of care, can do to play a meaningful role.

I applaud the nurses who came forward to participate in the studies (polling, discussion groups, surveys), lending your voices as agents of change. While we have the utmost respect for those who maintain the LTC system under very trying circumstances, we can no longer turn a blind eye as the system crumbles. We have a responsibility and an obligation to support and protect those most vulnerable in our society and this involves protecting the people in charge of their care. We must act now, collaboratively, in order to rebuild our broken homes.

Foreword

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Experts representing a wide range of long-term care (LTC) stakeholders believe that policy-makers must urgently respond to the critical issues affecting residents, their families, nurses and other LTC staff. As the Nova Scotia Nurses' Union's report makes clear, the status quo is not an option. Indeed, Nova Scotia could take a leadership position in Canada by addressing some of the critical issues raised in this report.

The report outlines that while wait lists and wait times grow, no new beds are planned. With demographic shifts, and with more people living with Alzheimer's and Dementia, more beds may be necessary to address community needs.

Like elsewhere in the country, workloads are increasing, which places pressure on the quality of care and working conditions. Nursing work is physically and mentally demanding, and there is little relief for LTC nurses. Nurses are expected to oversee the care of an increasing number

of residents, resulting in less time for each resident. Furthermore, the increasing acuity of residents means increased demands on nurses, as shown in the report. Nurses are also spending more and more of their time doing paperwork and computer work that does not necessarily contribute to making the job meaningful or to improving the care they provide. Indeed, some studies suggest that with too much paperwork teamwork suffers, making the work task-oriented and less relational. Task-oriented work is associated with negative outcomes for residents and staff.

Multiple stakeholders have stressed the importance of improving working conditions in long-term care. Unacceptably high levels of violence, illness and injury rates across Canadian facilities contribute to making LTC one of the most dangerous workplaces overall. Indeed, this report reveals higher levels of violence-related compensation claims in LTC compared to acute care. However, this level of violence and injury has become so ubiquitous that many think of it as a normal part of the work. This is not the case in European countries where staffing levels are higher, so why do we accept this here?

In addition, the LTC labour force is aging and the sector faces major challenges in retention and recruitment. We need to ensure that nurses who are trained to do the work and want to be in LTC are able to remain. High rates of turnover and very low job tenure are some of the consequences of poor working conditions, and the evidence suggests that rates are unacceptable in LTC. This report makes it clear that the pressures are 'taking a toll' on the nurses.

Even with the current number of beds, staffing levels are insufficient to meet the growing social and health care needs. A telling finding in the report is the care tasks that get 'left undone', including foot care, helping residents walk, and providing emotional support. The report also documents the extra effort that nurses put in, for example working while sick. Equally telling is the extent to which facilities operate below core staffing levels due to a shortage of replacements. Various experts have recommended staffing levels should exceed 4-hours per resident per day, with at least 1.3 hours of licensed nursing care, but Nova Scotia has yet to meet these important targets.

When we consider the added effects of residents' multiple-morbidities, it is clear now more than ever that we must increase nursing care, and without proper attention to residents' social needs, we may be increasing the health care burden. Indeed, many studies have shown that better health outcomes are associated with higher registered and licensed

staffing levels. Examining how Nurse Practitioners can improve work organization and residents' care, as recommended in this report, should be a priority.

We are part of a seven year study called "Re-imagining Long-Term Care (http://reltc.apps01.yorku.ca/) with 25 academics from North American and European Universities and over 50 graduate students. Our goal is to identify the promising ways to approach, organize, fund and make the sector accountable. We have conducted comparative studies in six countries and four Canadian provinces, including Nova Scotia. Our findings show that there are promising ways to provide LTC that take into account the dignity and well-being of both the residents and staff.

To conclude, LTC is a home for our most vulnerable citizens. It is also one of the most challenging workplaces in all of health care. It is time that the debate shifts to acknowledge that people don't choose to need LTC, much like someone does not choose to need a quadruple bypass. Families and residents need LTC because they can't remain at home, and therefore they deserve a LTC system that is exceptional. To do so, we must ensure there are enough staff with the right skill mix to support the changing health and social care needs of residents, and to make sure that we don't lose some of our most talented and committed nurses and other care staff. The recommendations in this report are consistent with best practices identified in the literature, and will go a long way towards improving LTC in Nova Scotia and making the province a leader in the country.

I. Background and Overview

Nova Scotia has one of the highest proportions of seniors (65+) in the country, at 18.9% in 2015 (Statcan, 2015). The prevalence of seniors leads to increased stress on our long-term care (LTC) sector given that they comprise the majority of residents. The Canadian Institute for Health Information (2014) estimates that 73% of Nova Scotian LTC residents are over the age of 85, which is eighteen percentage points higher than the national average (55%).

Table 1.1 Age of long-term care residents in Canada

	BC	MB	ON	NS	NL	YT	All
Average Age	85	85	83	88	81	78	83
% Younger than 65	5	4	7	3	9	14	6
% 85 and Older	59	62	53	73	43	0	55

Adapted from Canadian Institute for Health Information, When A Nursing Home is a Home: How Do Canadian Nursing Homes Measure up on Quality?, 2013 and from CIHI, 2014 LTC Data Tables.[1]

[1] *Data for Nova Scotia from CIHI based on sampling of 9 of 90 nursing homes reporting.*

There are currently around 6,900 Nova Scotians living in long-term care in about 90 facilities (DHW, 2015a). When the Department of Health and Wellness updated LTC placement policies in February, 2015, the wait list had reached 2,485. There are no immediate plans to open new beds or facilities. The Department's 2006 Continuing Care Strategy resulted in the introduction of 1,018 new beds into the LTC system, and yet the wait list has grown, nearly every year, with a total growth of 129% between 2006-07 and 2014-15.

Table 1.2 Number of Nova Scotians on wait list by year

	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Community	823	1,100	1,138	1,275	1,347	1,452	1,894	2,135	2,198
Hospital	257	326	248	245	245	241	332	284	261
Total	**1080**	**1426**	**1386**	**1520**	**1529**	**1693**	**2226**	**2419**	**2469**

Adapted from Nova Scotia Department of Health and Wellness Continuing Care Strategy Evaluation Draft Summary Report (2015).

Wait times for placement have experienced a concomitant growth – 97% for those waiting in the community and 89% for those waiting in hospitals between 2006-2007 and 2014-2015.[2]

Table 1.3 Wait times (in days) for long-term care in Nova Scotia

	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Community	169	196	186	222	221	188	233	293	333
Hospital	105	137	117	126	109	110	233	190	198

Adapted from Nova Scotia Department of Health and Wellness Continuing Care Strategy Evaluation Draft Summary Report (2015).

The need for LTC will only rise in the coming years. Between 2009 and 2038, the percentage of Nova Scotians over 65 is expected to rise from 15.8% to between 30 and 32% (Statcan, 2014). Long-term care is not just about seniors, but the aging population is driving demand for this type of care.

[2] An option for clients to defer placement, introduced in 2011, contributed to the wait time increase. This option was removed in 2015 so that if a client refuses placement he or she is removed from the wait list.

Nurses across the country are concerned with increasing workloads and the lack of serious, evidence-based responses on behalf of governments and health care employers. Workload issues are particularly severe in LTC, an often undervalued segment of the health care system where resources are scarce and nurses are regularly expected to oversee the care of a large number of residents. The public is beginning to recognize that there are problems with the current system. A recent national survey found that 64% of Canadians believe there is insufficient qualified staff available in long-term care (Praxis Analytics, 2013). A series of news articles in Nova Scotia media brought discussions of seniors' care to the forefront in the fall of 2013, and public interest is piqued periodically when some tragedy occurs – particularly the preventable deaths we have seen over the past couple of years, but in general, there has not been sufficiently sustained public interest to mount pressure for immediate reform.

Nurses in LTC report poorer health and less job satisfaction than counterparts working in acute and community care (CIHI, 2007). They experience high levels of burnout (Greco, 2006), and nationally, half of all nurses in LTC report having experienced physical assault by residents (Statcan, 2005). As in other sectors, nurses working in LTC report the desire to be consulted and recognized. They want support from management, supports in place for new nurses, professional development opportunities and adequate staffing (Leurer, 2007).

The Nova Scotia Nurses' Union (NSNU) has heard a consistent message from its nurses working in the long-term care sector: resident acuity is increasing, the complexity of care and the number and types of interventions required is increasing, staffing plans have not evolved to meet these changes, resident care is suffering as a result, and managers are either unable or unwilling to effect meaningful change. LTC nurses also experience unacceptable levels of violence and aggression and believe much more can be done to provide for safe and secure working conditions. NSNU has often engaged in efforts to address issues in the LTC sector, including participation in the 2002 Taskforce on Resident/ Staff Ratio in Nursing Homes. Unfortunately, effective change remains elusive.

In a fall 2012 bargaining survey, responses from NSNU nurses in long-term care revealed that many homes are not meeting the staffing requirement specified in the 1989 *Homes for Special Care Act* and many are concerned about current staffing levels. Three-quarters (75%) of LTC nurses surveyed believed the union should lobby government to update the *Act*, compared with only one in twenty (5%) who believed it should not.

This paper is designed to detail the situation of LTC in Nova Scotia, and of the nurses working there. It reviews current data and academic literature on LTC residents, work-life issues, staffing and staffing standards. It next considers the Nova Scotia context, including recent reports on the LTC sector and current staffing standards. It then considers findings from a 2013 survey (n=186) of Nova Scotia nurses working in LTC and four consultation sessions which followed this. These findings prompted a more thorough survey conducted by a third party consultant in the fall of 2015 (n=201), and highlights from the consultant's report will be detailed here. Finally, this paper considers concrete steps Nova Scotia can take to improve the well-being of residents and care providers in the LTC system. It is written primarily from the perspective of the working nurse, while recognizing that safety and security in the workplace and adequate staffing are integral to ensuring safe, quality resident care.

II. Literature Review

A. Acuity and Complexity of Care

There has been a marked and steady increase in the acuity and complexity of care required by long-term care residents over the past twenty years. In fact, serious and significant changes are evident over a much shorter period. The following table shows Canadian Institute for Health Information data on long-term care residents from 2008 to 2014, the earliest and latest years for which this data is available. Over these years there have been significant decreases in resident well-being along each of the eight areas of assessment.

Table 2.1 Proportion of residents in Canadian LTC facilities with specific health conditions

Disease type	2008 (%)	2014 (%)	Percent increase
Endocrine/Metabolic/ Nutritional Diseases	31.3	39.4	26
Heart/Circulation Diseases	61.1	70.4	15
Musculoskeletal Diseases	50.4	55.1	9
Neurological Diseases	73.6	78.7	7
Psychiatric/Mood Diseases	32.0	37.9	18
Pulmonary Diseases	14.0	17.2	23
Sensory Diseases	20.9	22.8	9
Other Diseases	45.3	52.0	15

Adapted from Canadian Institute for Health Information: Continuing Care Reporting System Quick Stats 2014-15 (2015)

Of note, over three quarters of residents now report some level of cognitive impairment with 31% suffering from severe cognitive impairment. This translates into an extensive workload for care providers. A full ninety-five percent of residents require assistance with Activities of Daily Living (ADLs, such as dressing, bathing and eating), and among them, 80% need extensive assistance with ADLs.

It is not just the number of adverse conditions that create difficulties but also the fact that residents are now more likely to suffer from multiple comorbidities. A 2008 Primary Health Care survey found that 76% of Canadian seniors reported having at least one of the 11 studied chronic conditions listed, and about one-quarter (24%) of seniors reported being diagnosed with three or more of these conditions (CIHI, 2011). Complex conditions require complex care, and providers with the skill and knowledge to provide it. Consider, for example, the management of medications in long-term care facilities. In 2012, 60.9% of seniors in LTC used 10 or more drug classes compared with 26.1% of seniors in the community (CIHI, 2014).

Given these trends, staffing and skill-mix (ratio of licensed to unlicensed staff) levels would need to be upwardly adjusted so as to maintain the same level of care. Instead, we have witnessed stagnant or declining levels of staff and qualification.

B. Staffing Levels and Skill-mix

Two decades of national and international research have consistently demonstrated a clear relationship between nurse staffing and patient outcomes. The presence or lack of nurses is known to influence mortality rates, pneumonia, urinary tract infections, sepsis, hospital-acquired infections, pressure ulcers, upper gastrointestinal bleeding, shock and cardiac arrest, medication errors, falls, failure to rescue and length of stay (Aiken et al. 2002; Twigg et al. 2011; Aiken et al. 2010; Berry & Curry, 2012; McHugh et al. 2011; Needleman et al. 2002; Trinkoff et al. 2011; McGillis Hall et al. 2010; Harless & Mark, 2010; Schilling & Dougherty, 2011).

