FOR THE CARE WE ALL DESERVE.

THE IMPACT OF WORKING SHORT ON MANITOBA PERSONAL CARE HOME WORKERS.

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CUPE MANITOBA

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INTRODUCTION

As with the rest of the country, the average age of Manitoba's population is increasing at a significant rate. The older adult population of the province is expected to grow faster than other age groups, with the number of people aged 65 and older expected to grow by 21.7% by 2018 (from 2008 levels); and by nearly 60% by 2028 (MB Bureau of Statistics, 2008). Over 90% of residents in Personal Care Homes (PCHs) in Manitoba are 75 years or older (Doupe *et. al.*, 2011); this segment of the population is expected to grow by 91% between 2006 and 2036 (OAG 2013). As a consequence, reliance on long-term care (LTC) facilities will greatly increase, creating more pressure on this part of the health care system (Doupe *et. al.*, 2011).

An important component of this increased pressure is the rising level of resident acuity that is occurring in PCHs, and which is expected to intensify significantly into the future. As life expectancies increase, the number of adults living with complex health conditions, such as Alzheimer's and dementia also increase. In response to aging populations with more complex health needs, many governments across Canada and other parts of the Organization for Economic Co-operation and Development (OECD) have reviewed their long-term and advanced care systems, and have increased the options of care available to older adults. For example, governments are providing additional support for them to stay in their own homes longer with home-care, and by providing alternative care models such as assisted and supported living (in Canada see e.g. Stunden Bower & Campenella, 2013; Novek, 2011). In Manitoba, this concept of expanded continuum of care is reflected in the 'Aging in Place' initiative introduced in 2006. These kinds of initiatives have resulted in increased options for care for aging Canadians, and ideally should result in a more responsive, patient-centred model of care, and are thus a positive step in long-term and advanced care health programs. However, it is important to recognise that a consequence of such programs is that, on average, by the time people do end up in long-term care facilities they are often older and/or have more complex health needs than has historically been the case (CUPE, 2009; HEU, 2009; Novek, 2011; Armstrong & Daly, 2004; McGregor & Ronald, 2011).

The Government of Manitoba's 'Aging in Place' strategy is an important program not only for providing more options for seniors to remain in familiar settings and contribute to and benefit from the social enrichment of their communities, but also for its ability to help alleviate some pressure from the PCH system by keeping seniors out of PCHs longer, or in many cases altogether. However, even despite this important program, both the numbers of PHC beds needed, and continued increasing patient acuity, is inevitable, simply due to considerable increases in the aging population. According to the Alzheimer's Society of Manitoba, "[c]urrently, over 20,000 Manitobans have Alzheimer's disease or another dementia. This number is growing at alarming rates and within one generation (25 years), it is expected to reach over 34,000" (Alzheimer's Society of Manitoba, 2014; info from Smetanin, P., *et. al.*, 2009). This will have a profound impact on patient acuity levels in long-term care. This situation is even more critical when other forms of increased patient acuity are taken into consideration.

Citing a 2010 study by the Canadian Institute of Health Information that examined over 50,000 PCH residents, Novek (2011) outlines the complex health needs of PCH residents as follows:

> *… the majority of long-term care residents had a documented diagnosis of Alzheimer's Disease or a related dementia (57 percent). Over ninety percent of seniors living in residential care facilities had moderate to severe cognitive impairment… Approximately 80 percent of residents required extensive assistance or were totally dependent on staff for activities of daily living and over 85 percent of residents were incontinent. Seventy percent of residents were prescribed psychotropic medications, 30 percent had possible depression and 60 percent exhibited "challenging behaviors" including physical violence and resistance to care (CIHI, 2010). One quarter of residents exhibited wandering and thirty three percent had experienced a fall during the last 180 days… These data suggest that residents in personal care homes suffer from a range of medical conditions, functional limitations and behavioral disorders that require complex medical and supportive care (p. 11-12).*

In addition to longer life expectancies that are adding to resident acuity in PCHs is the fact that a small but growing minority of residents are younger adults with disabilities and chronic conditions who have distinct care needs (Jansen, 2011, p. 11). Taken together, the factors leading to a steep growth in patient acuity present a critical problem for the future of long-term care in Canada and Manitoba.

What does working short-staffed mean?

The relationship between quality of care and staffing is well documented (HEU 2009; Murphy 2006; Collier & Harrington 2008; Jansen 2011; Harrington *et. al.*, 2012; Stunden Bower & Campenella, 2013).

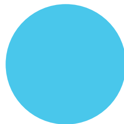
In 2005, the Hospital Employee's Union (HEU) in British Columbia commissioned research in partnership with the British Columbia Ministry of Health aimed at exploring the relationship between staffing ratios and resident outcomes. The research clearly established that quality of residential care is effected by staffing levels, and pointed to the need for minimum levels of health care aide, LPN and RN staffing in order to "avoid adverse outcomes and improve quality of care" (HEU 2009, p. 6).

