The only kind of dignity which is genuine is that which is not diminished by the indifference of others.
Cover Quotation

Dag Hammarskjold (1905-1961)
Swedish economist and statesman who served as second Secretary-General of the United Nations (1953–61) and enhanced the prestige and effectiveness of the UN. He was posthumously awarded the Nobel Prize for Peace in 1961.

Exclusive of the cover, the quotations featured throughout this report were chosen from over 700 nurses, responding to the 2006 Survey of Manitoba’s Long-Term Care Nurses conducted by Viewpoints Research.

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Executive Summary

Long-term care has is an area of Manitoba’s health care system that has long been neglected. It is governed by standards that have been in place for over 30 years. Personal care homes are often under-staffed and poorly equipped. Standards are not consistent throughout the province.

This report examines long-term care in Manitoba, bringing together the expert observation and analysis of Manitoba’s nurses and the work of a number of other studies that have looked at issues in long-term care in recent years. It examines key issues such as patient acuity, facility standards, workplace violence, resident health and safety and staffing from the perspective of the current situations, trends and what Manitobans should reasonably expect from the long-term care system. The report offers recommendations for action in all of these areas.

Key Findings

- The median age of the Manitoba population is projected to increase from 37 years to 43 years by 2031.
- Over the same period the percentage of Manitobans over 65 is projected to rise from 13.5% to nearly 22%.
- Levels of care and staffing models have not been modified since 1973.
- Manitoba maintains the highest PCH bed rate in Canada, at 121.2 (as of 2004)
- Only 0.4% or admissions to PCHs between 1999 and 2004 were classified as Level 1
- 64% of nurses report that acuity levels in PCHs have gone up in the last three years, and 31% report they have increased a lot;
- 84% of nurses working in a non-profit facility would recommend their facility for a family member while only 67% of nurses in for-profit facilities would make the same recommendation.
- 56% of nurses in non-profit facilities rate supplies as “good” or “excellent” while only 40% of those in for-profit facilities give the same rating.
- 65% of nurses in private, for-profit facilities report an increase in violence; 47% of nurses in non-profit facilities report an increase in violence.
- The difference in the rates of incidences, such as fractures and infections vary greatly among facilities in Manitoba, with the facility reporting the highest incidences reporting, in some cases, more than 200% more events than the Manitoba average.
- In every area (hip fractures, non-hip fractures, accidental falls, skin ulcers, respiratory infections and fluid/electrolyte imbalances) for-profit facilities report higher average rates of events than non-profit facilities.
- Nurses reported over 300 incidents in 2005 where “insufficient staff” was a contributing factor.
- Almost 20% of nurses report a resident to nurse ratio of greater than 80:1 on the night shift in their facilities.
Long-term care represents an increasingly critical aspect of Manitoba’s health care system. As the average age of the province’s citizens increases there is a greater reliance on the long-term care facilities. It is also one of the areas of our health system that will impact all of our families, at one point or another.

There is much debate throughout the country in terms of what priority should be placed on long-term care, what standards should govern it and how to integrate it with other aspects of the health care system. Alberta reviewed long term care in 1999 and 2005 and developed new standards. In British Columbia, the Liberal government has been taken to task for going back on promises to invest in long-term care beds. Their approach has resulted in significant bed reductions. Ontario has recently reviewed their long-term care strategy as well, but problems still remain.

Investments in health care have had a positive impact. Manitoba has the highest rate of long-term care beds per 1000 population over 75 in Canada. But having the beds available is only part of the answer and, arguably, the smallest part. As this report shows, there are a number of critical areas where long-term care in Manitoba is lacking, and this raises serious concerns about the care and welfare of Manitoba’s elderly, who are the primary users of long-term care. Facilities do not have enough staff and, in many cases, do not provide appropriate supplies or equipment. Residents’ physical and psychological needs are not provided for and their health and safety is often at risk. The quality of care in personal care homes is not consistent, despite consistent funding from government.
As the representatives of long-term care nurses in Manitoba, the Manitoba Nurses’ Union frequently hears from its members about their experiences working in long-term care facilities. They have a lot to say and express great concerns about the welfare of residents, since they are in such intimate contact with them on a regular basis. Often, efforts to understand issues in our health care system fail to capture the knowledge and experiences of nurses, and miss a valuable perspective on the issues at the bedside. This report brings this knowledge and perspective to an examination of our long-term care system.

In 2006, Viewpoints Research conducted a survey for the Manitoba Nurses’ Union of 500 of its long-term care nurses to help understand the challenges they were facing in their workplaces, and their concerns about their ability to provide quality care to residents. This report looks at these results as well as the results of a similar survey conducted in 2000. The results of this survey reveal that, while there has been progress made in the last 5 years, there is still a great deal of work remaining. Nurses reported increasing acuity levels, increasing violence towards nurses and that quality of care is declining.