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The evidence on the value of nursing in the acute care setting is incontrovertible, and there is now clear evidence linking staffing levels to resident outcomes in LTC as well (Zhang et al., 2006), though, as in acute care, some studies have had a difficult time establishing the nature of the causal link (Arling, 2007; Spilsbury et al., 2011). Loeb et al. (2003), for example, found that increased Registered Nurse (RN) staffing was associated with a reduced risk of MRSA, and Konetzka et al. (2008) found that increasing RN staffing by 50% would decrease the rate of pressure ulcers by 66% and urinary tract infections by 45% for the average facility. A recent review of literature on the value of RNs in long-term care found that higher RN staffing was associated with fewer pressure ulcers, better quality measures, lower

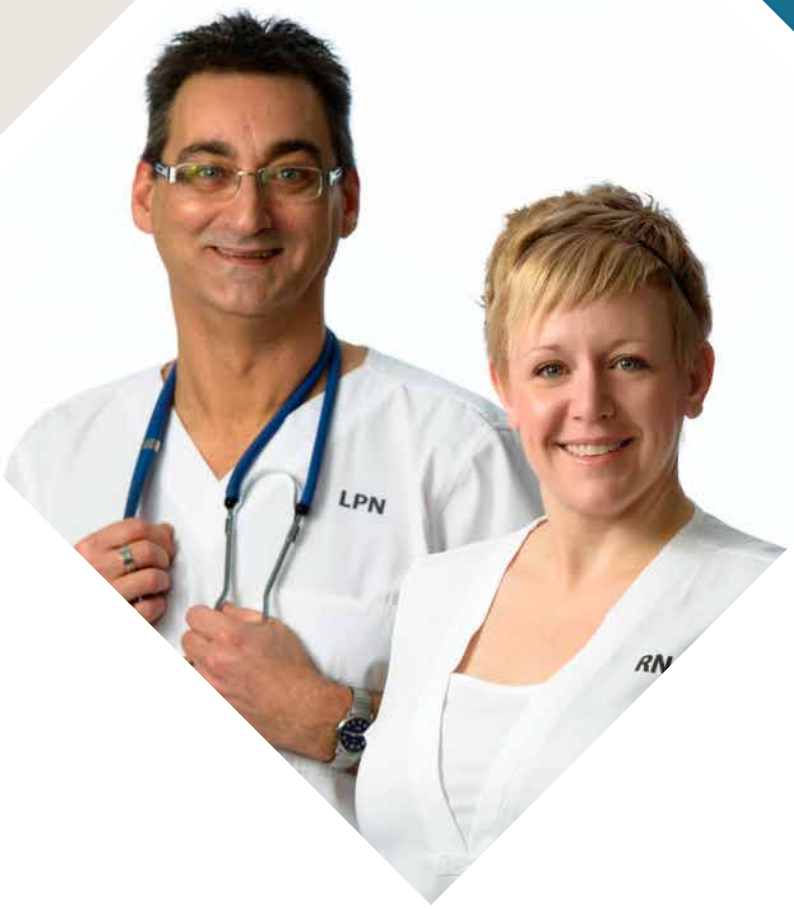
restraint use, decreased probability of hospitalization, fewer deficiency citations, decreased mortality, and decreased incidence of urinary tract infections (Dellefield et al., 2015). Castle et al. (2000, 2002) found that higher RN and Licensed Practical Nurse (LPN) staffing levels were associated with a decrease in restraint use and a decrease in the odds of poor resident care quality. Horn et al. (2005) found that increased RN staffing was associated with a 42% less deterioration in activities of daily living (ADL) and an 84% less likelihood of developing pressure ulcers; increased LPN care was associated with a 42% less likelihood of pressure ulcers and similar results were noted for Continuing Care Assistants (CCAs). [3] Castle and Engbert (2008) found that higher levels of all staff, RNs, LPNs and CCAs, were associated with better resident outcomes (see also Zhang et al. 2006; Schnelle, 2004; Dyck, 2007; Weech-Maldonado et al., 2004; Kramer et al., 2000; Castle et al., 2005; Intrator et al., 2004; Knoetzka et al., 2008).

> "there are critical staffing thresholds, below which the quality of care delivered to nursing home residents could be compromised"

A systematic review by Bostick et al. (2006), which included 87 research articles and reports, found that higher staffing levels, especially licensed staff, were associated with better resident outcomes, particularly functional ability, pressure ulcers, and weight loss. In 2015, Dellefield et al. also compiled a significant review that included 67 articles on RN staffing. Many studies in the review showed that higher RN staffing levels were associated with better resident care quality as measured by pressure ulcers, restraint use, hospitalizations, deficiency citations, urinary tract infections, and mortality. Many studies have also linked increases in nurse staffing levels with reduced hospitalizations (Grabowski, Stewart, Broderick, and Coots, 2008; Konetzka, Spector and Limcangco, 2007, Abt 2011).

The most in-depth study of LTC staffing was commissioned by the US Centers for Medicare and Medicaid Services (CMS) and involved over 5000 LTC facilities in 10 states. The expansive report demonstrated that "there are critical staffing thresholds, *below which the quality of care delivered to nursing home residents could be compromised*" (CMS, 2001, emphasis added). For so-called long-stay patients, these thresholds for CCAs ('Nurse Assistants' in the US) occurred at 2.8 hours per resident day (hprd), and for licensed staff at 1.3 hours per

[3] *This class of worker comprises the majority of the LTC workforce and provides the majority of personal care. They have different names in different jurisdictions (e.g. personal support workers) and often different levels of training. CCAs entering the Nova Scotia workforce are now required to complete a one-year certificate program.*



resident day. Within these licensed hours, the threshold for RN care hours was found to be 0.75 hours per resident day, coinciding with what the US Institute of Medicine would later recommend in 2004. These thresholds delineate staffing levels below which facilities were more likely to have quality problems in the areas studied. For example, facilities in the worst decile had two to 10 times the average rate of quality problems. The CMS study did not find a case for staffing beyond these levels, but other research points in this direction. The minimum level required to improve resident well-being, rather than merely prevent deterioration, was identified as 4.55 worked hours per resident day in a 2000 study (Harrington et al.) and somewhere between 4.5 to 4.8 worked hprd in a 2004 study (Schnelle et al.).

There are several conceivable ways to improve staffing standards, but experience shows that legislation is the most effective vehicle. Studies by Hyer et al. (2009, 2011) found that Florida's attempt to raise staffing ratios through financial incentive packages for facility operators was ineffective. It was only after new legislation provided for 3.9 hprd of care that staffing ratios

actually rose. The 2009 study found that actual harm citations decreased 71% in Florida following the implementation of legislated standards, to a rate of 8.2%, well below the national average of 17.6%. Similarly, a 2009 study examining the implementation of standards across the US showed that total deficiencies in LTC declined significantly as states increased staffing standards (Parks and Stearns). Several other studies echo these results, showing staffing standards leading to improved staffing levels and improved quality outcomes (Harrington et al., 2015; Bowblis, 2011; Harrington, Swan and Carrillo, 2007; Lin, 2014; Mueller et al., 2006; Mukamel et al. 2012).

Hyer et al. (2009, 2011) caution that standards need to be sufficiently robust and delineated by care provider category (RN, LPN and CCA) if they are to be effective. This helps to avoid a 'race-to-the-bottom' scenario wherein weak legislated standards become facility maximums.

▶ See Recommendation 1 on staffing standards

C. Nurse Practitioners

The Canadian Nurses Association defines Nurse Practitioners as "registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice" (CNA, 2006). In Nova Scotia, Nurse Practitioners (NPs) are self-regulated under the College of Registered Nurses of Nova Scotia, and are able to practice independently of and in collaboration with other health professionals.

In the LTC setting, NPs assess and evaluate residents, review charts and collaborate with visiting physicians, other nurses and support staff. NPs possess the expertise to manage the chronic and acute conditions that are prevalent among LTC residents such as diabetes, hypertension and other cardiovascular diseases (Donald et al., 2013). A 2013 comprehensive literature review of advanced practice nurses (NPs and clinical nurse specialists) in LTC revealed that they improve or reduce decline in health status indicators like depression, urinary incontinence, pressure ulcers, aggressive behavior, loss of affect in cognitively impaired residents, restraint use, psychoactive drug use, serious fall-related injuries, ambulation, and improved family member satisfaction (Donald et al., 2013). They also possess expertise valuable for providing and promoting high quality palliative care (Kaasalainen et al., 2013).

NPs, along with Clinical Nurse Specialists, have also been identified as ideal change agents to improve pain management protocols in the LTC setting (Kaasalainen et al., 2015). This

stems from, among other things, their ability to educate other staff on pain management and protocol implementation, ability to organize interdisciplinary practice and their ability to use advanced physical assessment skills.

NPs are also effective in staff education and consultation which contributes to improvements in resident outcomes, improved health status and quality of life for older LTC residents, and greater satisfaction levels among families (Donald et al., 2013). Other staff, including RNs, LPNs and CCAs, perceive that NPs help them increase their knowledge and skills, and keep them involved in care decisions, providing better overall care to residents (Sangster-Gormley et al., 2013). For their part, residents and families see NPs as providing resident and family-centred care, and as offering enhanced quality of care (Ploeg et al., 2013).

> NPs in LTC improve or reduce decline in health status indicators like depression, urinary incontinence, pressure ulcers, aggressive behavior, loss of affect in cognitively impaired residents, restraint use, psychoactive drug use, serious fall-related injuries, ambulation, and improved family member satisfaction.

At this time, Nova Scotia has about 150 NPs registered and practicing in the province, although only a few work in the LTC sector.[4] Indeed, the use of NPs in long-term care is still in its infancy across Canada, although Ontario has begun introducing them to this sector with extremely positive results. A study there involving three NPs (2.0 FTE) covering 22 LTC facilities showed that 39 to 43% of hospital admissions were prevented where an NP was used (McAiney, 2008). These outcomes are related to NPs' ability to assess acute conditions, deliver timely treatment, manage medical conditions and enhance other nurses' assessment knowledge and skills.

[4] The not-for-profit continuing care organization Northwood employs one NP for its two LTC facilities in the Halifax region, and there are four NPs in different areas outside of the HRM that support LTC facilities within their regions four days a week.

Buoyed by initial successes, the Ontario Ministry of Health and Long-term Care recently announced it will fund an additional 75 NP positions in long-term care, bringing the number of NPs in LTC from 18 to 93 in that province over the next couple years. The NPs will focus on primary care which the Ministry claims will reduce ambulance use, emergency department transfers, hospital admissions, falls and restraint use, and will improve the experience of residents and care-givers alike (Ontario MOHLTC, 2014). These claims are supported by the literature (for example see Bakerjian, 2008; Kane et al. 2003).

▶ See Recommendation 2 on NPs

D. Work-life Satisfaction

As mentioned, nurses in LTC have lower levels of job satisfaction than their acute care counterparts (CIHI, 2007). The acuity and complexity of resident care, and the ensuing excess levels of work are leading contributors to this.

> A stable and qualified workforce is central to the quality of resident care, and we therefore need to ensure that nurses and CCAs can practice in collaborative and respectful environments.

Another leading factor is the work environment, particularly the relationships among staff and management. A 2010 Canadian study surveyed 675 RNs, LPNs, CCAs and other staff from 26 long-term care facilities about their work environment and related factors, as well as their job satisfaction and turnover intentions. Among the findings, higher job satisfaction was associated with better organizational support and stronger work group cohesion. It was also associated with lower emotional exhaustion and higher empowerment. Higher turnover intention was associated with weaker work-group cohesion as well as lower job satisfaction and higher emotional exhaustion (Tourangeau et al., 2010).

Other studies have focused on the positive effects of supportive nurse management which has an impact on nurse-assessed quality of care and job outcomes, including satisfaction and turnover intention (Van Bogaert et al., 2013). Nurses' job satisfaction and patient outcomes

improve when there is a sense of nursing unit teamwork and leadership (Rafferty et al., 2001; Vahey et al., 2004; Galleta et al., 2011).

The work-life satisfaction of nurses is important for several reasons. First among these is the fact that work-life dissatisfaction impinges upon residents' satisfaction with their quality of care. In a US study from 2009, looking at 430 hospitals, the quality of the nursing work environment was positively associated with all patient satisfaction measures (Kutney-Lee et al., 2009). Other studies have established a direct correlation between nurse satisfaction and patient satisfaction, and indeed, nurses' job satisfaction has even been cited as the strongest predictor of patient satisfaction (Baumann et al., 2001).

Another important factor is the issue of nurse retention and recruitment in the long-term care sector. This fact is perhaps best displayed by looking at health facilities that exhibit positive work environments, and the classic case for this is so-called 'magnet facilities' (e.g. hospitals and LTC facilities). Magnet facilities exhibit key qualities that enable collaborative practice among nurses, including effective nursing leadership, collaborative teamwork, effective communications, clinical

autonomy and adequate staffing levels (MacPhee, 2014; Kramer & Schmalenberg, 2006). They result in better patient outcomes, improved nurse job satisfaction and lower levels of nurse burnout (Friese et al., 2008; Kelly et al., 2011). It is not surprising that facilities that exhibit these characteristics are known to retain and attract nurses (Kramer and Schmalenberg, 2006). A stable and qualified workforce is central to the quality of resident care, and we therefore need to ensure that nurses and CCAs can practice in collaborative and respectful environments.

▶ See Recommendation 6 on work-life

E. Violence and Aggression

Workplace aggression is known to disproportionately affect health care workers and nurses in particular (Edward et al., 2014). Workers in long-term care are particularly vulnerable given that they are often alone and must deal with a host of behavioural issues. Workplace aggression is known to lead to loss of confidence, absenteeism, breakdown of relationships with coworkers, self-medication and turnover (O'Connell et al., 2000; Kamchuchat et al. 2008). What is more, as many as 80% of incidents are not reported to managers (Pinar and Ucmak, 2011; see also Robinson & Tappen, 2008).

Violence and aggression in LTC take many forms. Banerjee et al. (2012) list common forms of violence in long-term care settings as "being hit, punched, pinched, poked, scratched, pushed or kicked. Having one's wrists twisted or hair pulled is also common." Aggression includes bullying, verbal threats and unwanted sexual attention (with the latter reported by 14.3% of Canadian LTC workers).

Low staff levels and high staff turnover have been shown to exacerbate resident aggression towards staff (Robinson and Tappen, 2008). A 2011 study comparing LTC working conditions in Canada with four Scandinavian countries found that an average Canadian direct care worker cares for 19.6 residents, whereas counterparts cared for 6.2 in Denmark, 7.7 in Norway, 8.5 in Sweden and 15 in Finland (Daly et al, 2011). Almost half of Canadian direct care workers (46.2%) reported working short-staffed almost every day, whereas only 15.4% of Scandinavian workers said this, and furthermore, 60.3% of Canadians claimed they had too much to do all or most of the time compared to 36.4% of Scandinavian workers. The same study found that, despite similarities in the resident populations, "violence reported in Canadian LTC homes was ubiquitous and persistent compared with much lower levels of violence reported in Scandinavia" (Daly et al., 2011). Several other studies confirm this relationship between staffing levels and the frequency of violence (e.g., Menckel & Viitasara, 2002 ; Sharipova, Borg, & Hogh, 2008).