In fact, some experts in the area argue that staffing levels are the key determinant in quality care, while also noting that staff education and positive work environments have "proven impacts of residents' health and well-being" (Jansen 2011, p. 11; CUPE 2009, p. 10). A comprehensive study conducted by CUPE health care researchers found that:

> **[t]he research is unequivocal: staffing levels are the most important factor in quality, and higher levels mean better health outcomes for residents. Controlling for other factors (like facility size and resident acuity), researchers consistently find that higher staffing is associated with fewer "adverse outcomes" such as falls, fractures, infections, weight loss, dehydration, pressure ulcers, incontinence, agitated behaviour, and hospitalizations. (CUPE 2009, p. 11).**

Important examples of the relationship between staffing levels and quality of care and resident outcomes include:

- Residents who received 45 minutes or more of direct care per day from licensed practical nurses were 42 per cent less likely to develop pressure ulcers than residents who received less care.
- Residents who received three or more care aide hours per resident day (hprd) had a 17 per cent lower risk of weight loss compared to residents who received less care.



- Residents living in higher-staffed facilities spent less time in bed, experience more social engagement, and consumed more food and fluids than residents in lower-staffed facilities.
- Residents living in facilities with higher care aide staffing levels were more likely to be involved in a scheduled toileting program, receive active or passive range of motion training, and receive rehabilitative training for such things as walking, getting out of bed, and moving around.
- Residents had better nutrition and hydration when care aides could focus on helping to feed or assist no more than two or three residents at mealtime. With less care, residents were more likely to cough and choke during meals and lose weight due to insufficient food intake.
- Care aide staffing below two hours per resident day was associated with roughly a four-fold increase in the likelihood of high hospitalization rates for a range of avoidable health problems, including urinary tract infections, electrolyte imbalances, and sepsis. When care aide time fell below 2 hprd, 32 per cent of residents developed pressure ulcers.
- The social-emotional aspects of care are the first to be cut when workloads are heavy, and residents' quality of life suffers. Meaningful activities and positive relationships are particularly important for residents with dementia. (CUPE 2009, p. 11).

The most extensive research conducted on the relationship between staffing levels and quality of care was a large national study commissioned by the United States Congress, and carried out by the Center for Medicaid and Medicare Services (CMS). This study found that a minimum staffing level of 4.1 *worked* hours per resident day (hprd) is required to avoid jeopardizing the health and safety of LTC residents (Health Care Financing Administration 2002).[1]

The CMS study is widely recognized as the most comprehensive and academically sound research to date on the subject. However, it was published in 2002, when acuity levels

[1] The 4.1 hprd includes 2.4–3.1 nurse aide hours and 0.95– 1.55 licensed nurse (registered nurse [RN] and licensed practical nurse [LPN]) hours, each with different health outcome improvements (Jansen 2011, p.11).

had not yet reached current levels. Consequently, the recommendations of this study are often thought to be too low to meet current care needs, and certainly too low to meet needs into the future. Also, it is important to note that this study maintained that 4.1 worked hours per resident per day (hprd) was an "avoid harm" minimum, not the number of hours required to improve care. In addition, the study looked at 'worked hours' not paid hours. Worked hours are substantially lower than paid hours (Jansen, 2011). While this study represents one of the most comprehensive, evidence from other studies in other jurisdictions has continued to corroborate its findings regarding the relationship between staffing ratios and resident outcomes. Subsequent studies claim that between 4.55 and 4.8 worked hprd are required in order to improve care (Collier & Harrington, 2008; Jansen, 2011).

Although the overwhelming majority of research in this area focuses on the positive relationship between higher staffing levels and resident outcomes, important observations are made also concerning the relationship between workplace safety and improved work environments and greater staffing levels (Harrington *et. al.*, 2012, p. 89; Banerjee *et. al.*, 2012). One of the most significant areas in which the positive relationship between increased staffing and workplace safety is found and relates to resident-to-staff violence. The majority of this kind of violence happens during direct care, such as bathing, feeding and toileting. The research has found that organizational conditions provide an important context for resident-to-staff violence – most notably, "insufficient time, low autonomy and inadequate staffing have been associated with violence (Banerjee *et. al.*, 2012, p. 1; Shaw 2004).