The goal of this report is to provide a picture of long-term care in Manitoba. While there are other recent studies of this area, this report ties this information together, giving an overall view and putting a human face on long-term care and the nurses that provide it. Reports from nurses verify what has already been established in research studies, and they provide a more detailed account of what is really happening. It is important to remember that, while statistical measures are valuable for evaluating some aspects of health care, often they fail to account for the fact that it is people who are providing care to people, and this is not always captured by numbers alone.

This report draws on evidence from a number of sources. The Manitoba Centre for Health Policy released a study in October 2006 examining methods to evaluate the quality of care in Manitoba’s long-term care system, and these results are used to examine issues of quality.
of care, patient safety and the character of Personal Care Homes and their residents. Results of the Manitoba Nurses’ Union’s telephone survey of 500 long-term care nurses, conducted in 2000 and repeated in 2006, reveal nurses’ perspectives on the situation in long-term care. A mail survey was also sent to all MNU members working in long-term care, and provided hundreds of comments and recommendations from those working most closely with residents.

Data from Workload/Staffing reports is also examined. These reports provide nurses with the ability to document situations which they believe are unsafe for themselves or patients and have prevented them from being able to properly practice. The MNU maintains a database of these reports and data from these reports are included throughout to provide another picture of our long-term care facilities. The number of Workload/Staffing submissions from Personal Care Homes (PCHs) are shown in Figure 1.

Based on our surveys and the data from Workload/Staffing reports, it is clear there are a number of key issues for long-term care nurses: Staffing ratios and workload, patient health and safety, patient acuity, workplace violence, and facility standards (equipment, supplies, patient supports). The report is divided into three sections. The first section provides an overview of the long-term care situation in Manitoba and in the Canadian context, including characteristics of Personal Care Homes in Manitoba. The second section looks at a number of issues in long term care that have been identified, both by MNU members and other studies. Finally, a number of recommendations are provided to guide the Manitoba government as it moves forward to reform the long-term care system in Manitoba.

Figure 1:
WLS Submissions, Personal Care Homes, 2001-2005

Long Term Care Facilities and Staff have long been thought of and treated as the “second cousins” in the medical field. Last in the list of facilities that need updating, last in the list of Staff that need to be informed, last in the list of facilities that need guidelines changes.
Overview

It is well known that Canada’s population is aging. With the aging population comes an increasing need to care for those whose health has deteriorated. In today’s hectic world, with extended families often less able to support them, elderly Canadians are often cared for in long-term care facilities. Governments have recognized this and there has been significant discussion about the pressures that will be faced in caring for an increasingly elderly population. In addition to increases in age, there is also an emphasis on directing patients away from acute care beds to other types of care in order to reduce hospitalization costs. This, too, has put pressure on long term care facilities.

This combination of factors has resulted in a fundamental change in the characteristics of long term care residents. In turn this has changed the nature of the work performed by staff in long-term care. Increasingly nurses are confronted with residents with greater health issues while, at the same time, working in facilities that are staffed based on the level of care required 30 years ago. Some provinces have made attempts to address this situation and not all successfully. Manitoba has yet to meet this challenge.

On top of the pressures created by changing resident care needs governments are increasingly under pressure to control health care costs, driven by the idea that, somehow, what we are doing presently is inefficient. This has resulted in an emphasis on cost savings often, it appears, at the expense of safety and quality of care. This is not an issue unique to Manitoba, rather it appears to be a serious issue in long term care in North America. The substitution of for-profit residential care (also known as “proprietary”) for non-profit (or “non-proprietary”) and government run facilities is one attempt to address what are perceived as rising costs. It is clear, however, that for-profit facilities are not able to provide less

If I knew 15 years ago, when I was a young grad, optimistic and eager to help seniors, that I would be seeing seniors having five-minute cold tub baths once a week, sitting in wet or soiled clothes, fed cold food, I NEVER would have chosen nursing.
expensive care; indeed, for a given expenditure of public resources, for-profit facilities provide less care and lower standards than facilities operated as non-profit.

The long-term care system is also greatly impacted by Manitoba’s changing demographics. As the population ages this will put increasing pressure on Manitoba’s long-term care resources. Statistics Canada projects that the median age of Manitobans will increase from just over 37 years (2005) to between 41 and 43 years by 2031. Over the same period, the percentage of Manitobans over 65 is projected to rise from 13.5% to as much as 22% of the population. As more and more Manitobans join the ranks of the elderly there will be a greater demand to provide the increasing health care that is required. Manitoba is fortunate that it has established Home Care and Assisted Living programs to deal with some of this demand. This creates another issue, however, as these programs cater to those who are fairly independent and not as sick and this, increasingly, leaves personal care homes to care for the oldest and most seriously ill, as well as those with multiple medical issues and other complicating conditions.

