

Transforming long-term care to keep residents healthy and safe

Do you support RNAO's call to transform funding models in long-term care (LTC) homes to improve resident care?

Will you commit to supporting minimum staffing levels in LTC homes so that residents can live safely and with dignity?

RNAO has long advocated that all seniors in Ontario should have the opportunity to live with dignity in an environment that fully meets their needs.^{1 2 3 4 5 6} This evidence-based advocacy is in line with the fundamental principles of the *Long-Term Care Homes Act, 2007*,⁷ which asserts that an LTC home must provide its residents with a secure, safe, and comfortable setting.

About LTC in Ontario

- LTC homes provide accommodation and care for people – primarily seniors – with long-term health and/or cognitive disabilities. In LTC homes, residents have 24-hour access to nursing and personal care as well as assistance with activities of daily living.
- Ontario spends about \$4 billion each year – almost eight per cent of the overall health budget – on LTC.⁸ There are 625 LTC homes in the province with more than 78,872 beds in total, comprised of a mix of public, private for-profit, private not-for-profit, and other (e.g., religious) providers.⁹ Facilities receive most of their funding from government, and most operate at 99 per cent capacity.
- The *Long-Term Care Homes Act, 2007* (LTCHA) is the single legislative authority for safeguarding residents' rights, improving quality of care, and improving accountability in LTC homes.
- Of the total number of health-care providers in LTC, RNs account for nine per cent, RPNs for 17 per cent, and NPs for less than one per cent.¹⁰ Other regulated professionals include nutritionists, social workers, and physiotherapists, who together account for eight per cent of all health-care providers in LTC. The remaining 65 per cent of care is delivered by unregulated staff such as PSWs.¹¹
- Under regulations in the LTCHA, homes are required to implement evidence-based practices to provide quality care for residents.^{12 13} RNAO has best practice guidelines (BPG) that address each of the mandatory programs that LTC homes must implement, and other BPGs relevant to the LTC setting. For instance: preventing falls; promoting continence; optimizing skin and wound care; alternative approaches to the use of restraints; preventing and addressing abuse and neglect of older adults; and caring for delirium, dementia, and depression.

LTC has not adapted to meet the increased needs of today's resident population

Ontario's population is rapidly aging. Experts estimate the number of seniors aged 75 and older will double within the next 20 years.¹⁴ Without dramatic system changes, there will be a shortfall of 48,000 LTC beds over the next five years.¹⁵

The needs of LTC residents are also changing. Compared to previous generations, residents in LTC homes today have increasingly complex care needs. This is due in part to changes to LTC admission criteria in 2010 that required new residents to have high or very high physical and cognitive challenges to qualify for admission.¹⁶ Nearly all residents have multiple chronic conditions (e.g., heart disease, diabetes, arthritis).¹⁷ About 90 per cent of LTC residents have cognitive impairment, including dementia,¹⁸ and about 80 per cent of residents with dementia have behavioural symptoms, including aggressive or severely aggressive behaviour.¹⁹

In fact, we have heard from our members working in LTC, and officials in the Ministry of Health and Long-Term Care (MOHLTC), that the complexity of LTC residents has increased to rival that of patients in alternative level of care (ALC) beds in hospitals, or complex continuing care (CCC). But funding for LTC is significantly less. This needs to change.

All LTC home beds receive the same base per diem funding for all funding envelopes, except nursing and personal care (NPC). Under the NPC envelope, per diem funding is adjusted based on resident complexity and care needs, identified by an indicator called the "case-mix index" (CMI) – a measure of relative patient acuity levels in a LTC home.²⁰ Case-mix classification uses formulas to cluster residents into clinically similar groups that reflect the relative costs of services and supports that individual residents, with different needs, are likely to use. Funding is also dependent on the LTC home's occupancy rate.

Funding and staffing must change to keep LTC residents safe

Despite the growing incidence of responsive behaviours (a term used to describe the behavioural and psychological symptoms of dementia)²¹ and an increasingly complex LTC population, funding and staffing standards have not changed. It is not surprising that we are hearing increased reports of violence in LTC homes.^{22 23 24 25 26} Adequate funding and staffing must be put in place to safeguard vulnerable residents. Every LTC home in the province strives to provide the highest level of quality care to its residents. However, the reality is that finite resources and complex resident conditions are straining the current system.