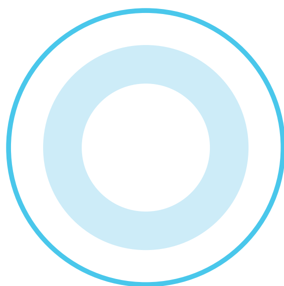
This kind of workplace violence remains one of the most common concerns amongst LTC staff, and is thus a great concern to CUPE. The importance of ensuring safe work environments provides a further compelling imperative to address understaffing in LTC. This imperative stands on its own merit; worker safety is vital and independent of other factors. However, it is important to note that there is an important connection between workplace violence, workplace environments, and resident outcomes. An important Canadian study comparing long-term care in Canada and Scandanavia noted that, "Canadian careworkers reported that they were unable to deliver the quality of care they knew they were capable of given their current working conditions" (Banerjee *et. al.*, 2012, pp. 5-6). The study described the conditions and resulting consequences as follows:

> **… workers' heavy workload, rigid work routines, low autonomy and low status were experienced as sources of physical and psychological distress. Focus group participants indicated that their working conditions contributed to conflict and violence. Care workers noted, for instance, they were frequently required to rush intimate care activities, resulting in residents' agitation and violence (Banerjee *et. al.*, 2012, p. 6).**

Workload, particularly working short-staffed, was identified as a primary factor in creating the above conditions. The situation was more acute in Canadian jurisdictions where 60% of the study participants reported that they had "too much to do… all or most of the time" compared to 40% of Scandinavian respondents (Banerjee *et. al.*, 2012, p. 6). This is perhaps not surprising given that the study also noted that Canadian care workers were responsible for almost twice as many residents as Scandinavian workers (Banerjee *et. al.*, 2012, p. 6).

Workload has important implications for both resident and staff well-being, and there is an integral relationship between the two. One of the most important concerns raised by the Canadian care workers was the impact that overwork had on the relational care they were able to provide, noting that this care is crucial for the "social, emotional, psychological and spiritual" well-being of those for whom they provide care (Banerjee *et. al.*, 2012, p. 6). Consequently, increased staffing was the number one recommendation made by the Canadian participants in the study. This was identified as a need for both resident and staff well-being.

While insufficient staffing was identified as a significant concern, added to this is the fact that 'working short' of already low staffing levels is a pervasive condition identified by Canadian LTC workers. "Short-staffing", occurs when staff that are absent due to illness, vacation or vacancies are not replaced. This was considered "routine" for the Canadian workers; "experienced daily by 44% of frontline care workers", compared to 12-23% of Scandinavian workers (Banerjee *et. al.*, 2012, p. 6). It is important to note however that the authors of the study suggest that the Canadian figures likely underestimate the problem as short-staffing due to unfilled vacancies is not represented in the Canadian figures (but is in the Scandinavian figures), although many Canadian workers did note that they experienced working short-staffed due to unfilled vacancies.



There are further complications adding to adequate staffing levels when you take into account that Personal Care Homes are ranked in the top 10 industries for musculo-skeletal problems (Novek, p. 17), the most common cause of worker absence and injury (MNU, 2006). Additionally personal care homes report high rates of job stress both physical and psychological which lead to staff burnout (Novek, p.18). Working short increases the likelihood for the above noted injuries to occur and when coupled with the violent residents, a very dangerous workplace.

We are also beginning to witness increasing friction between co-workers, and between workers and management, as LTC workers try to cope with ever-greater demands being thrust upon them. Conflict on the job is especially greatest when shifts go unfilled, and workers are suddenly stretched even further. This is creating a real morale crisis in some facilities. We fear that this worsening morale and growing conflict, has, and will continue to have, a negative impact of residents unless the issue of staffing levels and working short are addressed.

It is also important to remember that long-term care facilities rely deeply on the labour of immigrant women – a highly vulnerable community. As of 2011, over 37% of health care aides in Winnipeg are immigrants (Novek, 145). Health Care Aides performing

the majority of work in this sector are often invisible and undervalued because of the type of work; stereotypically “women’s work” (Novek, p.26). The high employment rate of immigrants, particularly women, in this sector has perpetuated the globalization of women’s work (p. 22), the global structure of inequality, gender and racial division of labour (Novek, 26). In Manitoba almost half (45%) of all health care aides are born abroad with over 20% of all health care aides in Manitoba being of Filipino origin (Novek, p. 1).

Further alienating these immigrant, women workers is the difficulty in entering the health care aid profession in the first place. The cost of acquiring health care aide certification is a major barrier to immigrants. The majority of training programs are offered by private, for-profit schools. These programs typically cost between $5,000 and $8,500, and provide various levels of instruction and practicum (Novek, p 79-80). There are a few public programs available that are much more affordable, for example Red River College with a cost of approximately $2,600. However, at present the Red River Program requires students to be a Manitoba resident to be accepted into the program, and some programs require a High School Diploma.

Adding to this vulnerability is a lack of stable, full-time employment in the industry, which suffers from a high rate of part-time and casual employment. Many health care aides work in multiple facilities on a regular basis, and still more on a casual basis. This reliance on a patchwork of employment is very difficult on workers, and creates difficulties for employers. We know that there are times where calls to replace sick employees go unanswered, as all regular and casual staff are already committed to work elsewhere.