At present, there are almost 10,000 long-term care beds in 122 facilities in Manitoba. The largest number of beds are located in Winnipeg, although there are many smaller PCHs located throughout Manitoba. The average number of beds in a Winnipeg PCH is 144.8, as opposed to 48.6 for PCHs outside of Winnipeg. As Figure 3 shows, the majority of for-profit PCHs are also located in Winnipeg, with 14 of its 38 PCHs being for-profit; only 5 out of 84 homes outside of Winnipeg are for-profit.
Access to long term care in Manitoba is, at the moment, better than in the majority of the country. In 2004, the province provided the highest rate of long term care beds per 1000 population in Canada at 121.2. This compares to the national average of 95.7 and a low of 83.0 in New Brunswick. In addition, Manitoba has one of the highest rates of non-profit facility ownership in Canada. Only 15 percent of long term care facilities in Manitoba are operated for profit, compared to 31.7 percent in British Columbia and 51.6 percent in Ontario. Against these strengths, the next section discusses some of the major issues that are facing long-term care in Manitoba. These are all issues that will have to be addressed in order to provide safety and quality of life to Manitoba’s elderly in the coming years.

I recently worked in charge on a night shift where I had direct care of 75 residents, but was responsible for another 75 on another floor. This also included administrative duties such as staffing and many non-nursing duties including making sure doors are locked, checking the kitchen, stocking the supply room etc. I have recently left long-term care and no amount of money would make me go back if the situation does not improve.
While access to care is one measure of success, perhaps the more important measures relate to the quality of care available in long-term care facilities. This is the point where a number of issues have to be confronted. This section of the report looks at some of the most important issues in long-term care in Manitoba: Resident acuity, facility standards, ownership type, workplace violence, resident health and safety, and staffing.

**Resident Acuity**

As any part of our health care system, long-term care facilities are greatly affected by the health status of those under their care. This can influence the training needed by staff and the resources that need to be spent on special facilities or programs. Traditionally, personal care homes have been thought of more as a supportive place for the elderly to live as they grew older and are unable to live independently. Increasingly, however, these facilities have been confronted with residents who are more sick and require more care than any time in the past. The more basic types of care have been taken up by Home Care programs and Assisted Living environments. Increasingly long-term care deals with residents with multiple medical issues, significant psychological challenges and, in the majority of cases, degenerative conditions such as Alzheimers.
The characteristics of residents in long-term care have changed. Compared to 1973, when Manitoba’s publicly-funded long term care system was first established, residents in personal care homes are older, increasingly frail and suffering from a wider range of conditions. While many of the standards and guidelines from 1973 are still in place, these no longer reflect the type of care that nurses and other professionals are required to provide.

The increase in resident acuity results from two main trends: an increase in the age of Manitoba’s population and an emphasis on moving patients from acute care to other forms of care. Working together, these factors mean that the residents of PCHs in Manitoba are older and sicker than ever. Whereas personal care homes were traditionally a place where elderly people would go to live with some supervision and basic care, increasingly these facilities are operating as another branch of the acute health care system, providing much of the same types of care provided in hospitals.

In Manitoba, during the course of the Manitoba Centre for Health Policy study on the quality of care in personal care homes (1999-2004), 50 percent of all PCH admissions were people 85 years and older and this group comprised approximately 55 percent of the population of Personal Care Homes\(^5\). In addition to age the health status of these residents has become more complicated as well. Over 65% of residents of PCHs in Manitoba have been diagnosed with dementia and 70% have been diagnosed with two or more categories of chronic diseases\(^6\). These changes have resulted in a resident population that places increasing demands on nurses and other staff.
Manitoba has a system that classifies long-term residents based on their requirements for care. In order to classify residents, there are six “areas of care” that are evaluated: bathing and dressing, assistance with meals, ambulation/mobility/transfers, elimination, professional intervention (treatment/medication), and behaviour management/support supervision. In Manitoba, there are currently four levels of care:

**Level 1** – Scored as ‘independent’ or ‘minimal dependence’ in each of six areas of care. Estimated to require 0.5 hours of care in a 24 hour period;

**Level 2** – Scored as any other combination of ‘minimal’, ‘partial’ and ‘maximal’ dependence, in all areas of care. Estimated to need 2.0 hours of care in a 24 hour period.

**Level 3** – Scored as a) ‘maximal dependence’ in two or three areas of care, and as ‘independent’ or ‘minimal dependence’ in all other areas of care; or b) ‘maximal dependence’ in the area of behaviour management/support supervision and ‘partial dependence’ in at least two other areas of care. Estimated to need 3.5 hours of care;

**Level 4** – Scored as ‘maximal dependence’ in four or more areas of care. Estimated to need 3.5 hours of care.

These levels of care have not been changed since the first days of publicly-funded long-term care in Manitoba, and they no longer represent a useful tool, given the condition of today’s residents. As an illustration, the
first level of care has been rendered virtually redundant by increases in acuity. During the five-year period of the Manitoba Centre for Health Policy study, only 50 residents were classified as a Level 1 at the time of admission; this represented 0.4% of all admissions during this period. Clearly developing a new method of classifying residents’ acuity must be a priority.