It is shocking that the only legislated LTC staffing requirements in Ontario are a vague instruction for care "to meet the assessed needs of residents"²⁷ and a minimum requirement of one registered nurse (RN) on duty at all times.²⁸ Currently, there is no legislated minimum staffing ratio (the number of nursing home staff members compared to the number of residents), and no legislated requirements related to how much care residents receive on a daily basis (paid hours of care per resident per day),²⁹ although a target staffing level of four hours of care per resident per day was recently promised by the Ontario government in its *Aging with Confidence: Ontario's Action Plan for Seniors*. Why is it that child care in Ontario has strict, mandated care requirements under the *Child Care and Early Years Act, 2014*,³⁰ but care for vulnerable seniors is left up to LTC home operators?

Funding for LTC homes in Ontario

The MOHLTC funds LTC homes on a level-of care (LOC) per diem basis within four spending envelopes, as follows:

Base LOC per diem funding (as of July 1, 2018):³¹

Funding envelope	LOC per diem
Nursing and personal care (includes direct care staff and care supplies)	\$100.91 <i>(variable)</i>
Program and support services	\$9.79
Raw food	\$9.54
Other accommodations	\$56.52
Total	\$176.76

LTC funding models are severely flawed and must be transformed and modernized

1. ***Disincentive to improve patient outcomes:*** Under the existing funding structure, there is a financial disincentive to improve patient outcomes. When evidence-based practices are implemented – such as RNAO’s BPGs and other resources available through our Long-Term Care Best Practices Program – and resident problems are prevented or resolved, resident acuity decreases. While this is good for residents, the home’s CMI correspondingly falls and funding in future years is decreased. In other words, the unintended and negative consequence of quality improvement is that LTC homes are financially penalized. This penalty acts as a disincentive to improve patient outcomes.
2. ***Increased complexity and prevention not accurately funded:*** Funding is not provided for activities or conditions that are not captured in the resident assessment tool,³² including some preventative interventions. For example, if a resident is incontinent, funding is provided for incontinence care and supplies, but funding is not provided for the staff hours required to implement prompted toileting at regular intervals to reduce the frequency of incontinence. Similarly, the highest level of funding that can currently be provided for the responsive behaviours of residents with dementia is inadequate to cover the most costly and time-consuming interventions that are required for residents displaying severe or very severe aggressive behaviours.
3. ***Retroactive data used to determine current funding:*** LTC homes receive funding based on retroactive data. For example, funding for 2017-18 was based on the case-mix data that was submitted at the end of the four quarters in 2015-16. Consequently, funding is always outdated. It does not take into account the rapidly increasing complexity of residents, and is often insufficient to care for the immediate resident acuity.

RNAO insists that the funding model for LTC homes be modernized. It must be transformed to advance residents' quality of life and health outcomes. A model that imposes a financial penalty for improving resident outcomes hurts patient and health system performance.

RNAO urges that the funding formula be modernized to account for both complexity of resident care needs *and* quality outcomes. **LTC homes that experience a reduction in case-mix index due to provision of quality, compassionate and evidence-based care should be able to retain all funding to reinvest into staffing and/or programs for residents.**

LTC needs the right mix and levels of staff to keep residents safe and healthy

In Ontario, LTC staff includes RNs, registered practical nurses (RPN), personal support workers (PSW), nurse practitioners (NP), allied health professionals (e.g., physical and occupational therapists, dieticians), and other employees (e.g., staff in housekeeping and food services). Each is trained to a different educational level and skill set.

Despite the best efforts of care providers, the needs of LTC residents are not being met due to inadequate staffing resources, inappropriate skill mix, and limited access to RNs and NPs.

Care delivered by the most appropriate provider

According to the College of Nurses of Ontario (CNO), the determination to use an RN or RPN should depend on three factors: the client, the nurse (or, in the case of LTC, other care providers such as PSWs), and the environment.³³ More complex patients with less predictability and less stability should be cared for by RNs, whereas other residents be cared for by RPNs or PSWs, as appropriate.