For the reasons identified above, staffing levels represent one the primary objects of study in long-term care research. In addition to highlighting the crucial relationship between adequate staffing levels and resident and staff well-being, an important body of this research has documented the positive outcomes that have resulted where staffing levels are legislated (Harrington *et. al.*, 2012, p. 89; Banerjee *et. al.*, 2012; Jansen, 2011). This has particularly been the case in the US where the practice of legislating minimum staffing levels has become more common (HEU 2009; Jansen, 2011). It is for this reason that the main recommendation being made by CUPE is for the Province of Manitoba to legislate minimum staffing levels for personal care homes.

Working Short in Manitoba

CUPE Manitoba represents over 3,000 members in the long-term care sector, covering a range of jobs from dietary aides, health care aides, housekeeping, cooks and laundry aides to trades people and activity coordinators.

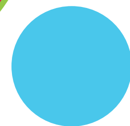
The experience of CUPE long-term care workers in Manitoba is very much reflected in the findings of the Canadian study discussed above. The problem of working short-staffed, largely due to the practice of not replacing absent workers, is an acute issue raised by our LTC membership. It came to the forefront in the past two years, with labour unrest in the sector almost resulting in a strike by two of our LTC locals. Workers at Maples Personal Care Home called on their employer to ensure sufficient staffing levels, claiming, that in an attempt to save money, the employer was not replacing staff who called-in sick. This is a common observation made by staff in this sector in Manitoba, and was also identified by Canadian LTC workers in the study discussed above (Banerjee *et. al.*, 2012).

A number of information pickets were conducted by our membership in an effort to bring attention to this persistent situation. The attention-raising efforts of these members culminated in a well-attended rally at the provincial legislature in the fall. These activities saw some progress made, for example, an agreement allowing CUPE to challenge staffing levels at Maples PCH, but which falls short of guaranteed staffing levels. However, the safety and well-being of LTC residents and staff should be ensured through proper policy and monitoring, backed-up by legally enforceable standards, not the ad hoc activities of LTC staff who would rather spend their time providing quality care to residents.

The province of Manitoba is not one of the five provinces in Canada that has "specific requirements for direct care staffing levels" (Harrington *et. al.*, 2012, p. 90), but it does have "guidelines" for hours of direct patient care per day. In 2007 the Department of Health developed PCH Guidelines with a target of 3.6 hours of direct care (Forbes, 2013) "for all residents, without differentiating the level of care" (OAG 2009, p. 79). The majority of these recommended hours are to be fulfilled by health care aides.[2] However, the chronic and pervasive problem of "working short" means that these guidelines

[2] 2.34 hours are to be performed by health care aides in PHCs with more than 80 beds, and 2.52 hours are to be performed by health care aides in PHCs with 80 or less beds. The remainder of the recommended hours are to be performed by registered nurses and licensed practical nurses (OAG 2009, p. 79).

are frequently not being met. Our research, supported by others (see e.g. Novek 2011) strongly suggests that the current policy of providing a minimum of 3.6 hours of care per resident per day is not being consistently met, and that instances of understaffing in this regard are not rare and contributable to unique and anomalous circumstances. Research with health care aides in Manitoba, conducted by Sheila Novek in 2009 and 2010, reflected the findings of Banerjee *et. al.*, 2012, as well as those conveyed to us by our members.



This problem is widespread, but our experience is that the problem is more acute in private care facilities, than in public facilities, though it exists in both. This experience corresponds with ample research in this area that has found that staffing levels are lower in propriety (for-profit) PCHs than in non-profit facilities (MNU 2006; Harrington *et. al.*, 2012; Harrington *et. al.*, 2001). We are encouraged that Manitoba has a relatively low number of for-profit cares home at approximately 14% of total PHCs. However, given the prevailing evidence of both lower staffing levels and lower quality of care outcomes, we recommend that any future growth in PHC beds occurs under the ambit of public provision, and that the government consider bringing already existing private care into the public realm.

We should also note that employment in for-profit long-term care facilities often means little or no benefits or pension plans, as well as a non-standardized rate of pay. The "for profit" long-term care facilities pay these lower wages and inferior benefits, although the work is exactly the same. Based on our observation of the sector, the issue of non-existent or inferior pension plans may also have a negative impact on residential care. We know that many older workers, often suffering from their own medical conditions or injuries have a difficult time maintaining the extremely rigorous work pace that is required in under-staffed facilities. However, these workers delay retirement, despite the overwhelming stress of the job, because they cannot afford to retire with their inadequate pensions. Adequate, guaranteed pensions would go a long way to address this issue.

While the problem of working short adds to the severity of workload pressures and compromised care, even when the guideline target

is being met, staffing levels are insufficient. Our members frequently tell us that they believe that the level of care they are able to provide even when working fully staffed is not at the level they believe is adequate. This is, of course, intensified when working short-staffed. Examples of some of the most common concerns raised by our members that affect both their own well-being and the quality of care they provide include:

- Having to rush residents to get ready for meals.
- Little or no time for social activities and interaction with residents.
- Exhaustion and "burnout".
- Missed or shortened breaks.
- A pervasive feeling of guilt or sadness due to an inability to provide adequate care and attention.
- Rushing residents during personal care (*e.g.*, bathing and toileting).
- Witnessing some things not being done at all (especially recreation and social activities).
- Increased resident agitation and resident-to-worker violence.
- Increased physical strain.