Nurses in Manitoba have reported the increase in acuity and felt its impact. Based on the MNU’s 2006 research, 64 percent of nurses report that acuity levels have gone up in the last three years and 31 percent report they have increased a lot. Indeed, more nurses today report increasing acuity levels, compared to 55 percent from the 2000 survey. In addition, information from nurse-submitted workload/staffing reports indicates that high patient acuity has been a consistent and increasing contributing factor in documented workload issues. As will become more obvious in the discussions on violence and safety, submitted workload reports represent serious issues, including patient falls, injury and even occasionally death. Obviously it is critical that these issues be taken seriously if long-term care patients are to be provided a safe place to live.

Comments and recommendations received from our mail survey reflect these concerns as well. The consensus among long-term care nurses is that every year they are being confronted with more acutely ill residents and that this is not being recognized, either in terms of staffing or in the standards of the facilities themselves. There is a growing sense of frustration that, despite their best efforts to provide care, without adequate support, it will be increasingly difficult to do. A number of recommendations for more staffing cite facilities that have shifts where 1 nurse is responsible for 100 or more residents, often including the responsibility for clerk duties or even more than one floor of a facility. Obviously, when dealing with increasingly ill residents, this makes the job of providing adequate care difficult, if not impossible.

Facility Standards

Personal care homes are just that – peoples’ homes. Many residents will spend years in these facilities and the standards maintained will profoundly impact their quality of life. From the quality of food provided to the activities available and the equipment and supplies for their care, each is a critical component of providing quality care. Since virtually all of our families have been touched by the long-term care system, as citizens and taxpayers we expect our family members to be treated with dignity and be provided the best care possible.
As publicly funded entities, it is critical that personal care homes be held to certain standards in terms of their facilities and the care they provide. All personal care homes in Manitoba receive the same funding based on the characteristics of the residents in their care. There is an expectation that, regardless of which facility someone calls home, they be provided with a similar level of care. For facilities that perform the same function and receive the same funding, a similar level of service should be expected.

Based on evidence from nurses, the standards of long-term care facilities in Manitoba are not consistent and, in many cases, do not meet what most would consider a minimum level necessary to provide a decent living environment for residents and a safe working environment for staff. In a number of cases facility management are restricting the availability of supplies to the point of compromising the health and safety of residents and staff. The rationing of gloves in some for-profit facilities, as an example, sends the message that the most important factor in operating a personal care home is cost and profits and that safety and health are secondary. Trading safety for profit is not acceptable in any workplace in Manitoba, so it should certainly not be acceptable in personal care homes.

There are two specific areas of concern regarding standards that are raised repeatedly by nurses: Lack of equipment and lack of access to appropriate supplies. In terms of equipment, this can vary from lifts used to assist in handling patients to electric beds to blood pressure monitors. Supplies include gloves, gauze, towels, incontinence pads and other things necessary for the daily care of patients. In both cases, nurses increasingly find that what they are provided with is inadequate.

Establishing and enforcing standards for long-term care facilities is critical. Manitobans expect a decent level of care and they expect care to be consistent across facilities. This does not appear to be the case. Standards and quality of care vary greatly among long-term care facilities in Manitoba, as can be seen in the results of the MCHP study and in the reports from nurses in the facilities.
Ownership Type

There is an important distinction to be made when looking at long-term care facilities between those that operate on a private, for-profit basis and those that operate as non-profit. In Manitoba, in contrast to other parts of Canada, the majority of facilities are non-profit. Most private, for-profit PCHs in Manitoba are located in the WRHA and Brandon RHA, where they comprise 36.8% and 40% of all PCHs, respectively. The only other RHAs that have any for-profit facilities are Interlake and South Eastman.

The presence of private, for-profit facilities is an area of concern, as there is an increasing body of evidence that demonstrates that, for a given level of funding, private long-term care facilities deliver a lower quality of care than their non-profit equivalents. In Manitoba, for-profit PCHs provide lower levels of both nurses and nurses’ aids than non-profit facilities in Winnipeg or the rest of the province. Non-profit facilities in Winnipeg provided 0.9 hours per resident day of nursing care and 2.4 hours per resident day of care by nurses aides while private, for-profit facilities provided only 0.8 hours of nursing care and 2.2 hours of care by nurses aides. As the MCHP study points out, even a 0.1 hour rate change is very significant: In a comparison between two 40 bed facilities, this represents up to 1460 additional hours of care per year, or 0.7 additional full-time staff. These lower levels of staffing are despite the fact that residents in for-profit facilities appear to have a higher level of chronic illness; in for-profit facilities in the WRHA, 81% of residents had been diagnosed with two or more different categories of chronic diseases, as opposed to 70% in Manitoba PCHs as a whole.