> "violence reported in Canadian LTC homes was ubiquitous and persistent compared with much lower levels of violence reported in Scandinavia"

Part of the difficulty in addressing this problem is rooted in the culture of care institutions like LTC homes. Aggression and violence have in many ways become normalized, 'just the way it is here', and so workers and managers treat violence and abuse as a normal occurrence, "expected, tolerated, and accepted" (Gates et al., 1999).

▶ See Recommendations 8+9 on violence in LTC

F. Staffing and Finances

The health of long-term care residents and of long-term care providers should be of paramount concern. However, the current fiscal context makes it impossible to discuss significant changes without considering the financial implications. Clearly, increasing professional staffing levels will have costs associated with it. However, these costs can be offset through higher quality care. The benefits of employing NPs mentioned previously, for instance, are associated with financial savings to the health care system. Pressure ulcers and other wounds, for example, affect about 30% of patients in non-acute settings such as LTC (Woodbury and Houghton, 2004), and treatment of an ulcer can cost tens of thousands of dollars a year (CMS, 2008). NPs could save millions of dollars by preventing pressure ulcers and implementing timely effective treatment when necessary.

Researchers have argued that increased nurse staffing in the acute sector largely, or even completely, offsets increased costs when expenses associated with poorer health outcomes and provider turnover are factored in (Shamliyan et al., 2009; Kane et al. 2007; Needleman et al., 2006; O'Brien Pallas et al., 2010; Jones and Gates, 2007). Similar arguments hold for the LTC sector. The Department of Health and Wellness' Continuing Care branch claims that approximately one in three residents require a visit to the ER every year resulting in 2200 visits per year (DHW, 2015a), and this is a factor influenced by staffing levels. A 2010 report in the US looking at this same issue noted that $2.1 billion USD could

be saved in that country annually if hospitalization rates among LTC residents were reduced by 25% (Zigmond, 2010). A study by the US Inspector General found that 25% of Medicare nursing home residents were readmitted to the hospital for common and preventable problems in 2011 at a cost of $14 billion USD (US OIG, 2013). Another study by the US Inspector General found that substandard treatment, inadequate monitoring, or failures and delays in treatment – all factors sensitive to the level of nursing and CCA staff on hand – resulted in adverse events that caused harm, jeopardy or re-hospitalization of almost 60 percent of residents, costing Medicare $2.8 billion (US OIG, 2014).

▶ See Recommendation 12 on tracking ER transfers

A 2008 study by Horn et al. measured the social benefit associated with increasing direct care hours by RNs in long-term care and the corresponding effect on only three indicators: pressure ulcers, hospitalizations and urinary tract infections. More RN time per day was strongly associated with better outcomes and lower societal cost. Other factors not considered in this analysis would add to the financial case for increased nursing care (see also Buchanan et al., 2002).

Many of the issues discussed in the previous section, including workload issues and violence and aggression, are also associated with increased costs to the system and so addressing them is at the same time a cost-saving measure. For example, absenteeism, turnover, and injuries are known to increase with poor working conditions. A 2015 Canadian Federation of Nurses Unions study of labour force data revealed that the annual cost of public sector nurses missing work due to illness or disability was estimated at $846.1 million a year for 2014, and we know that the absenteeism rate is higher for nursing homes than for the public sector (i.e. hospitals) (Lasota, 2009). Turnover is another costly indicator directly affected by nurses' working conditions. In the acute sector, the cost of turnover has been estimated at $25,000 per nurse given the need to backfill with overtime during the vacancy and decreased productivity in the orientation phase (O'Brien Pallas et al., 2010).

Poor working conditions also result in higher rates for workers' compensation. The 2016 premium rate for the hospital sector is set at $1.63 per $100 of payroll whereas the rate for nursing homes is set at $5.19 – over three times as high. These rates are driven by various types of injuries including musculoskeletal injuries and violence-related claims which disproportionately affect workers in the long-term care sector. Millions of dollars could be saved in the LTC sector if its rate could be driven down by an improved safety record. Unfortunately, the rate has been rising steadily over the past years – over half a million ($540,000) more will be collected from LTC facilities in 2016 than in 2015.

As policy is developed around long-term care, it is important to avoid a siloed, myopic look at spending. Increased spending in long-term care can offset costs in many other areas, including the acute system where care is typically much more expensive to provide. An October 2014 news article, for example, noted that 160 hospital beds in the former Cape Breton District Health Authority were occupied by people awaiting placement in long-term care (Ayers, 2014). Nationally, the Canadian Institute for Health Information reports that Alternative Level of Care (ALC) patients – hospital patients who no longer require acute hospital care – account for 14% of all hospital days. On any given day, 5,200 acute beds in Canadian hospitals are occupied by ALC patients who could receive more appropriate and much less expensive care elsewhere (CIHI, 2009). Providing care to these individuals in the appropriate setting is both an opportunity to improve their quality of living and to realize significant cost savings.

G. Data Collection in Long-term Care

Over the past twenty years, the RAI-MDS tool has become the industry standard for measuring interventions and outcomes in long-term care. The tool was developed by the interRAI Collaborative, a global network of researchers and clinicians from over 30 countries. The collaborative submits its tools to rigorous research and testing to ensure reliability (InterRai, 2015).

Use of the RAI tool entails the collection of data from patients and caregivers to determine residents' level of functioning and individual care needs. Residents are assessed when they enter a facility and again usually every three months thereafter, unless there is a significant change in their condition. According to the Canadian Institution for Health Information:

> *The RAI-MDS 2.0 is a comprehensive assessment that documents the clinical and functional characteristics of residents, including measures of cognition, communication, vision, mood and behaviour, psychosocial well-being, physical functioning, continence, disease diagnoses, nutritional status, skin condition, medications and special treatments and procedures (2010).*

The data generated allows for the categorization of residents into a case mix classification system known as Resource Utilization Groupings (RUGs). This information is then used to create care plans for residents.

The use of the RAI-MDS tool provides a common language for both the public and analysts so that quality and performance can be measured and evaluated. It has contributed to improvements in outcomes such as bed sores, dehydration, nutrition and falls (Hawes et al., 1997).

The RAI-MDS system, for all its strengths, is no panacea. For one, it does not track certain important indicators such as quality of resident life, autonomy and satisfaction. (Armstrong et al., 2015; Sutherland et al., 2013), nor does it generate an indicator for 'social engagement', another factor important in quality of life (Gerritson et al., 2008). Researchers familiar with the RAI-MDS describe its failure to accurately capture or translate social care into action, which is arguably the kind of care that makes life worth living (Armstrong et al., 2015). They also claim the tool does a poor job measuring for mental health.

The RAI tool can also contribute to RN and LPN workloads if there is no consolidation of data management systems and paperwork, and if time for charting is not accounted for. Further, there is often a lag between changes in the level of care required and levels of funded

staff, and without appropriate staff data management suffers as well. Data management should add to, not take away from, patient care.

In Ontario, an arms-length agency of the government known as Health Quality Ontario provides online public reporting on health indicators, including RAI-MDS data from the LTC sector. Data on falls, incontinence, pressure ulcers and restraint use can be accessed by region, by facility and province-wide. The following table shows an example of a report on one home.

Table 2.2 Sample reporting data from Health Quality Ontario - Indicator Results for this Home

Year	Percentage of Residents Who Had a Recent Fall	Percentage of Residents With Worsening Bladder Control	Percentage of Residents Who Had a Pressure Ulcer That Recently Got Worse	Percentage of Residents Who Were Physically Restrained
2013-14	14.9%	20.4%	4.1%	15.2%
2012-13	16.1%	16.3%	4.8%	13.8%
Provincial Average 2013/14	14.2%	19.5%	3.0%	8.9%
Benchmark	9%	12%	1%	3%

Adapted from Health Quality Ontario, 2015, available: www.hqontario.ca/public-reporting/long-term-care

Unfortunately, further data is weighted and typically only available to facility managers for the purposes of care planning, resource allocation, quality improvement, research and other purposes. One important gap, for example, is data on the number of staff per number of residents providing care in each facility. This and other data should be available to the staff that contribute to it so that they know they are charting for a reason and so they can see their efforts having an effect on care in their facility. More aggregate data should also be available to the public in order to adequately scrutinize the care of our seniors and other LTC residents.

> Nursing involves a look at the whole person, including their history, setting and temperament, and it involves the use of foundational knowledge that goes beyond simply completing a list of specified tasks.

Lastly, the RAI-MDS model is based on the measurement of tasks – meals eaten, baths taken, medications given, interventions provided etc. The danger here is to reduce nursing care to a list of tasks. (Armstrong et al., 2015) Nursing involves a look at the whole person, including their history, setting and temperament, and it involves the use of foundational knowledge that goes beyond simply completing a list of specified tasks. Data systems like the RAI-MDS tool can present a misleading picture of the role and value of nursing and this is something we must resist.

In spite of these flaws, the RAI-MDS remains a powerful tool that can increase transparency and accountability and can help ensure appropriate levels of staffing and care. Many of the flaws mentioned here can be eliminated or mitigated by ensuring that nurses are given the time and training to use the tool and ensuring that staffing levels and working conditions are responsive to the data.

▶ See Recommendations 10+11 on data management in LTC

III. Situation in Nova Scotia

A. 2002 Task Force and Progress

Between 1999 and 2001, several Nova Scotia health care unions joined with employers and the Department of Health (now the Department of Health and Wellness) to form a task force to review staffing in long-term care (Task Force, 2002). The resulting report noted that no overall provincial human resources management plan exists for the LTC sector. It also noted that LTC facilities were not being asked to report human resource statistics to the Department of Health.

The task force made a series of recommendations in a bid to improve long-term care in Nova Scotia. Among these, the first two recommendations are particularly pertinent. First, the Task Force called on the Department to implement the Resident Assessment Instrument (RAI-MDS 2.0 tool) province-wide. Second, the task force called on the Department of Health to establish a multi-disciplinary monitoring committee charged with determining and monitoring adequate and safe levels of resident care.

Unfortunately, there has been little or no action on these recommendations. The Department of Health and Wellness still does not compile health indicator information from the various

long-term care facilities. The Continuing Care branch does use the RAI tool, but only for assessments prior to facility placements. Only nine of the 90 LTC homes in Nova Scotia have begun using the RAI tool within facilities. The department does keep critical incidence reports and licensing reports. The former should include data on unanticipated deaths, serious impairments, unanticipated service disruptions for over 24-hours, events involving multiple clients, public health hazards, events that may undermine public confidence in the health care system and other serious incidents (Department of Health and Wellness Long Term Care Administration Handbook). The licensing reports are supposed to occur unannounced annually or more frequently, and involve checking compliance with the applicable legislation, policies and standards. This should include actual staffing levels. Unfortunately, neither of these reports are tabulated anywhere so they are not available to the public or stakeholders. The Nova Scotia Nurses' Union has requested to see the Department of Health and Wellness Continuing Care branch's data on critical incident reports but has received nothing yet.

Despite the flaws noted above with the use of the RAI-MDS tool, simply not using an advanced practice and outcomes measurement tool is not an option. As the old adage goes,

you can't manage what you don't measure. It goes without saying that tracking deficiencies in the LTC sector is incredibly important. Investigations in the United States have found that violations are under-identified, serious violations are under-rated and that penalties are not enforced (Harrington et al., 2015; US GAO, 2002, 2007; 2009a,b; US OIG, 2014).

▶ See Recommendations 10+11 on data management in LTC

Regarding the second recommendation from the Taskforce, to our knowledge there is no committee that monitors the adequacy of resident care, including important factors like staffing levels.

▶ See Recommendations 1-5 on staffing in LTC

B. Auditor General Reports

Recent reports from the Nova Scotia Auditor General (AG) make it clear that staffing standards are not being monitored and that we do not know if they are based on recognized standards. The June, 2007 AG report (Ch4: Long-term Care – Nursing Homes and Homes for the Aged) noted that the Department of Health and Wellness already recognizes that many of the requirements of the *Homes for Special Care Act* do not reflect current standards. At the time, the Department claimed they would begin working to update the legislation in 2008-2009. This has not happened even though the AG claimed that updating the *Act* is urgent.

The AG noted that Departmental inspections of nursing homes do not include a review of financial management, internal controls, accreditation status or, what is important for present purposes, staffing standards. Accreditation is provided through Accreditation Canada, but this merely ensures that there are staffing plans in place and does not mean that staffing levels are measured against evidence-based standards. Staffing levels are not addressed in the inspection process and there is no review and analysis of actual resident care staffing levels compared to the number of staff funded.

The May, 2011 report (Ch5: Health and Wellness: Long-term Care – New and Replacement Facilities) noted that none of the 8 recommendations from the 2007 report were implemented. Particular attention is given to the request to update the *Homes for Special Care Act*, a request made repeatedly since 1998. The AG noted that service providers (i.e. facility administrators) are required to have Departmental approval before changing staffing levels. It is unclear as to whether this is occurring.

In May, 2014, the AG's report noted that only three of seven recommendations from 2011 had been implemented in some form or were in progress. One of the 2011 recommendations was to immediately implement the 2007 AG recommendations. Although the DHW agreed with the vast majority of the recommendations, they have yet to implement any from 2007.

C. NS LTC Staffing Guidelines: *Homes for Special Care Act* and DHW Policy

The 1989 *Homes for Special Care Act*, the legislation governing long-term care in Nova Scotia, says little with respect to staffing requirements. Section 18(2) states:

> *In every nursing home and nursing care section of a home for special care where there are less than thirty residents, there shall be at least one registered nurse on duty for no less than eight hours every day, and in the absence of the registered nurse there shall be a person on duty in the home who is capable of providing emergency care*

and 18(3)

> *In every nursing home and nursing care section of a home for the aged where there are thirty or more residents, there shall be at least one registered nurse on duty at all times.*

The staffing regulations in the *Act* have not changed since they were drafted in 1977.