Of these common concerns, the feeling of guilt and sadness over "not being able to provide residents with the care they deserve" is one of the most frequently raised issues. Our members often come in early, stay late, and work through breaks to ensure that workload is met and residents care is received. This speaks to the commitment that LTC staff have to providing the best quality of care to PCH residents. Legislating provisions for required staffing levels would not only safeguard resident safety and care, but would mean that safe and healthy work environments for PHC workers is ensured by law.

As was discussed earlier, prior to current acuity levels, the best research in this area maintains that 4.1 worked hours per resident day (hprd) is required to avoid jeopardizing the health and safety of LTC residents. Acuity levels have risen significantly since that time, and are expected to continue to rise dramatically in the near and medium-term. This makes the unmet goal of 3.6 *paid* hours of direct care even more alarming, and increases the imperative of both increasing staffing levels, and ensuring that they are consistently met.

Conclusion

While Manitoba does not have specific requirements for staffing levels legislated, it does have a Residents Bill of Rights that is enshrined in *The Health Services Insurance Act* under the 'Personal Care Homes Standards Regulation' (brought into force in 2005).

This bill of rights stipulates, amongst other things, that residents must be "sheltered, fed, dressed, groomed and cared for in a manner consistent with their needs" and "residents are to be provided with a safe and clean environment" (Government of Manitoba, 2005). This comprehensive piece of legislation provides an important framework for insuring resident quality of life. It also highlights a wide range of vital duties performed by PHC support staff. However, these rights can only be ensured if LTC staffing levels are adequate to perform the corresponding tasks. Many of the concerns raised in this brief suggest that they are not sufficient to meet all of the rights identified above.

A report conducted by CUPE in 2009, noted that:

> **the evidence linking staffing and quality is strong in both the *quality of care* and *quality of life* literature. The data and research on *quality of care* in long-term care facilities offers convincing evidence that staffing lies at the heart of quality. Research on *quality of life* is more recent and less abundant, but it underscores the importance of staffing – in particular, the value of social-emotional care and residents' relations with staff (2009, p. 32).**

This has certainly been echoed by our LTC members in Manitoba, who seem exceedingly concerned with the lack of "social-emotional" care for, and their social relations with, residents.

A 2006 report conducted by the Manitoba Centre for Health Policy, University of Manitoba Faculty of Medicine, noted that workload issues were becoming more prominent in PCHs, and that it is therefore "imperative to understand how the amount of care provided

by different types of staff influences" quality of care indictors (Doupe *et. al.*, 2006, p. xxi). At the same time, the number of PCH beds required in the province by 2030 may increase by up to 29.1% – 40.0%. The number of people currently accepted but waiting to get into a PHC has increased in recent years (Doupe *et. al.*, 2011).

The government has made important commitments to increasing the number of care beds in long-term care beds in the province. In previous throne speeches the government has made commitments to provide 200 new PCH beds in Winnipeg, and has already opened a new PCH in Niverville in the summer of 2013, and announced a new 100 bed personal care home in Transcona in June, 2014. The Winnipeg Free Press reports that two new facilities in Morden and Lac du Bonnet are in development, and that efforts are being made to address the increased need for complex care. While CUPE lauds these initiatives, we must stress that it is imperative that the issue of adequate staffing is critical not only in the development of any new long-term care initiatives, but in current care provision. As evidenced by labour action in the summers of 2013 and 2014, and through extensive consultation with CUPE members working in long-term care, this is an issue that requires urgent attention. Consequently, as a result of both primary and secondary research, consultation with CUPE members, and experts in the field, we've developed the following recommendations that we would like to see the province implement with the aim of providing safe, quality care and safe work environments in the LTC sector.

Recommendations

1 There is significant evidence noting the positive relationship between adequate staffing levels and resident outcomes and safe work environments. ***Recommendation:*** *That the Government should ensure that all LTC facilities are legally bound to minimum staffing levels. Given the increasingly intensive needs of PCH residents, we recommend the province put in place a plan to reach staffing levels between 4.55 and 4.8 hrpd. In the meantime the Province should immediately set staff levels at 4.1 hrpd to ensure the basic safety of residents.*

2 According to personal care home managers and health care aides, the lack of full-time and regular employment contributes to recruitment and retention problems and leads to chronic understaffing. Our members tell us that the lack of full-time positions is significantly responsible for them working short-staffed. Consultation with research staff from other unions representing health care support workers has corroborated this claim, leading us to believe that it is a significant problem. ***Recommendation:*** *That a review of current equivalent full-time positions (EFTs) is conducted, with the goal of increasing the number of full-time positions for health care aides, and other health care support staff where a lack of sufficient full-time positions is found.*