The link between profit and lower staffing is not unique to Manitoba. A number of studies in other jurisdictions have reached the same conclusions. A study of nursing homes in British Columbia found that non-profit status was associated with 0.34 more hours per resident day provided by direct care staff and 0.23 more hours per resident day provided by support staff. The study also points out that, at the time it was conducted (2001), there were no standards or regulations governing how facilities were to allocate government funding between staffing, administration and property costs. This same situation is found in Manitoba, where there is little or no accountability for how facility funding is allocated.

The MCHP report further discusses the issue with respect to Quality Indicators (QIs), which are used to measure the standard of care provided in personal care homes. What the study calls “diagnostic QIs” included incidences of hip fractures, non-hip fractures, accidental falls, skin ulcers, respiratory infections and fluid and electrolyte imbalances. While differences in these Quality Indicators between RHAs were generally not statistically significant, each of these categories of QI were higher in for-profit facilities in the WRHA than the Manitoba average, and each of these was statistically significant. This means that a resident of a for-profit PCH in Manitoba is more likely to suffer an incident such as a fall or infection than a resident in a non-profit facility.

No hot water was available for 1 week. Maintenance was slow to respond to having it fixed, Health Care Aides had to warm face cloths in microwave ovens and boil water in kettles to do pericare.
Differences between Personal Care Homes based on ownership type were also noted in the phone survey conducted by Viewpoints Research for the Manitoba Nurses’ Union in September 2006. In one question, nurses were asked whether they would recommend their facility for a family member: 84% of nurses working in public facilities said they would recommend their facility, while only 67% of nurses in private facilities would make the same recommendation. In further evaluating the quality of the PCHs in which they work, 81% of nurses in public homes responded that they considered “bathing” in their facility to be “good” or “excellent” while only 74% of those in private facilities responded this way. The same difference was noted when nurses rated “supplies” in their facilities, with 56% of public-facility nurses rating supplies as “good” or “excellent,” while only 40% of nurses in private facilities did so. Perhaps the greatest concern is that, according to nurses, workplace violence is more prevalent in private facilities than public: 65% of nurses in private facilities feel there has been an increase in violence, as opposed to only 47% in public facilities.

It is apparent that, in a number of areas, there are obvious quality deficiencies in for-profit personal care homes, not to mention safety concerns for staff. Given that the people of Manitoba fund these long-term care facilities and they receive the same funding per patient as not-for-profit facilities, a critical question is whether it makes economic sense to fund facilities that are run on a for-profit basis. One nurse may have made the point precisely in recommending that the province, “disallow any and all private for profit LTC facilities – any profits should be returned to improvements in facilities.” As the Ontario Health Coalition noted in a 2002 report, there are a limited number of places for a for-profit facility owner to seek their profit: “quality of the facilities; staffing levels and/or wages and working conditions; quality of patient care; and the imposition of new user fees.” It should be no surprise then to see for-profit facilities in Manitoba suffering in patient care, staffing and facility quality.

Figure 9:
Percentage Rating “Bathing” and “Supplies” as “Good” or “Excellent”

Linen and incontinence products given out with much stinginess - often have no towels, sheets, even on bathing days.
Workplace Violence

Workplace violence is increasingly an issue across North America and Long Term Care is no exception. In fact, in the United States, long-term care is among the most dangerous workplaces in terms of exposure of staff to assault. A study of Minnesota nurses' found an physical assault rate of 13.2 per 100 persons per year. It also found that 75 percent of nurses who reported being physically assaulted also reported non-physical violence, including more than 7% of nurses that reported sexual harassment, 17% that reported threats and 34% that reported verbal abuse. Fully 46% of these nurses reported that this behaviour was continuing. The most damning fact is that in many health care facilities violence against nurses is not treated as a serious issue. And when nurses come to management for support they often do not find it.

Our research indicates that 52% of nurses report that there has been an increase in the incidence of violence in their facilities, and that this has increased from 45% in 2000. In private facilities the situation is more dire – here 65% of nurses report an increase in violence, compared to 47% in public facilities. Workload/Staffing reports support this concern as well, as they show an increase in report of “staff abuse,” as well as situations that create the potential for this abuse (Figure 10).

Workplace violence policies are a common feature in many workplaces, and an important tool in dealing with this serious issue. In long-term care in Manitoba, however, these policies appear to be absent in practice, if not in fact. Research demonstrates that workplace violence policies in health care settings, and their adoption and enforcement by management, can be effective at protecting nurses. Another study based on data from Minnesota nurses looked at the effectiveness of workplace violence policies and found that many different types of policies had the effect of reducing violence against nurses. “Zero Tolerance” policies, and policies prohibiting certain types of behaviour were found to be particularly effective.