The evidence is clear that RNs improve the quality of care in LTC homes. Research demonstrates that increasing RN staffing ratios in LTC homes reduces mortality, improves resident outcomes and lowers the probability of hospitalizations and associated health system costs.^{34 35 36 37 38 39 40}

In recent years, there has been a marked increase in the share of nursing and personal care employment held by RPNs and PSWs in Ontario's LTC homes.⁴¹ This is troubling when compared to the trend of increasing complexity of LTC home residents, for which RNs are best suited to care. This may also place greater burden on other parts of the health system. For example, if one resident's care needs are beyond the scope of an RPN, and the home has inadequate RN staffing, this resident will be transferred to hospital, causing unnecessary disruption for the resident and increasing the burden of care and costs on the acute care sector.⁴²

While RPNs and other care providers play important roles in LTC, it is critical to match skill mix to resident needs. RNAO's preferred model of care delivery in LTC homes would include NPs, RNs, and RPNs working to their full scope of practice with assistance from PSWs. Each resident would be assigned to one primary nurse provider, with RNs assigned total nursing care for complex and/or unstable residents with unpredictable outcomes. The assigned provider would take responsibility for all of the assigned resident's care needs on a continuous basis. This type of staffing model provides continuity of care and caregiver and would result in substantive improvements to resident outcomes and the broader health system.

Mandated staffing levels in LTC

Specific regulation in Ontario stipulates that one RN, who is both an employee of the LTC home and part of the home's nursing staff, must be on duty and present in the home at all times.⁴³ This number is the same for all LTC homes despite varying sizes. The average number of residents in a nursing home in Ontario is 124. Thus the current staffing requirements translate to an average of just one RN for every 124 LTC residents. This is compounded for larger homes, which can legally employ one RN for upwards of 400 residents.

The previous government committed to increasing staffing levels in LTC to ensure a provincial average of four hours of direct nursing, personal, and therapeutic care in the target average number of hours.⁴⁴ RNAO welcomed this step, but we believe that funding should be provided for no less than an average of four hours of nursing (NP, RN, and RPN) and personal care (unregulated providers) per resident per day. Therapeutic care should be in addition to these four hours, with more hours for residents with greater acuity. This should be a home average, not a provincial average. RNAO calls for this minimum standard to be legislated.

Given the increasingly complex needs of Ontario's residents, RNAO continues to call for a legislated staffing mix in LTC that includes a minimum of one Attending NP for every 120 residents,^{45 46} as well as at least 20 per cent RNs, inclusive of clinical nurse specialists, 25 per cent RPNs, and no more than 55 per cent PSWs for every LTC home in Ontario.

Attending NPs in LTC

RNAO successfully advocated for the creation of the *Attending NP* role in LTC, with the goals of ensuring resident care needs were met on site in a timely manner, and providing continuity of care by allowing NPs and residents to develop long-term therapeutic relationships. Unlike attending physicians who typically visit LTC homes on a weekly or bi-weekly basis, *Attending NPs* are meant to be based in their respective LTC homes full-time. The *Attending NP* has the overall responsibility for managing and co-ordinating resident care in their respective LTC home. NPs can also play an important role in LTC through early detection and treatment of medical complications, treating chronic conditions, and dedicating time for health promotion, thereby reducing the need for hospitalization of LTC residents.

MOHLTC announced in 2015 the creation of 75 *Attending NP* in LTC positions, to be funded in three phases.¹ To date, 60 positions have been funded through phases one and two. Phase three has not been funded, and thus, 15 *Attending NP* positions are owed to Ontarians who live in nursing homes. LTC homes and their residents are in desperate need to have the committed 75 *Attending NP* positions be funded, hired, and working full time – on-site – as per the role description.

Note: the MOHLTC's role description stipulates that 70 per cent of an *Attending NP's* time is to be spent on direct resident care, and the other 30 per cent in clinical mentorship and research.

Sufficient staffing numbers and the right mix of staff must be in place to deliver high quality care to LTC home residents and to safeguard their safety.

Long-Term Care Homes Public Inquiry: An opportunity for transformation

Thanks to the advocacy of RNAO,^{47 48 49} the broad-based Public Inquiry into the Safety and Security of Residents in Long-Term Care (Inquiry) was announced in July 2017 to examine the circumstances surrounding the murders, attempted murders, and aggravated assaults on nursing home residents by former RN Elizabeth Wettlaufer.