3 The 2009 Auditor General report also outlined the monitoring process in relation to the five standards that are deemed as 'core standards'. These entail: standards for integrated care plans, use of restraints, pharmacy services, safety and security, and staff education (OAG 2009, p. 50). There are 21 additional standards outlined in the Regulations that are considered non-core standards. Staffing hours are not addressed in any of the core or non-core standards.[3] Furthermore, while specific aspects relating to services performed by physicians and nurses are clearly outlined in the Standards, the work performed by health support workers is not, despite the fact that this work spans all or almost all of the core and non-core standards, and despite its crucial role in areas such as infection control and sanitation, recreation, physiotherapy and the use of restraints. ***Recommendation:*** *Given the key relationship between adequate staffing levels and patient outcomes and quality of care, we recommend that staffing levels be incorporated as one of the core standards, and that these include specifications for hours for non-nursing and non-physician care.*

[3] The 21 PCH standards covered the following areas: Resident Bill of Rights; Resident Council; Eligibility for Admission; Information on Admission; Participation in Care Plan; Initial Care Plan; Freedom from Abuse; Physician Services; Nursing Services; Health Records; Dietary Services; Housekeeping Services; Laundry Services; Recreation; Spiritual and Religious Care; Disaster Management; Infection Control Program; Person in Charge; Qualified Staff; Complaints; and Reports About Occurrences (OAG 2009, see also (Government of Manitoba, 2005)).

4 In addition to the positive relationship between staffing levels and patient outcome is the positive relationship identified in the research on long-term care between good work environments and quality care. ***Recommendation:*** *That work environment issues be incorporated into the regulation standards and that input from staff on work-place environment be solicited, through a confidential process, as part of the inspection process.*

5 According to the monitoring process outlined by the Office of the Auditor General, each PCH visit evaluated compliance with each of the five core-standards, as well as a varying group of seven of the 21 non-core standards. These visits took place on a rotating basis, which resulted in core standards being reviewed every other year and the other standards being assessed once every six years. In our opinion this does not constitute sufficient monitoring to ensure compliance with core standards, and does not reflect the practice carried out in other provinces. For example, the *Long-Term Care Act* enacted in 2010 in Ontario mandates yearly, unannounced, comprehensive inspections that take several days to several weeks to conduct. Given concerns identified both in the auditor General's 2009 report, and those raised by CUPE Health Care workers, indicating that aspects of patient care covered by the Personal Care Homes Standards Regulation are not being met, there is a need to increase monitoring of both the core and non-core standards. In order for this monitoring to be effective, and to ensure that practices are being carried out in the course of normal activity, it should be conducted without warning and advanced preparation. ***Recommendation:*** *We recommend that the number of unannounced visits to personal care homes be increased. These inspections should take place at minimum on an annual basis, and more frequently at sites where past violations have taken place.*

6 Part of improved insight involves having a well-informed public and a transparent system of reporting. In order for family members and patients themselves to be able to make well-informed decisions about facility choice and to be able to advocate effectively for quality care, accurate and sufficient information must be available to the public, residents and staff. ***Recommendation:*** *We support the recommendation made by the Office of the Auditor General (2009, p. 83) that the government "enhance publicly available information on PCHs to include information on compliance with PCH standards", and further recommend that the government implement a public reporting process and better access to information, and that daily staffing levels be posted in facilities where both staff, residents and the public can view them. The results of Standards Reviews, and compliance with other quality indicators, should be posted in facilities and on health authority or department websites.*

7 We are encouraged that the province of Manitoba has a relatively low number of for-profit PCHs (14%). However, given the research evidence that public PCHs perform better than private facilities in resident outcomes and work environment quality, and tend to have higher staffing levels (also corroborated by our members' experience in Manitoba). ***Recommendation:*** *That all new PCH facilities fall under public provision, and that the province phase out existing private care.*

8 There is nominal federal funding for long-term care, but LTC services are not covered by the *Canada Health Act* and are not subject to federal regulations as governed by the *Act*. Nor are they subject to any other federal regulations or standards. The current Canada Health Transfer covers extended health care services, but there are still no program delivery criteria. As a consequence, LTC has become a patchwork of provincial systems with varying patterns of public and private ownership, levels of public funding, access and standards. ***Recommendation:*** *That the provincial government pressure the federal government to establish federal legislated standards for residential long-term care, including Canada Health Act criteria (public administration, universality, comprehensiveness, accessibility, and portability) and conditions (no user fees or extra billing).*

9 A further consequence of the near exclusion of LTC from medicare is that LTC care in Canada is a two-tiered system. Even in publically subsidized facilities, many medical and personal expenses are not covered (e.g., depending on public subsidies, these can include: dentures, hearing aids, specialized wheelchairs and cushions, therapeutic mattresses, diagnostic tests, over-the-counter drugs, personal hygiene products, personal laundry, telephone, physiotherapy, foot care, and personal expenses like gifts and clothing). Those seniors who can afford to pay privately get a richer package of goods and services in publically-subsidized facilities, and the disparity is even greater between those living in public facilities and residents of private facilities. ***Recommendation:*** *That the province pressure the federal government to substantially increase federal funding to LTC by extending medicare to cover LTC, tied to legislated standards, including universality and other Canada Health Act criteria.*