Having violence policies is only part of the solution. As many of our nurses report, even though policies are on the books, awareness of these policies is very low and, in many cases, there is little support from management in enforcing them. The significance of organizational buy-in is reinforced by the Minnesota study:

“Organizational culture may have a significant impact on behaviours, regardless of the existence of policies. If a nurse interprets the employer’s attitude as having a low tolerance to violence, behaviours may be adjusted accordingly; the opposite is also true – having a zero tolerance policy without management commitment may indicate little about the true impact of policies. Policies cannot stand alone; a strong commitment by management and administration must accompany the policies.”

Long-term care standards must establish the requirement for policies protecting all employees from violence and harassment and must provide sanctions when these policies are violated. Facility management must take the leadership in promoting, explaining and enforcing these policies, as such policies are only as useful as the buy-in from management and staff.

Families have unrealistic expectations, often nurses receive verbal abuse. Perhaps families need more education with disease process.
Nurses do not have as much time to provide direct care and the physical assessments that are needed to observe the changes in Residents’ physical and mental health. We are unable to catch acute problems as early and the mental health deterioration that causes care problems.

This leaves our Residents at risk for prolonged illnesses that contribute to increased needs for medication and hospitalization, for decreased personal care, and for abusing staff as their care is being done because they no longer understand what is happening due to their decreased mental functioning.
**Resident Health and Safety**

Perhaps the most important issue in examining the state of long-term care in Manitoba is resident health and safety. The Manitoba Centre for Health Policy study has a lot to say about this. The goal of the study was not to make qualitative judgments about the results presented, but it does provide a great deal of information about the quality of care in personal care homes and some of the potential hazards to residents. In this report, looking at the bigger picture, it is our responsibility to say that patient health and safety must be held to a higher standard, especially in an environment that is a home to so many, and where so many residents are unable to advocate on their own behalf. More importantly, these standards should be consistent across facilities: Patients should have an expectation that they will be equally safe, regardless of in which facility they reside.

As a starting point, we can examine some of the findings of the MCHP report and the results for their Quality Indicators (QIs). The report looked at 6 “diagnostic” QIs: Hip fractures, non-hip fractures, accidental falls, skin ulcers, respiratory infections and fluid and electrolyte imbalances. In considering patient safety, fractures and falls provide some measure of the safety of a long-term care environment. What is most alarming about the figures for fractures and falls is not the rates themselves, but the degree to which these rates vary. For hip fractures, the rate for all of Manitoba PCHs was 2.7/100 person-years (which roughly translates that hip fractures occurred in 2.7% of beds annually). The rate for for-profit Winnipeg PCHs, however, was 3.5 and St. Adolphe Nursing Home in South Eastman had a rate of 6.5 over the five year study period. The same range can be found in non-hip fractures as well, where the Manitoba rate was 4.9, the for-profit WRHA rate was 6.4 and the highest rate was 10.5 for St. Paul’s Residence in the Nor-Man RHA. Finally, for accidental falls (resulting in hospitalization but not all of which resulted in fractures), the Manitoba rate was 4.5, the for-profit WRHA rate was 5.2 and the highest rate reported was 11.8 at Westview Lodge in the Assiniboine RHA.

One conclusion to draw from this information might be to assume that a few particularly accident-prone residents were at the root of many of these falls and fractures. The MCHP study found, however, that 98.8% of residents who suffered a hip fracture suffered only one fracture during the study period. The equivalent figures for non-hip fractures and accidental falls were 94.5% and 96% respectively. From this it appears that the characteristics of individual residents have little to do with these figures and, instead, it is the characteristics of the facilities themselves that account for these differences.

In terms of the health of patients, the MCHP study looks at skin ulcers, respiratory infections and electrolyte imbalances. Not surprisingly the striking variations among facilities is reflected in these figures as well and, in some cases, the variations are even more pronounced. For skin ulcers, the rate for Manitoba as a whole was 7.9 events per 100 person-years; in for-profit facilities in the WRHA the rate was 14.0 while the highest rate, 22.5, was reported at the Pembina Mennonite Personal Care Home in Winnipeg. Respiratory infections displayed the same disparities, with the Manitoba rate being 17.3, the Winnipeg for-profit rate 22.6 and the highest rate in Manitoba, 51.3, reported at Eriksdale Personal Care Home in the Interlake RHA. Finally, the rates for fluid and electrolyte imbalances range from a provincial average of 6.6 to 10.2 in for-profit facilities in the WRHA to a high of 24.7 events, again at the Eriksdale Personal Care Home (Figure 11).
Information about patient safety can also be gathered from the Manitoba Nurses’ Union’s Workload/Staffing database. Figure 12 shows the number of WLS submissions citing actual patient hazards in a number of areas including falls, deterioration, injury and death. These reports cite over 60 patient falls reported in 2005 that resulted from what the reporting nurse deemed was an unsafe situation (such as lack of staff, lack of supplies or equipment, high patient acuity).