RNAO is a participant in the Inquiry.⁵⁰ Through our participation we highlight the significant systemic issues in Ontario's long-term care sector that must be addressed to ensure that seniors living in nursing homes are safe and secure.⁵¹ Many of the witnesses in the Public Hearings stage spoke about the increasing complexity of residents in LTC homes. RNAO's Public Hearings closing submission highlights the critical changes required to fix the flawed funding model, and improvements needed to staffing levels and mix.^{52 53}

We are confident that our continued participation will assist the Commissioner to make recommendations to bring positive changes that will protect the health and safety of all LTC home residents.

RNAO's LTC ASKS

Funding

- Review and transform funding models in LTC to account for both complexity of resident care needs and quality outcomes. LTC homes that decrease acuity (CMI) due to evidence-based care should retain all funding to reinvest in staffing and/or programs for residents.
- Support the use of evidence-based practices in LTC homes, such as RNAO's Long-Term Care Best Practices Program and coordinators, to promote and sustain improvements in resident health and well-being.
 - Incentivize LTC homes to proactively implement RNAO BPGs to meet legislative requirements⁵⁴
 - Mandate the use of relevant RNAO BPGs when homes are found non-compliant after MOHLTC inspections. This would be similar to the approach Ontario has taken with the Quality Based Procedures in hospitals⁵⁵

Skill mix and staffing levels

- Legislate minimum hours of care as a home average of four hours of nursing and personal care per resident per day.
- Legislate minimum nursing and personal care staffing and skill mix standards in LTC, accompanied by the necessary funding to support these changes.
 - We urge no less than one Attending NP for every 120 residents, and a skill mix consisting of at least 20 per cent RNs inclusive of Clinical Nurse Specialists, 25 per cent RPNs, and no more than 55 per cent PSWs. This ratio would guarantee all LTC residents receive care when they need it from the most appropriate provider
- Release funding for the outstanding NP in LTC positions. Develop and implement an accountability framework to hold LTC homes accountable for hiring Attending NPs in the manner specified by the MOHLTC role description and funding policy.

NOTES FOR RNAO LEADERS

They say, we say

This section is for RNAO leaders only. It provides additional information and suggested responses for statements we may receive about this issue.

Why are you trying to get rid of PSWs in LTC?

RNAO respects all members of the care team. We need more RNs, more RPNs, more PSWs, and more Attending NPs working in all of Ontario's LTC homes.

We advocate for matching LTC residents to the most appropriate regulated provider (RN or RPN) based on their complexity of care, stability, predictability, and risk for negative outcomes, with unregulated providers (PSW) assisting in care provision. Residents who are stable with low complexity and predictable outcomes can be safely cared for by RPNs with assistance from PSWs. The rapidly increasing complexity, acuity, and unpredictability of the LTC population means residents should increasingly be cared for by RNs. LTC homes must have at least one and preferably more RNs on site at all times.

Won't these recommendations increase costs? How will we pay for this?

This is a matter of equity and fairness as well as patient safety.

The complexity and level of care LTC residents require is higher than ever before, and it continues to increase. Resident safety is at risk every day. Evidence clearly shows more staffing, and, in particular, more RNs will mean better quality care and better resident outcomes.^{56 57 58 59 60 61 62} If we have created legislation that specifically establishes staffing requirements to ensure the safety of children, why are we not doing the same for seniors?

Staffing is the responsibility of individual LTC homes and LHINs, not the ministry.

The province's role in safeguarding residents in LTC must be strengthened. LTC homes are governed by provincial legislation that sets policies regarding the provision of services, funding arrangements (e.g., per diem rates), and staffing standards. However, each LTC home is responsible for determining the level and type of staffing it needs based on the assessed needs of each resident and available resources. Just as the province regulates staffing in daycare centres, *Long-Term Care Homes Act* regulations should be put in place to specify staffing mix and levels in long-term care.