Nurse and CCA staffing is one of, if not the most important indicator of resident quality of care. There are regulations determining the space available for food preparation, and yet, apart from the minimal requirement noted above, there are no regulations on the number of RNs, LPNs and CCAs available to provide care.

What is more, nurses in Nova Scotia frequently report that employers are not meeting the RN coverage standard mentioned above. Some employers interpret "on duty" to include "on call" such that the RN coverage can be provided from a nurse who is not actually at work. Other employers sometimes consider one RN to be "on duty" for two facilities that are a 20 to 30 minute drive apart.

▶ See Recommendation 3 on the RN requirement

Information obtained from the Department of Health and Wellness reveals funding guidelines based on hours of care per resident day (hprd). The Department provides funding for 4.0 hprd to LTC facilities based on the following formula: 1.0 hprd of licensed care (RN and LPN

combined), and 3.0 hprd of CCA care. Reports from NSNU nurses suggest that LTC facilities are not staffing at these levels (see page 46). This funding model is what is referred to as the 'augmented traditional' approach. The department also funds a 'full-scope' model wherein qualified CCAs who have completed the CCA program apply their skills with respect to household management, personal care, mobility assistance, meal preparation, recreation, respite and emotional support (DHW, 2012). This model is applied to facilities where residents are divided into 'households'. Each household can comprise 15 residents and is allotted 40 hours of personal care from CCAs as well as 10 hours for housekeeping and meal preparation. Each resident is also allotted an average of one hour of professional nursing care from RNs and LPNs each day.

It is important to note that many LTC facilities also include adjoining residential care facility (RCF) wings that house residents assessed as not requiring nursing care. Despite this designation, licensed nursing staff are required to perform daily checks on RCF residents and to respond to emerging problems. RCF work is not factored into licensed staffing allotments.

▶ See Recommendation 4 on RCFs

> There are regulations determining the space available for food preparation, and yet, apart from the minimal requirement noted above, there are no regulations on the number of RNs, LPNs and CCAs available to provide care.

D. Nursing in Long-term Care

Since the 1990s, the Nova Scotia Nurses' Union has made a concerted effort to align collective agreements in long-term care (and home care) with those in the acute care sector. Since 1997, LTC RNs and LPNs are paid the same annual wage as counterparts in acute care, and since 2006, LTC nurses are members of the same pension plan.

These significant achievements should not obscure the fact that certain disparities remain. Long-term care nurses make slightly less in overtime, they have a smaller retirement allowance, and a few facilities do not provide benefits like long-term disability coverage. Sick leave benefits are sporadic in LTC, yet consistently less than those earned by nurses in the acute sector. This can be an important consideration given that LTC nurses are typically older than their acute care counterparts. The Canadian Institute for Health Information (2015) reports that 13.9% of LTC nurses are over 60, compared with 8.9% in the acute sector.

Another significant difference stems from the fact that casually employed nurses in LTC have been, to now, considered non-union, and therefore do not enjoy the same benefits and protections as their coworkers.[5] This may lead nurses seeking casual employment to prefer the acute care sector where they enjoy the security and benefits of unionization.

The Government of Newfoundland and Labrador (2015) recently introduced a comprehensive classification framework and transparent and efficient job evaluation system, designed to determine the relative value of jobs within an organization such as a hospital or long-term care facility. The evaluation used nine factors, each with its own weighting in the final evaluation: knowledge, interpersonal skills, physical effort, concentration, complexity, accountability/ decision making, impact, leadership and environmental working conditions.

The NL evaluation on RNs and LPNs working in long-term is instructive. It recognized that the leadership, knowledge, accountability and skills required to practice nursing in this sector amounts to a level of specialization requiring a higher level of compensation.

There are other differences that stem from the different ways that acute and long-term care services are funded. For example, a patient with behavioural issues may be assigned a 24-hour sitter in a hospital recovery ward. However, when this patient becomes a resident in a LTC facility, they may have no sitter at all, or may have sparse or uneven coverage. This disparity has implications for care providers' workload, their sense of safety and security, and their perceived value before their employer. Oftentimes the facility will expect the family to pay for a sitter out of pocket, placing an extra burden on the family. In the case of an aggressive resident the family may also be asked to hire security. Other important funding differences include lack of access to professional services, particularly rehabilitation resources like physical and occupational therapists.

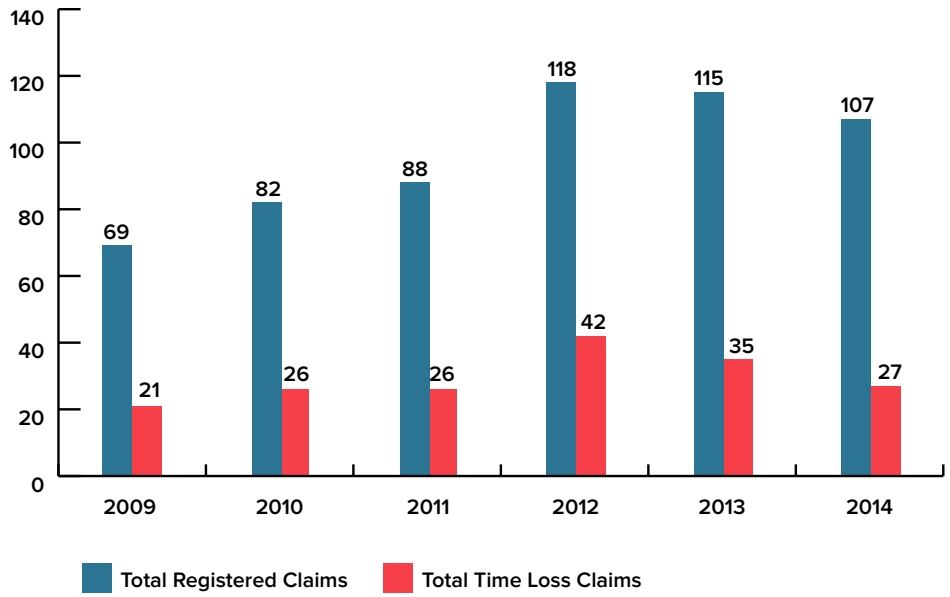
[5] *This stance has been challenged before the Labour Board on several occasions.*

Facility operators (employers) could likely list a host of noticeable differences from their perspective. They must juggle limited budgets, augmented with revenue they generate, or from facility fundraisers, to pay for things like furniture, general upkeep, furnaces and climate control, resident transportation, activities for residents and even portions of labour costs.

Another relevant difference worth noting for nurses in long-term care in Nova Scotia is the prevalence of on-the-job injury. As data obtained from the Workers' Compensation Board of Nova Scotia indicates, despite the vast size difference between the LTC and hospital sectors, there were 867 total registered WCB claims in the LTC between 2007 and 2013, compared to 1057 in the much larger hospital sector, and about 60% more of the LTC claims resulted in lost time as compared with the hospital sector claims (AWARE-NS, 2013).[6] Claims in LTC are well above the provincial average and the health and social service sector average. In fact, there were 215 LTC workers absent from work due to injury for the whole of 2014, compared with 116 in the acute sector.

Violence-related claims are particularly problematic in the LTC sector.

Figure 3.2 Violence-related Workers' Compensation Board claims for Nova Scotia LTC, 2009-2014



Data obtained from the Workers' Compensation Board of Nova Scotia (2014).

[6] *It should be noted that the WCB database is designed to track injury claims rather than provide the most accurate picture possible of the prevalence of different types of injuries. The data should be taken as indicative rather than rigorous and precise.*

It is instructive to note that, according to communications with the Worker's Compensation Board of Nova Scotia, the hospital sector had 81 violence related claims in 2013, compared to the 115 in the LTC sector, and the hospital sector has at least three times as many employees. Staff at the WCB cautioned that the reported data likely under-represents the actual number of claims as violent acts can often lead to other sorts of claims like musculoskeletal injuries or overexertion. Further, the WCB recognizes a trend among nurses to rely on sick time plans instead of WCB claims due to the inadequate remuneration levels offered by the latter.

> The hospital sector had 81 violence related claims in 2013, compared to the 115 in the LTC sector, and the hospital sector has at least three times as many employees.

There are important initiatives in Nova Scotia designed to address violence and behavioural problems in LTC. In 2004, the DHW launched its 'Challenging Behaviour Program' which helps providers address the care needs of residents with cognitive impairments and who may display or are at risk of displaying violent or aggressive behaviours. Integral to this program is an educational philosophy known as P.I.E.C.E.S., a holistic and person-centered approach to care that supports team-based solutions and collaboration with external partners. The Department employs 11 full-time positions to support the program with on-site education, mentoring, coaching and consultations. The Health and Community Service Safety Association, AWARE-NS, also provides an excellent five-step (the last of which is in development) education program called 'Steps for Safety' aimed at promoting violence-free workplaces.

Both of these programs are important in the effort to create safe and secure workplaces. However, injury data makes it clear that more needs to be done.

▶ See Recommendations 8+9 on violence in LTC

Many of the differences in both remuneration and service level between LTC and acute care are historical hangovers from an era when LTC residents were typically mobile and alert, with low acuity and only one or two health issues to manage. Indeed, nurses used to 'retire' into long-term care from acute care in order to finish their careers in a more relaxed environment. Those that try this today are in for a rude awakening. They are often the only

licensed professional on the floor or even in the building, with dozens of residents under their purview suffering from various and often multiple maladies. They have very little time to deliver the care they are trained to provide. And unfortunately, all of this makes it very difficult to attract and retain nurses to work in the LTC sector, particularly in remote areas.

▶ See Recommendation 5 on an HHR strategy for LTC

The quality of resident care is, of course, not dependent on nurses and CCAs alone. Nova Scotia LTC residents have some access to professional services like physical therapists and occupational therapists, but access is uneven and typically inadequate. Manitoba offers an instructive example of how to provide equitable and sufficient coverage. Professional and other non-nursing services are under the jurisdiction of the government rather than individual facilities. Residents are assessed and services are brought to the facilities. Similarly, there are provisions to cover the cost of sitters for potentially violent residents and money for extra CCA coverage if a resident requires more than one-on-one care.

▶ See Recommendation 7 on remedying disparities in LTC

IV. NSNU Survey and Consultation Groups

Between January 24th and February 18th, 2013, an online survey was open to all NSNU members working in long-term care. One hundred and eighty-five nurses responded to the survey, representing roughly 18% of our LTC membership.

A. Winter 2013 Survey

Quality of Care

Of the nurses surveyed, over half (51%) noted a decline in the quality of care over the past 3-5 years while only 16% noted an improvement. Of those who noted a decline in quality, 27% attributed this primarily to having fewer nursing staff while 63% attributed it to increases in workload. Falls, delivering care late and providing medication late were cited as the top problems related to staffing levels.

Staffing Levels and Workload

Nearly three-quarters (74%) of respondents claimed that resident acuity has gone up over the past three to five years, and 60% claimed the increase has been significant or very significant. Forty-nine percent of workplaces sometimes operate below core staffing, while an additional 25% usually or always operate below core staffing. A full 59% of respondents claimed that core staffing at their workplace is inadequate for providing safe, quality resident care.

Seventy-five percent (75%) of nurses reported that staffing levels are a significant or very serious problem, while 70% said the same about workload. The next most cited problem reported was lack of support from management (53%).

Aggression and Violence

Nearly a quarter (23%) of nurses surveyed reported experiencing bullying and aggression from residents frequently (defined as a couple of times a month or more) and another 26% of nurses reported it often (defined as a couple of times a year). Similarly, 14% reported incidents of violence from residents frequently, while 24% reported it often. Nearly a third of respondents (32%) claimed their work environment is not safe and secure, and twice as many believe it is less safe rather than more safe compared to three to five years ago (35% vs 17%).

B. NSNU Consultation Groups

In the Fall of 2013, the NSNU held four consultation groups with LTC nurses. Meetings were held for between four and eight nurses (RNs and LPNs), with meetings in the Northern, Central, Western and Eastern regions of the province. The purpose of the sessions was to drill deeper into the findings from the survey.

The responses of consultation group participants were strikingly similar in each region. Nurses spoke of the difficulty in retaining and recruiting qualified staff, the ever-present threat of violence, the lack of equally qualified collaborators, the sheer number of residents under their care at a given time, the ever-increasing complexity of that care, and being overwhelmed by the level of responsibility expected of them.

Several key themes are worth highlighting here. The first surrounds the value that our society places on the lives of LTC residents and, concomitantly, the value of LTC nurses and other health care workers. Nurses spoke of residents being ‘abandoned’ into LTC facilities where there is no time to provide adequate care and attention. Some residents have family members who visit them, while many others are alone virtually all of the time. Nurses spend a good portion of their waking hours in the company of residents, and unlike their colleagues in acute care, LTC nurses often have the time to get to know residents over months and years. They become friends and confidants of the residents and they deeply regret the fact that they cannot give them more time and more care.

LTC residents, many nurses claimed, are seen as second class citizens, and this is why more is not being done about their level of care. As one nurse put it, "If I had to change one thing? Recognition from everyone of the significance and value of every life that is cared for in long-term care, despite their ability to contribute to society or not anymore. I think if we had that, the rest would come."

Nurses believed this lack of respect for seniors and LTC residents was reflected in the respect that they themselves receive. Their weaker benefits, the enormous pressures placed upon them and the expectation that they regularly subject themselves to violence and aggression – this was all a sign to the nurses that their work and contribution to the health system are not valued. "I think as a society we don't value the nurses in LTC. Some of that is that we don't value the senior that is no longer producing for the country...there's no value in them. They're not paying taxes, not working...they're a liability now."