10 Canada is the only G8 country without a national Alzheimer's strategy. The economic burden of Alzheimer's and dementia in Canada is expected to be $293 billion per year by 2040. In Manitoba the current cost of these diseases is $885 million, and is expected to reach $4.4 billion by 2038 (Alzheimer Society, 2013; Alzheimer's Society of Manitoba, 2014). ***Recommendation:*** *That the province pressure the federal government to develop a national Alzheimer's and Dementia Strategy.*

11 It is critical that an effective process exists that allows LTC residents and their families to advocate for their interests. The *Personal Care Homes Standards Regulation* sets out the conditions upon which resident councils may be established in each personal care home. This is important enabling legislation, but it does not go far enough. The legislation stipulates that concerns raised by resident councils are addressed, "... including an investigation of the concern if necessary, and that a response, or preliminary response, is provided to the council at or before its next meeting". All other complaints processes outlined in the Regulations are similarly directed to the operators. This invests too much authority in the operator and does not provide sufficient independent investigative oversight. While many concerns may be addressed to the satisfaction of councils and residents in this manner, there needs to be a formal mechanism established that provides a complaints process on behalf of residents, their families and resident

councils, independent of the operator. Moreover, it is imperative that resident councils are provided with access to professional, independent advisors in order to effectively fulfill their advocacy role. ***Recommendation:*** *Establish a residents' advocate, independent of facility management, to work with resident councils and report to an appropriate body, such as the Protection for Persons in Care Office, capable of carrying out, or overseeing, independent investigations by a delegated authority and to whom complaints received by operators are also submitted. The results of Standards Reviews and compliance with other quality indicators should be made available to resident councils and the residents' advocate.*

12 While the *Public Interest Disclosure (Whistleblower Protection) Act* provides a certain level of retaliatory protection for LTC workers who report on incidents or conditions that negatively affect residents' care, most LTC workers are unaware of the whistle blowing process, or the protections that are provided to them. ***Recommendation:*** *The Ombudsman should be mandated to undertake an education campaign in the LTC sector, both public and private, to educate workers in the sector about their rights under the existing legislation.*

13 There is no set standard for Health Care Aide training courses in Manitoba. Courses range from weeks to months of training. Costs for training are too high at the "for profit" colleges. Access to public programs sometimes excludes immigrants. ***Recommendation:*** *The Province of Manitoba should review Health Care Aide training in Manitoba with the intention of brining all certification under provincially funded schools and programs. These programs should be standardized to ensure uniformity in training. These programs need to be barrier free, ensuring that immigrants and low-income Manitobans have equal access to high quality, affordable training. This review should also look at the issue of foreign training and credentials, including equivalency testing where appropriate, to ensure that that the training and education of immigrants are properly recognized.*

14 LTC workers in private, for profit LTC facilities often have insufficient retirement savings plans – leaving workers without basic financial security in retirement. ***Recommendation:*** *Until such a time as all LTC facilities are brought under public administration, the Province of Manitoba should require that all private LTC facilities provide the same, or equal, pension benefits as presently made available to public LTC workers through HEB Manitoba.*

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References

Alzheimer Society (2013). Alzheimer's Disease: An Economic Time Bomb, speech delivered by Mimi Lowi-Young, CEO, at the Economic Club of Canada, Friday, September 20, 2013. Available at: http://www.alzheimer.ca/pei/~/media/Files/ national/Advocacy/speech_alzheimers_economic_time_bomb_sept202013_e.ashx

Alzheimer's Society of Manitoba. (2014). Disease Stats. Available at: http://www. alzheimer.mb.ca/about-dementia/disease-stats/

Armstrong, Pat and Daly, Tamara. (2004). "There are not Enough Hands: Conditions in Ontario's Long-term Care Facilities." Canadian Union of Public Employees. Available at: http://cupe.ca/updir/CUPELTC-ReportEng1.pdf

CIHI (2010. *Caring for Seniors With Alzheimer's Disease and Other Forms of Dementia*. Ottawa: Canadian Institute of Health Information. Available at: http://secure.cihi.ca/

cihiweb/products/Dementia_AIB_2010_EN.pdf

Collier, E. and C. Harrington. (2008). "Staffing Characteristics, Turnover Rates, and Quality of Resident Care in Nursing Facilities." 1(3): 157–70

CUPE (2009). Residential Long-Term Care in Canada: Our vision for better senior's care. Canadian Union of Public Employees, Ottawa. October 2009. Available at: http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf

Doupe, M., Fransoo, R., Chateau, D., Dik, N., Burchill, C., Sooden, R., Bozat-Emre, S & Guenette, W. (2011). Population Aging and the Continuum of Older Adult Care in Manitoba. Manitoba Centre for Health Policy, University of Manitoba, Faculty of Medicine, February 2011

Doupe, M., Brownwell, M., Kozyriskyj, A., Dik, N., Burchill, C., Dahl, M. Chateau, D., De Coster, C., Hinds, A., & Bodnarchuk, J. (2006). Using Administrative Data to Develop Indicators of Quality Care in Personal Care Homes. Manitoba Centre for Health Policy, University of Manitoba, Faculty of Medicine, October 2006

Forbes, H. (personal communication, January 24, 2014). Hana Forbes – Director, Continuing Care Branch, Regional Policy and Programs, Manitoba Health

Government of Manitoba, (2005). The *Health Services Insurance Act*. (C.C.S.M. c. H35). Personal Care Homes Standards Regulations

Government of Manitoba (2007). Province Invests More Than $40 Million for Recruitment Strategy to Increase Personal-Care Home Nursing Care and Supports. New Release, November 29, 2007. Available: news.gov.mb.ca/news/index.html? archive=2007-11-01&item=2707

Harrington, C., Olney, B., Carillo, H. and Kang, T. (2012). Nurse staffing and deficiencies in the largest for-profit nursing home chains and chains owned by private equity companies. *Health Services Research*, 47, February, 1-20

Harrington, C., Jacqueline C., Goldman, M. Jacobsen, F., Lloyd, L., McGregor, M., Stamatopoulos, V. and Szebehely, M. (2012). Nursing Home Staffing Standards and Staffing Levels in Six Countries. Journal of Nursing Scholarship, 44(1), 88-98

Harrington, C. Woolhandler, S., Mullan, J., Carrillo, H., and Himmelstein, D. (2001). Does Investor Ownership of Nursing Homes Compromise the Quality of Care? *American Journal of Public Health*, 91(9), 1452-1455

Health Care Financing Administration, 2002. *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Report*. Washington, DC: US Department of Health and Human Services

HEU (2009). Quality of Care in B.C.'s Residential Care Facilities: A submission to the Office of the Ombudsman on Seniors' Care. Hospital Employees Union, January 2009

Jansen, I. (2011). Residential Long-Term Care: Public Solutions to Access and Quality Problems. *HealthcarePapers*, 10(4), 2011

McGregor, M.J. and L. Ronald. 2011. *Residential Long-Term Care for Canada's Seniors: Non-Profit, For-Profit or Does It Matter?* Montreal, QC: Institute for Research on Public Policy. Retrieved January 25, 2011. <http://www.irpp.org/summary.php? id=359>

Murphy, J.M. (November 2006). *Residential care quality: A review of the literature on nurse and personal care staffing and quality of care*. BC: Nursing Directorate British Columbia Ministry of Health. Retrieved December 10, 2008 from http://www.heu. org/~DOCUMENTS/research_reports/November%202006%20CNAC%20report%20on%20residential%20care%20staffing%20 and%20quality%20of%20care.pdf

MB Bureau of Statistics, (2008). MANITOBA'S FUTURE POPULATION GROWTH 2009 TO 2028 A CONSERVATIVE VIEW

MNU (2006). Long-Term Care in Manitoba. Manitoba Nurses Union, December, 2006

Novek, S. (2011). Women, Migration and Care Work: Filipino Health Care Aides in Canada. Master Thesis; Department of Community Health Science, Faculty of Medicine, University of Manitoba, Winnipeg Manitoba

OAG (2013). Follow-up of previously issued recommendations, 2013. Office of the Auditor General, Manitoba

OAG (2009). Report to the Legislative Assembly – Audits of Government Operations, 2009. Office of the Auditor General, Manitoba

OHC (2008). Violence, Insufficient Care, and Downloading of Heaver Care Patients: An evaluation of increasing need and inadequate standards in Ontario's nursing homes. Ontario Health Coalition. Toronto, Canada, May 2008

Red River College. Health Care Aid Fee Schedule. http://me.rrc.mb.ca/Catalogue/ProgramDatesAndFees.aspx?ProgCode=HEACF-CT&RegionCode=WPG, August 7, 2014

Red River College. Health Care Aid Overview. http://me.rrc.mb.ca/Catalogue/ ProgramInfo.aspx?RegionCode=WPG&ProgCode=HEACF-CT, August 8, 2014

Shaw, M. M. (2004). Aggression toward staff by nursing home residents. Journal ofGerontological Nursing, October, 43-54

Smetanin, P., Kobak, P., Briante, C., Stiff, D., Sherman, G., and Ahmad, S. (2009) Rising Tide: The Impact of Dementia in Manitoba 2008 to 2038. RiskAnalytica.

Stunden Bower, S. & Campenella, D. (2013). From Bad to Worse: Residential Elder Care in Alberta. Parkland Institute, University of Alberta, Edmonton

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