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- ³ RNAO. (2012). *Submission to the Government of Ontario's Seniors Care Strategy*. Retrieved from http://mao.ca/sites/mao-ca/files/RNAOs_Submission_to_the_Government_of_Ontarios_Seniors_Care_Strategy_-_Sept._6.pdf.
- ⁴ RNAO. (2011). *Strengthening client centred care in long-term care*. Retrieved from http://rno.ca/sites/mao-ca/files/Position_Statement_LTC_client_centred_care.pdf.
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- ⁶ Development and implementation of clinical practice guidelines in the area of elder care has been one of five top priorities of RNAO's Best Practice Guideline Program since its inception. RNAO has supported the uptake of clinical practice guidelines relevant to elder care, including: falls prevention, alternative approaches to the use of restraints, continence and constipation, prevention and management of elder abuse, pressure ulcer prevention and management, dementia, and chronic disease management. For more information, see <http://mao.ca/bpg>.
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- ¹³ O. Reg. 79/10, s. 48.
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¹⁹ OANHSS. (2016). *Ensuring the care is there. Meeting the needs of Ontario's long-term care residents 2016-17 provincial budget priorities*. Retrieved from <https://muskoka.civicweb.net/document/27441>.

²⁰ Residents are assessed on admission, if there is a significant change in their status, and on a regular quarterly basis, using the Resident Assessment Instrument – Minimum Data Set (RAI-MDS). This assessment puts the resident into a clinically similar group. These groups are believed to consume a similar set of resources and, by extension, have similar costs. Each group is associated with a CMI, which is a relative measure of the expected resource consumption intensity of any group. Source: Costa, AP., Poss, JW. & McKillop, I. (2015). Contemplating case mix: A primer on case mix classification and management. *Healthcare Management Forum*, 28(1), 12. More information about case-mix systems used to allocate resources is available from CIHI at <https://www.cihi.ca/en/submit-data-and-view-standards/methodologies-and-decision-support-tools/case-mix>.

²¹ Responsive behaviours is a term to describe the behavioural and psychological symptoms of dementia, which includes, to varying levels of severity, changes in mood, delusions, apathy, agitation, wandering, calling out, repetitive questioning, and sexual disinhibition. Source: RNAO. (2016). *Delirium, dementia, and depression in older adults: Assessment and care (2nd ed.)*. Retrieved from http://rmao.ca/sites/mao-ca/files/bpg/RNAO_Delirium_Dementia_Depression_Older_Adults_Assessment_and_Care.pdf.

²² Anon. (2017, May 16). Grey matters: Mistreatment and abuse of patients in long-term care homes is anything but rare. *National Post*. Retrieved from <http://nationalpost.com/news/canada/grey-matters-mistreatment-and-abuse-of-patients-in-long-term-care-homes-is-anything-but-rare/wcm/b1ac28f5-2473-4014-b22d-92076a8804ef>.

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²⁶ Geriatric and Long Term Care Review Committee. (2016). *2015 annual report*. Retrieved from <http://www.mcscs.us.gov.on.ca/sites/default/files/content/mcscs/docs/GLTRC%202015%20annual%20report%20ENGLISH.pdf>.

²⁷ *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8, s. 8(1) Every licensee of a long-term care home shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents.

²⁸ *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8, s. 8 (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

²⁹ The previous standard of 2.25 hours of personal and nursing care per resident per day was repealed in 1996.

³⁰ The *Child Care and Early Years Act*, 2014, S.O. 2014, c. 11, Sched. 1, sets out the rules governing child care in Ontario. This includes, among other restrictions and standards, setting a ratio for the maximum number of children that a child care centre or home child care provider can care for (e.g., minimum ratio of three staff to ten children

younger than 18 months for licensed child care centres; maximum six children under the age of thirteen for a licensed home child care provider).

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- ⁵⁴ The use of RNAO’s BPGs is not mandatory; however it is an important resource for the LTC sector and enables improved resident outcomes.
- ⁵⁵ Quality-based procedures clinical handbooks outline the evidence and clinical best practice recommendations for specific groups of patient services (e.g., hip fracture, tonsillectomy, chronic kidney disease). The goals of the program are to standardize care and ensure that patients get the right care at the right place and time. Providers (i.e., physicians) receive a standard funding amount on a ‘price times volume’ basis to implement quality-based procedures. Source: MOHLTC. (n.d.). Health system funding reform. Quality-based procedures. Retrieved from http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding_qbp.aspx.
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