▶ See Recommendation 7 on remedying disparities in LTC

The other major theme of the focus groups surrounded the difficulty of working in the long-term care sector. One of the biggest factors in this was the dramatic rise in behavioural problems among residents. Even though an aging demographic is driving the increasing need for LTC, facilities in Nova Scotia are also home to many younger residents with psycho-social illnesses. For example, there are many young males who have suffered brain injuries related to accidents or drug use who nevertheless maintain their physical strength. One nurse expressed her anxiety thus: "There are no facilities any more for [behavioural] patients and we've become a dumping ground. In hospital they have one on one sitters, they arrive at your facility and 'they don't need a sitter anymore'." And another: "We had a gentleman that gave a couple of staff concussions, broke their noses. He's in a place where he shouldn't be."

▶ See Recommendations 8+9 on violence in LTC

> "We had a gentleman that gave a couple of staff concussions, broke their noses. He's in a place where he shouldn't be."

As we have seen with the data from the Canadian Institute for Health Information, the acuity and complexity of LTC patients has been rising steadily, and this is not lost on the nurses. Nurses spoke of treating conditions that, until a few years ago, would have been addressed in a hospital setting with a full range of equipment, technology and other health specialists and support. Now, LTC nurses are expected to provide this care with very little in the way of equipment and technology and virtually no outside support; "The complexity as compared to years ago…it's incredible, it's absolutely incredible…who's coming through our door and what we're expected to care for in terms of complexity, in terms of skill, in terms of knowing more than it ever was. That impacts our workload."

The workload is taking a toll, a problem compounded by the fact that most LTC facilities have difficulty retaining and recruiting nurses. Nurses spoke of job postings never being filled, of employers giving up on recruitment efforts. Others noted that many new recruits didn't last through orientation. Many nurses were simply unable to take vacation while others managed to eke out a short vacation through an elaborate shift exchange exercise with the other nurses. Typically there are no casuals to call upon during vacations or to fill in during sick leaves. "I had the flu and they called and said, you are the least sick of the sick people we have. Can you come in? "Yeah, I guess so…" I had the flu shot, so I went in."

▶ See Recommendation 5 on an HHR strategy for LTC

There is a clearly cyclical relationship between working conditions and retention and recruitment. "I love nursing and wouldn't give it up. But sitting around the table at work, there are many nurses who are in the process of or are thinking of or playing with the idea of changing careers. One in accounting, another in education…another wants to work at Walmart because it has to be less stressful."

The work takes a toll on the nurses. But it would be wrong to see this only as an issue of having a tremendous amount of work to do. Time and again, the nurses spoke about moral exhaustion arising from their inability to provide the level care they are trained for, and that residents deserve. Many nurses spoke about 'taking work home with them' – they worried that care was left undone, that nurses on the following shift would not have time enough to spend with a particular resident, that they were unable to even say a kind word to a resident who is dying. "We don't have time. It broke my heart going home last night knowing this gentleman is by himself…dying. That really bothers me to know someone is dying alone."

V. Fall 2015, Third Party Survey

The NSNU LTC survey and focus groups motivated further research on the state of LTC in the province, and on various solutions proposed in the literature. By the summer of 2015, the NSNU Board of Directors determined that a second survey should be conducted by an independent party to get a fuller understanding of key factors affecting the quality of resident care and the work-life of LTC nurses.

The new survey was designed to determine NSNU LTC members' opinions on changes and impacts in a number of key areas including quality of resident care, quality of work-life, safety and security in the workplace, changes in staffing, and the collaborative care model.[7]

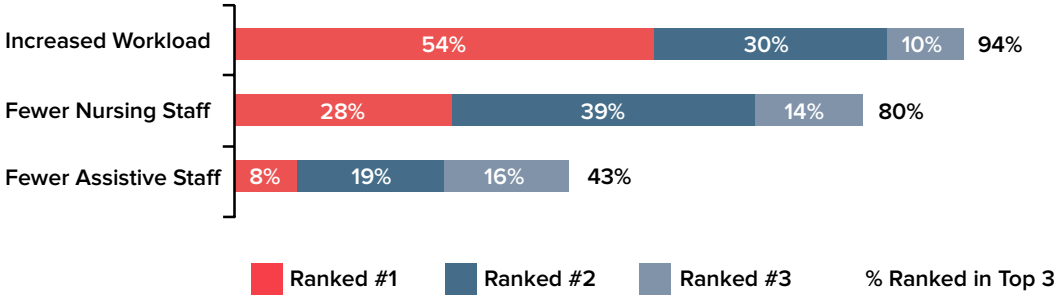
The survey was conducted online (via secure invitation) between September 23rd and October 7th, 2015. A total of 248 NSNU nurses working in LTC accessed the survey of which 201 members completed the survey in full – a 32% response rate based on available email addresses.

[7] *Survey conducted by the Halifax, Nova Scotia branch of MQO Research, an accredited Gold Seal Member of the Marketing Research and Intelligence Association.*

A. Quality of Resident Care

Four in ten nurses reported that the quality of resident care has declined in recent years while slightly more (42%) believe it has remained the same. Increased workload and fewer nursing staff clearly emerged as the top two reasons for declining care.

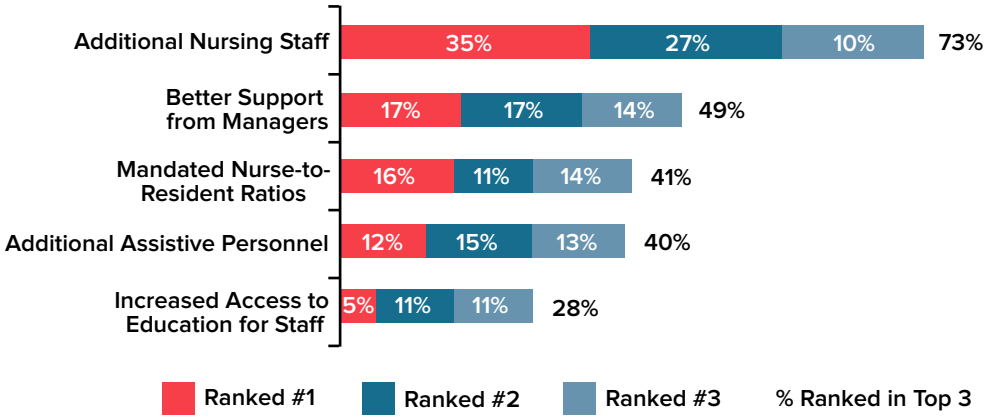
Figure 5.1 Top reasons for decline in quality of care over past 3-5 years



Q: In your assessment, what are the top three factors that have contributed most to a decline in quality of care in your facility?

Nurses were clear in their assessment that additional nursing staff was the top means of support they needed to increase the quality of patient care. Better support from managers and mandating nurse-to-resident ratios rounded out the top three.

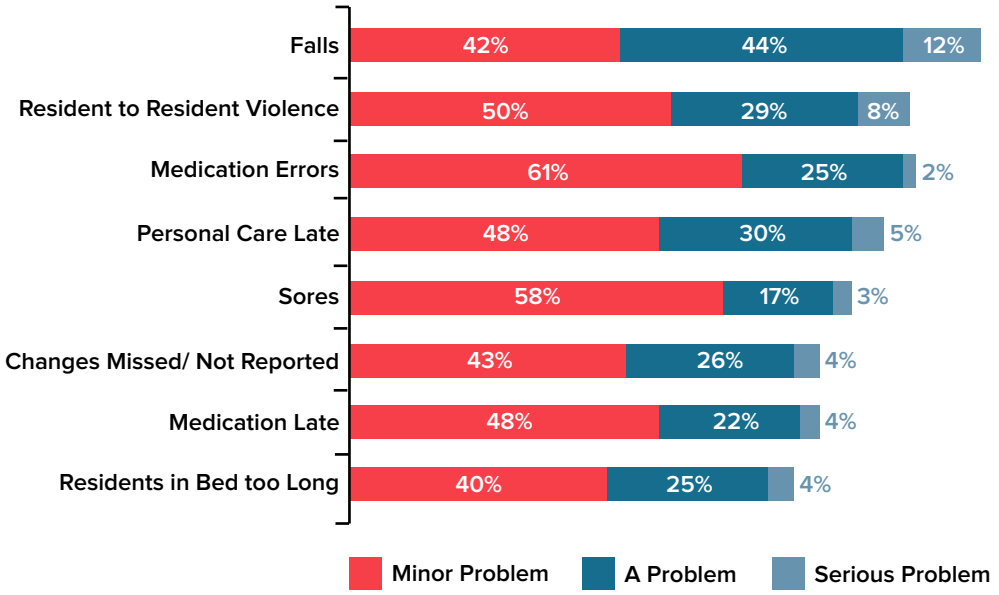
Figure 5.2 Top forms of support for improving the quality of resident care



Q: In your assessment, what are the top three forms of support for nurses that would most improve the quality of resident care in your facility?

When nurses were asked to rank quality of care problems, falls ranked as the number one problem with over half identifying them as either a problem (44%) or a serious problem (12%). Resident to resident violence emerged as the second worst problem.

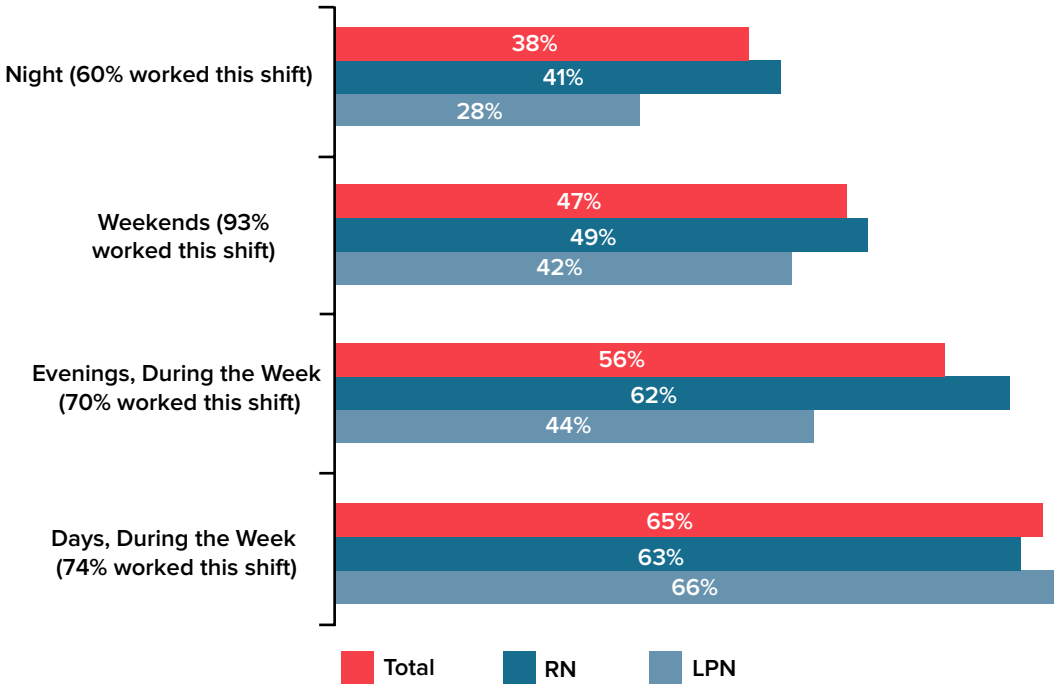
Figure 5.3 Top problems at facility



Q: To what degree are the following a problem in your facility?

Nurses were also asked to identify which shifts were the most problematic with respect to workload. The majority of RNs working day shifts and evening shifts during the week said that they did not have enough time to properly care for residents. A majority of LPNs also found the lack of time most common during the day shift.

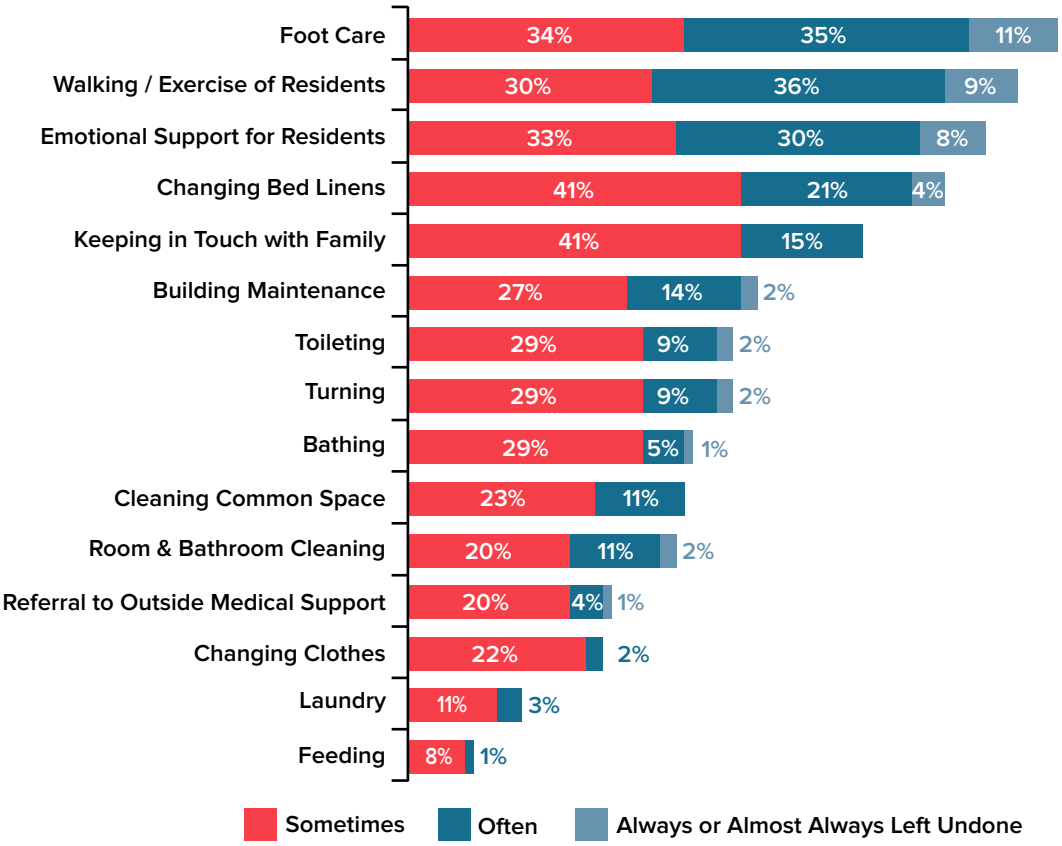
Figure 5.4 Time to care for residents
Percent of those who worked the shift who said "No, not enough time."