Figure 13 shows potential patient hazards, or situations reported by nurses that created the potential for one of these hazards to occur. In both 2004 and 2005 nurses reported nearly 250 situations that created the potential for a resident fall, and almost as many situations that created the potential for resident injury. Most alarming of all, for 2004 and 2005 nurses reported 125 or more situations that created the potential for the death of a resident. While these reports are subjective and based on the judgement of nurses, it highlights the fact that nurses, trained in the protection of patient health and safety, are identifying serious safety concerns in Manitoba’s long-term care facilities.

So what does all this mean for the safety of long-term care residents in Manitoba? For one it means that, depending on where you reside, you could be more than twice as likely to suffer a broken bone or be injured in a fall. It means that almost once a week in 2005 a long-term care nurse reported a dangerous or unsafe situation that resulted in a resident falling. It means that more than twice per week in 2005 a long-term care nurse reported a situation that had the potential to result in the death of a resident.

Based on this information residents and families should be concerned that there are not appropriate standards to ensure the safety of residents and staff in personal care homes and to ensure a consistent standard of safety between homes. Having information like this more readily available to nurses, families and governments would make it easier for long-term care facilities to be held accountable for safety and other standards.
Staffing

Adequate staffing is critical to ensuring the safety of staff and residents. Data from the US indicates that nursing homes are among the top 10 industries for musculoskeletal problems, the major cause of worker absence, injury and illness. Indeed, higher rates of musculoskeletal injury have been reported among nursing home workers than in other occupations. A study of data from 12 hospitals in Minnesota found that when RN positions were decreased by 9%, work-related illnesses and injuries among nurses increased 65%18. Another study, of nursing homes in three states, looked at the relationship between nurse staffing and injuries. It found that total nurse hours was significantly associated with worker injuries. In fact 38% of the variance in worker injury was accounted for by changes in staffing. For each additional hour increase in nursing care, the study predicted a decrease in injuries of nearly 16%19.

The provincial staffing guidelines are obsolete and do not accurately reflect the amount of care required by our aging population. The classification process for levels of care does not accurately reflect the care required either. Our staff is running from patient to patient with no time for interaction or psychological support. It is a race to complete tasks rather than provide quality, supportive care.

Figure 14: WLS Reports Citing “Injury to Staff” as a Working Hazard, 2001-2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Potential</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>125</td>
<td>75</td>
</tr>
<tr>
<td>2002</td>
<td>150</td>
<td>100</td>
</tr>
<tr>
<td>2003</td>
<td>175</td>
<td>125</td>
</tr>
<tr>
<td>2004</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>2005</td>
<td>225</td>
<td>125</td>
</tr>
</tbody>
</table>

PREPARED BY THE MANITOBA NURSES’ UNION – DECEMBER 2006
Staffing levels in long term care facilities is usually determined based on an evaluation of the level of care needed by residents. This, in theory, is used to ascertain how much nursing care a given patient would require in a 24 hour period. Ideally, this system would ensure that there were adequate levels of staff to meet the needs of residents in long term care facilities. Manitoba’s staffing guidelines were developed in 1973, and remain in effect today, although the degree to which they are known or utilized is not clear.

The level of staffing in a long-term care facility can have a number of impacts. Not only can shortages of staff impact the staff directly, increasing stress and causing concerns with safety, staff shortages can also impact resident safety, health and well-being. Higher staffing levels have been found to be associated with a reduced risk of poor nutrition in long-term care residents. It is part of a larger problem resulting from deficiencies in care due to low numbers of staff, and particularly in for-profit facilities

There is a growing body of evidence that demonstrates the impact that inadequate staffing has on both the welfare of long term care residents and also on the cost of long term care to the health care system. Studies have shown that more average RN direct care time per resident day results in reductions in a number of adverse events, including pressure ulcers, hospitalization, urinary tract infections and deaths. It also results in less weight loss, less deterioration in the activities of daily living and greater use of oral nutritional supplements.

Long-Term Care facilities are greatly affected by the acuity of their residents. Over the last decade, the acuity level of long term care residents has increased substantially. More and more long term care facilities

Lobby whoever is responsible for setting client to nurse ratio. This has not been changed for years, I believe! Need increase nurse - client ratio.

Nursing staff need to have more input into what supplies are needed and readily available!
are dealing with patients who, in the past, would have been cared for in hospital. Patients are being discharged sooner from hospital procedures and more patients suffering from degenerative illnesses are being cared for and treated in these facilities.