Q: Do you have enough time to properly care for residents when you are working the following shifts?

Staff cited excessive workloads and staff shortages as the principal reasons for not having enough time to provide appropriate resident care. This sometimes translated into different forms of care being left undone. Foot care, exercise and emotional support were the most common forms of care left undone.

Figure 5.5 Care left undone



Q: Over the past 14 days, how often have the following tasks been left undone?

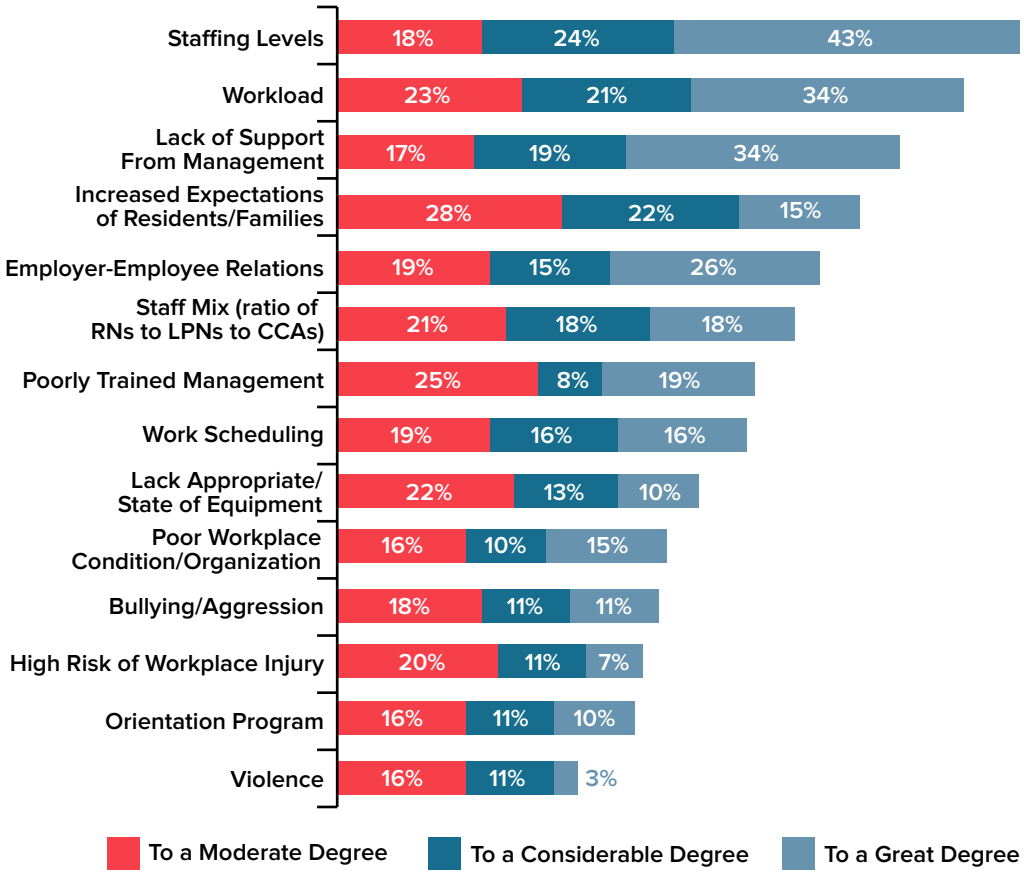
Nurses were also asked whether they would recommend their facility to a loved one. Most nurses (57%) said they would, but nearly a quarter (23%) said they would not and another 19% were unsure.

B. Quality of Work-life

Only four in ten nurses reported that they are often or always satisfied with their work-life, a view that was consistent across RNs and LPNs. Colleagues and the social aspect of work, and an atmosphere of professionalism and respect, emerged as the top two contributors to work-life satisfaction.

Staffing levels and workload emerged as the top contributors to work-life dissatisfaction. Other important factors include a lack of support from management and increased expectations of residents and families.

Figure 5.6 Contributors to work-life dissatisfaction



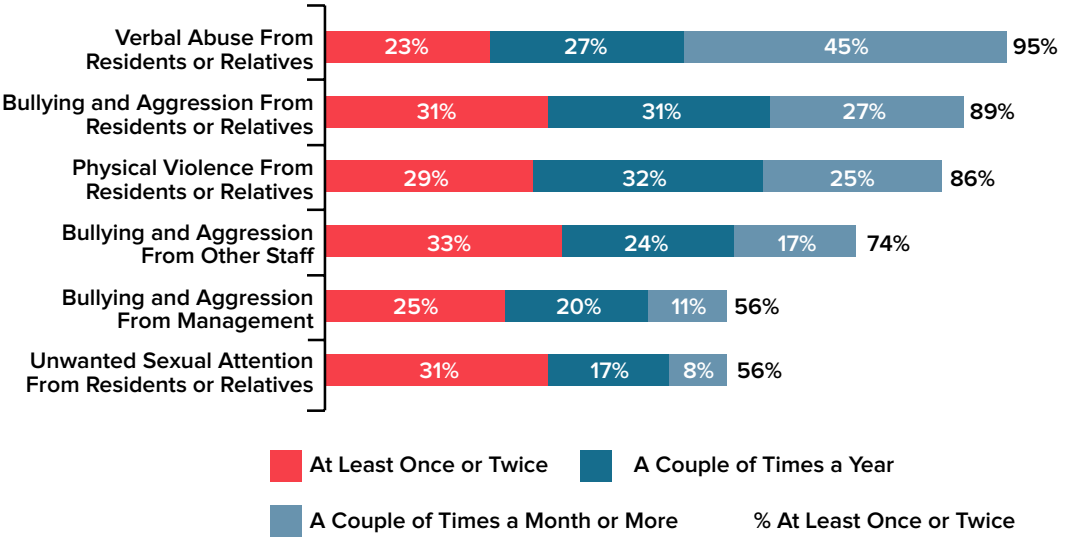
Q: To what extent do each of the following contribute to work-life dissatisfaction?

The majority of RNs and LPNs (75%) agree that they would recommend their facility to other nurses. However, when it came to considering new graduates, less than half of nurses (47%) would recommend they work in their facility.

C. Safety and Security in the Workplace

Considering the last three to five years, half of nurses (50%) indicated that they had personally experienced an incident at work which negatively impacted their personal safety and security. Nurses clearly set the threshold high when answering this question because incidents of violence and aggression turned out to be quite common. Verbal abuse, bullying and physical violence from residents and relatives top the list of the incidents that impact safety and security at work. In fact, almost half of nurses experienced verbal abuse a couple of times a month or more. Twenty-seven percent of nurses experienced bullying and aggression from residents and families a couple of times a month or more and a full 25% experienced physical violence from residents or families a couple of times a month or more.

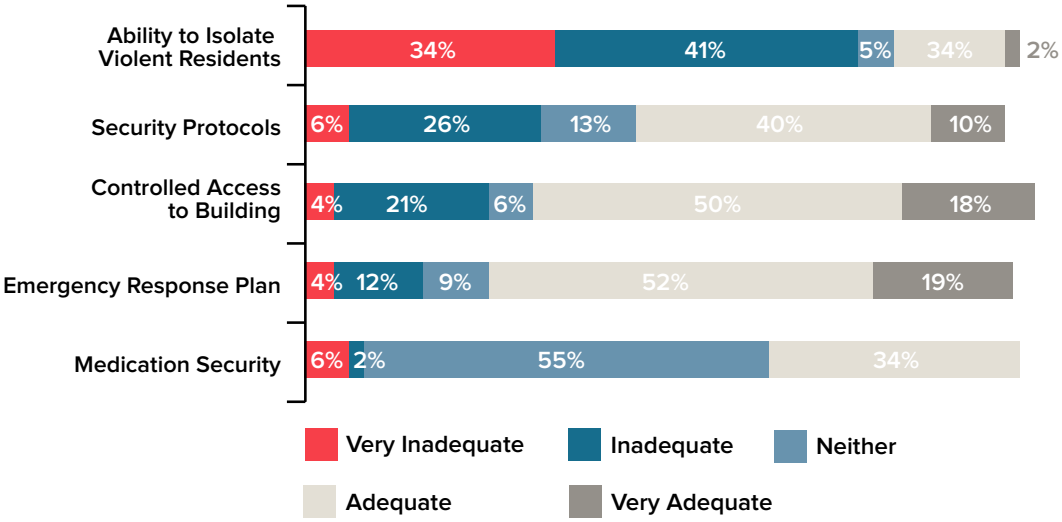
Figure 5.7 Experiences with violence, abuse, aggression



Q: How often have you personally experienced any of the following?

While half of nurses surveyed believe the safety and security of their workplace has not changed over the last three to five years, over a third of nurses (35%) believe their workplace has become less safe and secure, compared with only 15% who believe it is more safe and secure. The top security issue cited was the ability to isolate violent residents where 75% describe security surrounding violent residents as either very inadequate or inadequate. About a third of respondents (32%) believe their facility's security protocols are inadequate or very inadequate and a quarter (25%) are concerned with controlled access to the building.

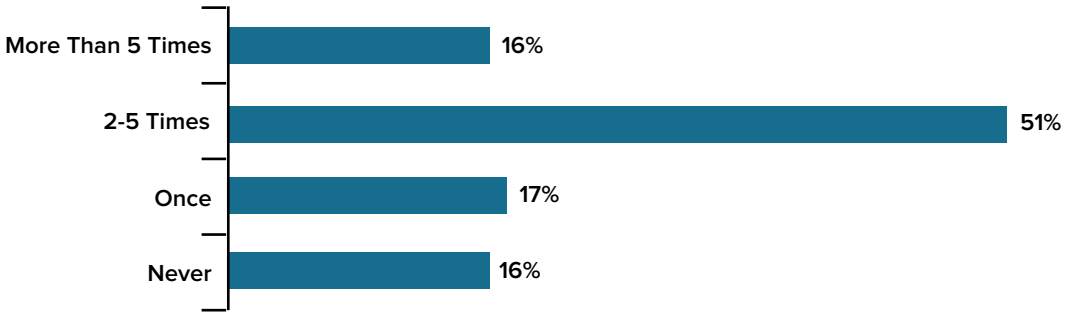
Figure 5.8 Workplace safety concerns of nurses



Q: How would you rate the safety and security of your facility with respect to the following factors?

Nurses frequently come to work even when they are sick or injured, with about two-thirds (67%) reporting they had been to work sick or injured two to five times or more within the last 12 months.

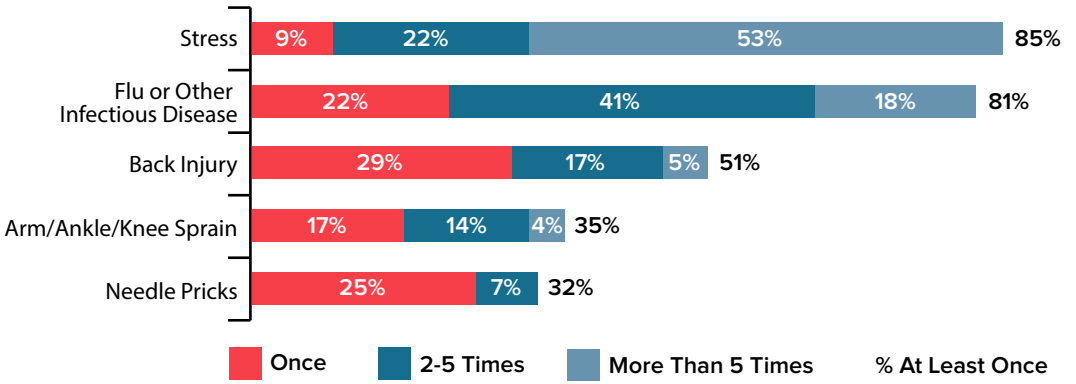
Figure 5.9 Frequency of reporting to work while sick or injured



Q: In the last 12 months, how many times have you been at work even though you were sick or injured, and should have reported yourself sick?

Nurses also report high levels of illness and injury as a result of their work. Stress and flu or other infections were the top injuries and illnesses identified while over half (51%) of nurses reported back injuries since being employed at their facility.

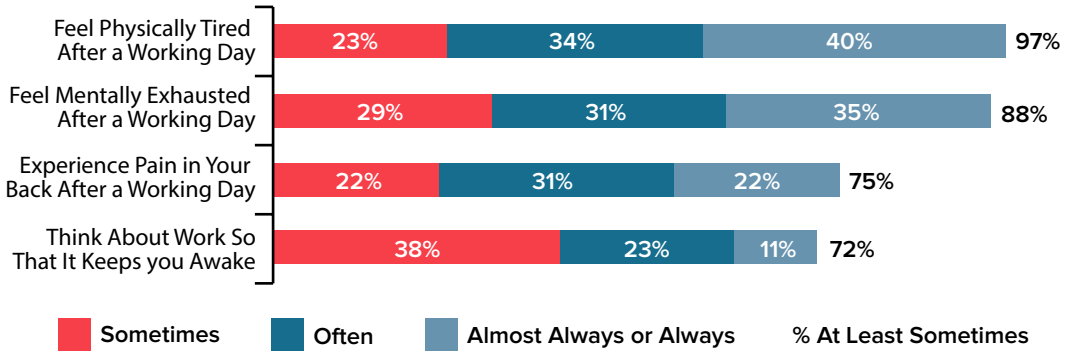
Figure 5.10 Most common on-the-job Injuries



Q: Since you began working at this facility, how many times have you suffered any of the following injuries or illnesses as a result of your job?

Physical and mental exhaustion impacts almost all nurses at least some of the time. Four in ten (40%) said that they always feel physically tired and 35% mentally exhausted at the end of the workday.

Figure 5.11 Reported state after work

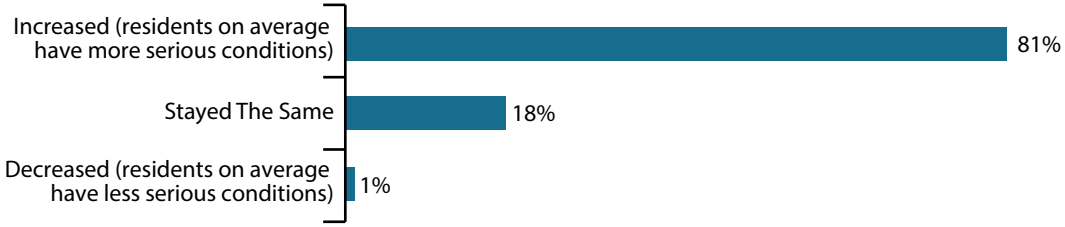


Q: How often do you...?

D. Resident Acuity and Staffing

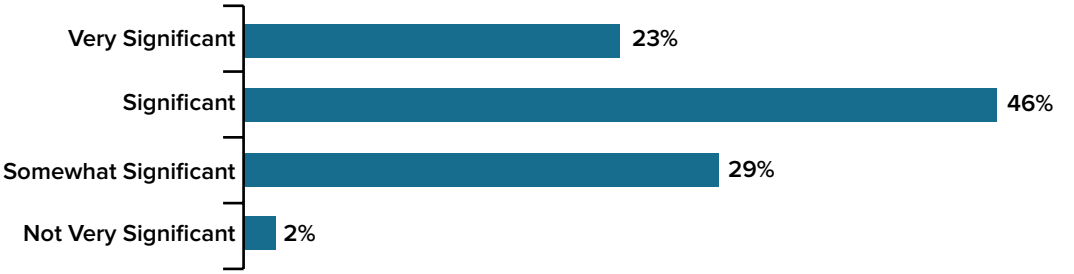
There was strong agreement that resident acuity is a growing problem. Eight in 10 nurses agree that the acuity of residents has increased over the last three to five years, and seven in 10 report that the increase has been significant or very significant.

Figure 5.12 Resident acuity



Q: Has the acuity of residents increased, decreased, or stayed the same in the past 3.5 years?

Figure 5.13 Degree of change in resident acuity



Q: How significant has the increase been?

Slightly under half of nurses (49%) indicated that their facility always meets the minimum standard of RN coverage as outlined in 1977 regulations that accompany the *Homes for Special Care Act*. Another 35% said they often meet it, while 10% said they sometimes do, and 5% and 1% said they rarely or never do, respectively. When standards are not met, coverage by an LPN is the most common solution.

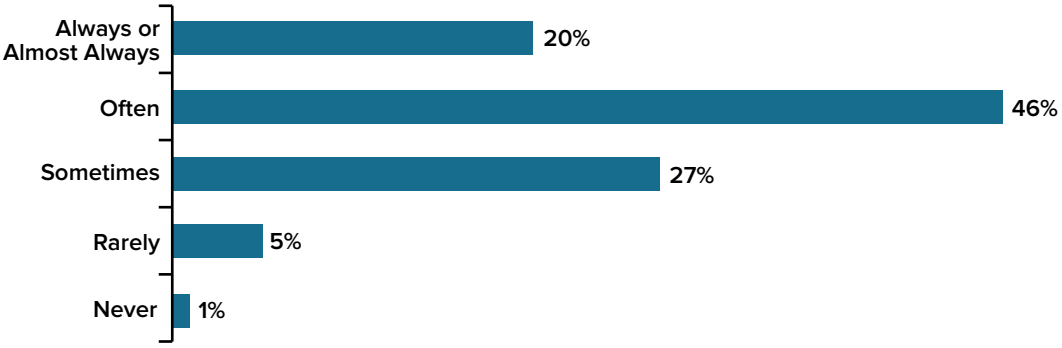
Thirty-two percent of nurses work in facilities with Residential Care Facility (RCF) residents. Of these nurses, 40% claim that RCF residents often, always or almost always contribute to their workload while another 37% claim they sometimes do. Typically, this contribution is small (33%) or moderate (42%), but 23% of nurses claim the contribution to their workload is considerable or great.

The ratio of nurses and CCAs to residents, calculated and cited as hours per resident day (hprd), is similar across facilities. The average RN hprd (i.e. the average amount of time a resident would receive care from an RN each day) was 0.39 hours. The average LPN hprd was 0.62 hours and the average CCA hprd was 2.57 for a total average of 3.57 hours of care per resident day.

It is important to note that these numbers reflect the amount of paid time nurses and CCAs are present in their workplace (when core staffing is met) and do not accurately reflect direct care hours. Nurses in particular spend a large amount of time charting and performing administrative work, and they often take on management tasks outside of normal business hours.

The calculation for hours per resident day cited above was based upon facilities' core staffing levels. Nurses were also asked how often core staffing levels were maintained in their facilities. Two-thirds of nurses (66%) reported that their facility often, always or almost always operates below core staffing with another quarter (27%) claiming this is sometimes the case.

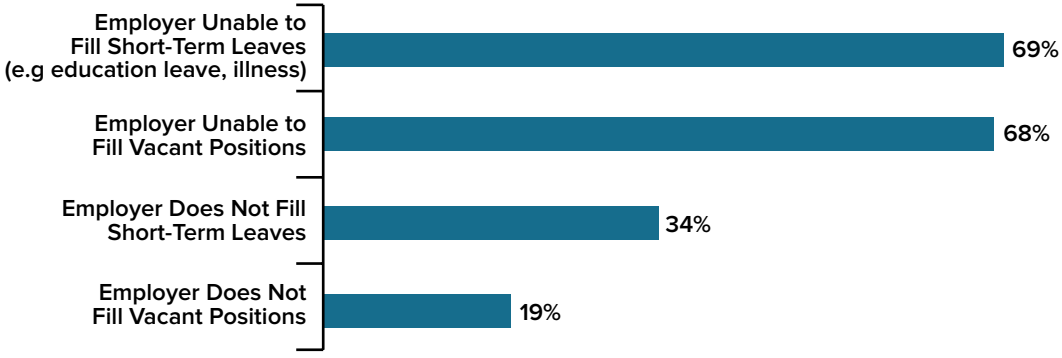
Figure 5.14 Operating below core staffing levels



Q: How often does your workplace operate below core staffing?

Nurses were also asked why their facility was sometimes operating below core staffing. The inability to fill short-term vacancies and the inability to fill vacant positions were cited as the two primary reasons for working below core levels.

Figure 5.15 Reasons for operating below core staffing levels



Q: What are the main reasons for your facility operating below core staffing?

Given the staffing situation, it is not surprising that LTC nurses work large amounts of overtime. Of particular interest was the amount of overtime nurses worked because they felt they had no other choice. In the past year, one in four nurses reported working overtime at least a couple of times a month when they preferred not to, while another 12% said this happened about once a month and nearly half (46%) said it happened a few times during the year. Working overtime because there was no one to replace them at the end of the shift was rarer but still common – 60% said it happened a few times over the last year while 17% said it happened once a month or more.

The frequency of missed breaks is another interesting indicator of workload. Fifty percent of nurses reported taking only half of their scheduled breaks while another 15% said they rarely get breaks.

Working conditions appear to be taking a toll on LTC nurses. Nearly two-thirds of nurses (64%) have seriously considered quitting their jobs in the past year. Management issues, including lack of support and bullying, and excessive workload, were the most common reasons cited by both RNs and LPNs. Being short-staffed, and experiencing stress and exhaustion rounded out the top five issues.

> Working conditions appear to be taking a toll on LTC nurses. Nearly two-thirds of nurses (64%) have seriously considered quitting their jobs in the past year.

E. Impact of the Collaborative Care Model

The majority of nurses have seen no change in the number of staff relative to residents. However, 29% noted a decline in the number of CCAs (relative to residents), 21% noted a decline in LPNs and 32% noted a decline in RNs. Only 9% saw an increase in CCAs, 11% an increase in LPNs and 3% an increase in RNs. For those who noted a change in the number of staff relative to the number of residents (in either direction), 79% claimed the change had made their work more difficult. When considering the responses of LPNs alone, this number rose to nearly nine in 10 (87%).

VI. Discussion and Recommendations

The literature, the analysis of the situation in Nova Scotia, and the voices of front-line nurses, reveal the need for serious reform in the long-term care sector. It will be helpful to break down recommendations into three key areas: first, the issue of appropriate staffing levels, second, the unacceptable prevalence of violence and aggression experienced by caregivers and residents in this sector, and third, the dearth of high quality, accessible data and the ensuing lack of transparency and accountability.

A. Staffing

As we have seen, staffing levels are well below what the Department of Health and Wellness purports to be funding. The reported LPN and RN staffing levels correspond to the funding allotment of one hour of licensed care per day, but the reported number of CCAs is about 15% below what is funded.

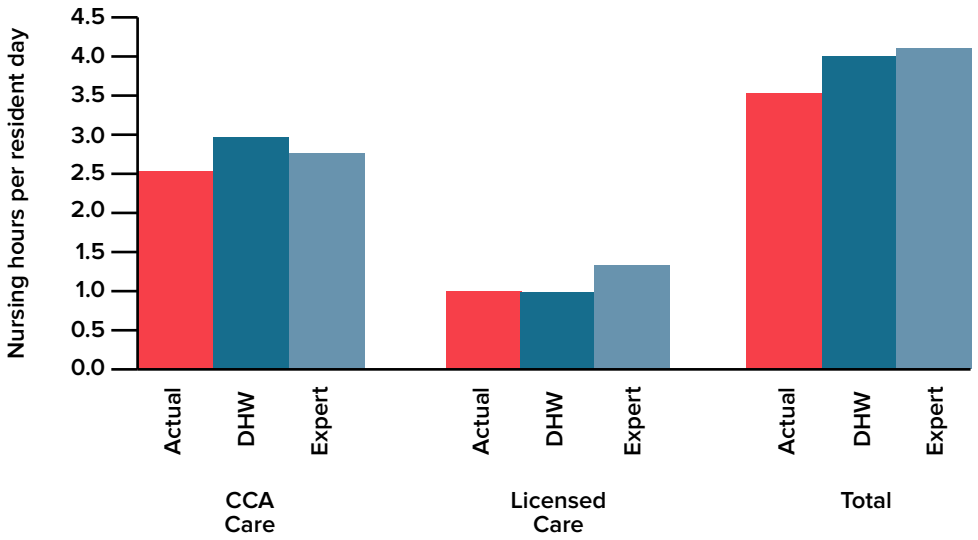
The Department's funding formula is itself problematic, however, given the low levels of licensed care. The survey revealed staffing levels well below the expert-recommended standard of 1.3 RN and LPN hprd and 2.8 CCA hprd, the standard below which quality of resident care was found to be compromised.

Table 6.1 Actual vs expert recommended hours per resident day (hprd)

	Licensed Nurse Care (RN + LPN) hprd	CCA hprd	Total hprd (RN + LPN +CCA)
Actual (Survey	1.01	2.57	3.57*
Expert Recommended	1.3	2.8	4.1
% Difference	28.7%	8.9%	14.8%

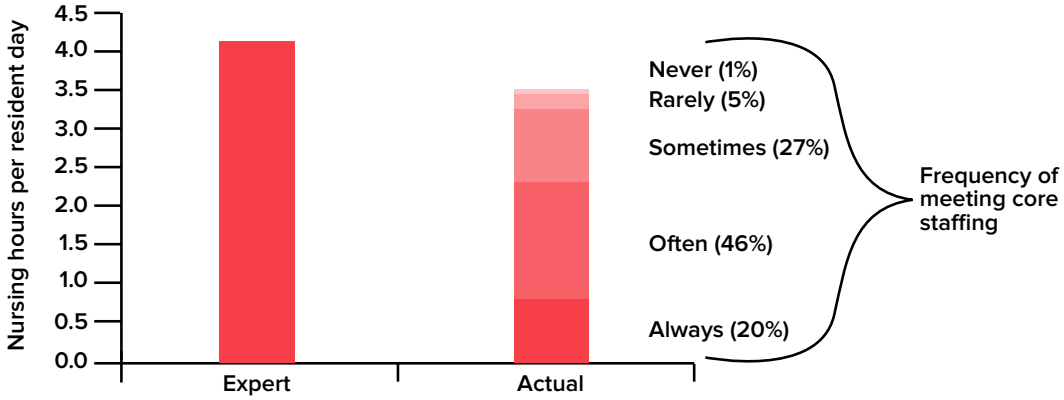
**Note that the total is 3.57 (not 3.58) after corrections for rounding.*

Figure 6.1 Comparison of actual (survey) care hours provided (CCA and licensed hours) versus Nova Scotia Department of Health and Wellness (DHW) funded, and expert recommended



We should bear in mind that this is an evaluation of core staffing levels, and that 20% of nurses report their facility almost always operates below core staffing, 46% report this is often the case, and another 27% say it is sometimes the case.

Figure 6.2 Comparison of care hours per resident day, including the frequency of working below core staffing



It should also be noted that roughly a third of our LTC facilities also host residential care facility residents and that many nurses feel that these residents contribute significantly to their daily workload. In effect, nurses are being given more residents to care for without this being reflected in the time and resources allocated by the DHW.

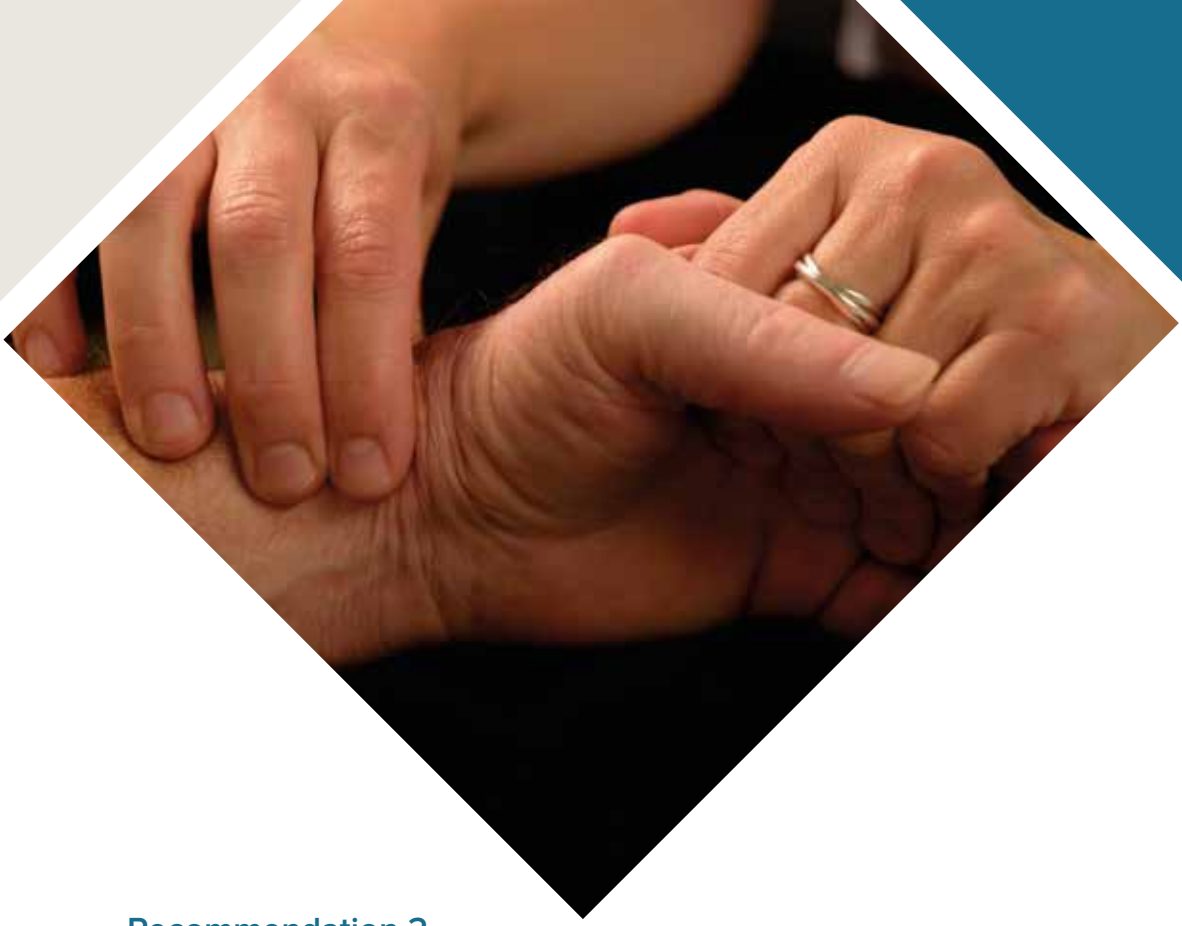
The Department of Health and Wellness' upcoming renewal of the Continuing Care Strategy for 2017, and the promise to revise the *Homes for Special Care Act*, present ideal opportunities to implement meaningful staffing standards that will ensure high quality care for our seniors and other residents of long-term care while ensuring that nurses and CCAs are able to provide adequate care without suffering from burnout. As we move towards a new standard, we cannot ignore the fact that we are often failing to meet the very minimalist standard we now have with respect to RN coverage in LTC. A care hour per resident day formula should be taken as an advancement upon the RN requirement.

As mentioned, the number of LTC residents is set to increase dramatically in the coming 20-25 years. We now have an opportunity to implement appropriate standards ahead of the coming influx. We can also take the opportunity to make better use of Nurse Practitioners in the LTC setting, given their ability to help care for chronic diseases, manage pain and medications, educate other staff and reduce costly hospital admissions.

> The number of LTC residents is set to increase dramatically in the coming 20-25 years. We now have an opportunity to implement appropriate standards ahead of the coming influx.

Recommendation 1

Implement explicit, evidence-based staffing standards that will better guarantee the health and well-being of long-term care residents, and of the nurses and CCAs who care for them. Residents should receive a minimum average of 1.3 hours of nursing care per day (RN and LPN), as well as 2.8 hours of care from CCAs for a total of 4.1 care hours per resident day. This is an average, and staffing plans should take into consideration the varying levels of acuity and complexity of care.



Recommendation 2

Given the immense potential for Nurse Practitioners in long-term care to improve the health and well-being of residents, provide timely advanced care, prevent hospital transfers and admissions and provide valuable staff education, the Department of Health and Wellness should fund Nurse Practitioners to practice in long-term care facilities across the province. As a starting point, the Department should fund 30 full-time equivalent Nurse Practitioner positions for our roughly 6900 residents.

Recommendation 3

The Department of Health and Wellness should immediately implement mechanisms to test for compliance with the minimal RN staffing requirement outlined in the current Homes for Special Care Act, and establish penalties for non-compliance.

Recommendation 4

The Department of Health and Wellness should immediately review the Residential Care Facility program as implemented in many long-term care facilities across the province, measure its workload impact on LTC nurses, and allocate appropriate resources to care for RCF residents.

Recommendation 5

The Department of Health and Wellness, with input from relevant stakeholders, should devise a dedicated retention and recruitment strategy for care workers in the long-term care sector. This strategy should be sensitive to the unique challenges of both rural and urban settings. It should reflect the research on safe staffing and a commitment to respect core staffing levels.

B. Building Healthy Workplaces

The consultation sessions with nurses revealed a strong feeling that nurses in LTC receive less recognition and respect than their counterparts in acute care. The survey revealed that nurses in LTC often feel a lack of support from their managers, and that this has an impact on their work-life satisfaction. As we have seen, healthy workplaces are important for a number of reasons, including the quality of resident care and the retention and recruitment of nurses.

The NSNU survey also revealed that aggression, bullying and violence are very much a part of work life in long-term care and it demonstrated the high prevalence of bullying and violence experienced by LTC residents. We cannot continue to ask residents and care providers to live and work in a setting that is dangerous to their physical and mental health. Addressing workplace violence requires effective policies based on evidence and backed by a true system-wide commitment. In particular, a prevention program should be backed by senior management, with an appointed program lead and an inter-disciplinary steering committee.[8] Facilities should perform a comprehensive risk assessment which includes current workplace violence issues, the physical environment and the work setting, including the residents, practices at the point of care, and staff perceptions of violence. The employer should develop an effective reporting mechanism with appropriate training for employees and supervisors. The employer should also develop an internal response procedure (i.e. code white, staff alert) for emergency situations, provide for prompt and detailed investigations of violent incidents, and do this in consultation with joint occupational health and safety committees. Lastly, programs require an effective communication and education strategy, as well as ongoing review and evaluation.

Moving forward, it will be helpful to engage the Nova Scotia Health and Community Services Safety Association, AWARE-NS, as an important partner to drive reform around violence prevention in the long-term care sector. The Association has developed a comprehensive violence prevention program known as Steps for Safety which includes sample assessment, investigation and reporting tools as well as sample policies and procedures (AWARE-NS, 2013).

[8] Most of the recommendations here are adapted from The Ontario Safety Association for Community Healthcare, 2006, as referenced by the Registered Nurses Association of Ontario.

Recommendation 6

The Department of Health and Wellness should implement a nursing and care team training program that facilitates positive working relationships between nurses, CCAs and management staff, that optimizes organizational support and team adhesion by empowering staff, encouraging leadership and establishing an effective, team-based professional practice.

Recommendation 7

The Department of Health and Wellness should commit to parity of care and working conditions between long-term care and acute care, ensuring equal levels of support for patients/residents and care providers alike. Patients should not lose the supports they require as they move from hospital to LTC and nurses and CCAs should be provided the same benefits as their acute care counterparts.

Recommendation 8

Government, employers and unions should convene a roundtable on aggression, violence and sexual aggression in the long-term care sector to review best practices, and to develop and adopt common policies and/or collective agreement language that provide a comprehensive response to the problem of violence and aggression (including sexual aggression) in the long-term care sector.

Recommendation 9

Licensing reports to the Department of Health and Wellness should include reporting on aggression (including sexual aggression), bullying and violence experienced by residents and care-providers as well as a review of each facility's violence prevention program.

C. Data and Accountability

We have seen that Nova Scotia suffers from a dearth of accessible data when it comes to the long-term care sector, and without transparency there is no accountability. This impedes any serious attempt to introduce reform. There is no centralized repository of indicators such as falls, bed sores, restraint use, catheterization, activities of daily living, staffing levels and so on that would allow one to track the quality of care in our facilities and determine whether it is improving or deteriorating. This is unacceptable. The publicly accessible data provided online by Health Quality Ontario offers an instructive of example on how to begin this process, though we should be wary of the flaws mentioned previously.

Recommendation 10

Immediately begin implementing a data measurement tool such as the RAI-MDS in all long-term care facilities across the province and enforce the necessary reporting requirements. The tool should be rolled out in such a way that it does not add to the workload of care providers. Data, including staffing levels, and the number of deficiencies, should be accessible to the public and those inputting the data.

Recommendation 11

Relying on the RAI data, include actual staffing levels in all licensing reports as per the Auditor General's recommendation, and also include their relationship to legislated guidelines, making this data available to the public.

Recommendation 12

The Department of Health and Wellness should track the occurrence and cost of transfers between long-term care and acute care in order to better determine how resources should be spent to realize efficiencies and improve the quality of care.

D. Longer Term

The nursing literature, and the research presented here, makes it clear that Nova Scotia's long-term care sector is in serious need of reform. This, in and of itself, is not news, but the depth and the magnitude of the problems facing the sector are more serious than most realize and still only partially understood. This paper focused on the perspective of front-line nurses, but there are many other factors that affect the quality of life of LTC residents including the quality of food and accommodations, social programs, spiritual care programs, physical and occupational therapy and more. A survey and consultation groups focused on the experiences of CCAs could also unearth problems best seen from their perspective. It is therefore incumbent on Government to not only embark on the measures outlined above, but to continue examining this issue until a thorough, comprehensive and forward-thinking plan for reform can be crafted.

Recommendation 13

Given the growing severity of issues in our long-term care sector, including issues around transparency and accountability, the adequacy of staffing levels and resident care, and the insidious prevalence of violence and aggression in long-term care settings, the Nova Scotia government should commission an independent, non-partisan and comprehensive inquiry into the status of long-term care in Nova Scotia, to be completed before the Fall 2016 sitting of the Nova Scotia Legislature.

Recommendation 14

As an interim step towards the previous recommendation, the Executive Council (Cabinet) of Nova Scotia should request that the Office of the Auditor General look into the issues raised in this report, and other related issues as the Auditor General sees fit.

Recommendation 15

Lastly, the aforementioned recommendations should inform a revised Continuing Care Strategy and a revised Homes for Special Care Act. The Act should include evidence-based staffing standards, violence prevention mechanisms and a demonstrable commitment to accountability and transparency. The revised Strategy and Act should form the foundation for the future of long-term care in Nova Scotia.

VII. Conclusion

The critical issues highlighted in this report will not go away on their own. It is imperative that we commit to evidence-based standards now instead of trying to catch up to the expectations and demands of the baby-boomers who will soon serve to double our current LTC population. An ageing population with ever-increasing complex needs means that the problems we see today could grow dramatically if action is not taken. Now is the time to put our minds to what's on the horizon. As Lewis and Sullivan (2013) shrewdly point out, "[w]hatever money is saved through short-term restraint will be lost in panicked spending down the road. That's been the lesson of the past 20 years."

There is, in the first place, a moral duty to ensure our seniors and other LTC residents receive the care and attention they deserve. Only then can we begin to meet the standard invoked by the government's Continuing Care Strategy – 'Living Well in a Place You Can Call Home'. Getting there requires providing adequate nursing and CCA staffing. Further, we owe it to care providers in the LTC sector to ensure that their workplace is a healthy one, free from injury, aggression, bullying and violence, and one where they are able to provide the quality of care they were trained to deliver. Last, it also requires that we drag our LTC

system into the era of data and develop a transparent and accountable system with close to real-time indicators on the quality of care and the level of staffing.

On behalf of all of its nurses, the Nova Scotia Nurses' Union urges our government to listen to these recommendations and to engage with stakeholders in this sector in order to design the long-term care system of tomorrow, one that delivers quality care to residents and provides a safe and secure work environment for residents and care workers alike.

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" I think that as a society we don't value the nurses in long-term care. Some of that is we don't value the senior that is no longer producing for the country...there's no value in them. They're not paying taxes, not working....they're a liability now."

Nova Scotia nurse working in long-term care

"Nurses and Continuing Care Assistants are keeping the long-term care sector alive despite growing demands and a sense of feeling invisible. They can only prop it up for so long under such formidable pressure."

Janet Hazelton, President, Nova Scotia Nurses' Union

Nova Scotia Nurses' Union

Nursing Led By Nurses