As Figure 16 illustrates, Workload/Staffing reports indicate that, more than any other factor, insufficient staff is a contributing factor in reported incidents in Manitoba personal care homes. Recommendations from nurses repeatedly request more staffing to ensure residents receive adequate care. Administering medications and treatments, as well as attending to health issues and emergencies requires a certain level of staffing. The reality is that almost 20% of nurses report a resident to nurse ratio in excess of 80:1 on the night shift in their facilities. As many nurses’ comments also point out, these nurses are often responsible for residents on more than one floor, as well as numerous duties including stocking supplies and building security. Inadequate staffing continues to be at the root of many of problems identified in this report, and is one of the most critical needs that must be addressed.

Staffing levels need to change.; they are based on an out-dated and much lower requirement for services than now exists (and has for some time). We can’t give the quality of care we want to and that seniors deserve without increased staffing.
The long-term care system in Manitoba has seen improvements over the last five years. Manitoba maintains the highest rate of long-term care beds to population in Canada and, on certain measures of care, nurses report that the situation in personal care homes has improved. On several key measures, however, the long-term care system fails to meet an acceptable standard. Resident acuity continues to increase in step with increases in the average age of the province’s population. Staffing models and facility standards, however, have not been adapted to meet these challenges.

The long-term care system in Manitoba needs to be reviewed and renewed around the idea that resident health and quality of life should be the priority. The current system, mixing for-profit and non-profit facilities, does not provide a consistent or adequate level of care. Staffing models have not been adapted to reflect changing circumstances. As a result nurses are struggling with the demands of increased patient acuity.

The path ahead is clear. There are specific and manageable solutions to the problems facing long-term care. The recommendations provided below provide a starting point. The nurses of Manitoba look forward to a new era in long-term care, and to being partners in these positive changes.
The goal of long-term care: To give elderly and those who are not able to look after themselves a ‘Home’ in which they receive holistic care. They should receive complete healthcare that meets all of their needs to stay healthy physically, mentally and spiritually. This should not be a facility in which physically and mentally burnt out staff are the only ones available to care for them.

**Facility Standards**

1) Measurable provincial facility standards;
2) Increased unannounced inspections;
3) Ensure standards are equivalent between for-profit and non-profit facilities;
4) Future facilities should be operated on a non-profit basis.

**Staffing Guidelines**

1) New staffing guidelines to reflect the current situation with respect to acuity and other issues;
2) Regular review of guidelines by Government/Nursing/Management Committee;
3) Guidelines to reflect need for greater support staff (i.e. Health Care Aids, in addition to nursing staff).

**Workplace Violence**

1) Standardized provincial workplace violence policy for healthcare;
2) Strong sanctions enforced for violations on the part of employers;
3) Support for nurses bringing complaints with respect to workplace violence.

**Recruitment and Retention**

1) Implement incentives for long term care nurses;
2) Establish a recruitment plan to target nurses to work in long-term care;
3) Campaign to improve the image of long-term care as a workplace of choice.

**Public Accountability**

1) Publish long-term care home standards;
2) Publish results of long-term care home evaluations/inspections.
Footnotes

1 (Page 2) Malcolm Doupe, et. al. “Using Administrative Data to Develop Indicators of Quality Care in Personal Care Homes.” Manitoba Centre for Health Policy, October 2006, p. 38. While long-term care residents can be any age, they are predominantly elderly. Only 3.9% of PCH admissions during the MCHP study period were for people between the ages of 0-64.


6 (Page 9) Ibid., p. 45-46.

7 (Page 10) Ibid., p.147-148.

8 (Page 11) Ibid., p.42.

9 (Page 13) Ibid., p.34.

10 (Page 13) Ibid., p.38

11 (Page 13) Ibid., p.46


17 (Page 15) Nachreiner, p.680


19 (Page 19) Ibid., p.1222.


Doupe, Malcolm, Marni Brownell, Anita Kozyrskyj, Natalia Dik, Charles Burchill, Matt Dahl, Dan Chateau, Carolyn De Coster, Aynslie Hinds and Jennifer Bodnarchuk. “Using Administrative Data to Develop Indicators of Quality Care in Personal Care Homes.” Manitoba Centre for Health Policy, October 2006.


Gnaedinger, Nancy. “Changes in Long-Term Care for Elderly People With Dementia.” Hospital Employees’ Union, September 2000.


More Nurses Speak Out

Throughout this report, we have featured some of the comments and suggestions as reported by Manitoba’s Long-Term Care Nurses taken as a part of the 2006 Survey of Manitoba’s Long-Term Care Nurses conducted by Viewpoints Research. Here are some of their additional comments.

“They need more stimulation in terms of recreation, more mobility, more contact with staff ie. Communication and on a social level.”

“Mandate and enforce humane treatment of dementia clients – warehousing is NOT ACCEPTABLE!

“To me it is essential that the person in charge of the nursing dept should be a nurse – our supervisor is not a nurse making it very stressful on the nurses working the floor.”

“Reminding sometimes is necessary – caring is a decision, not an attitude. Thanks for listening.”

“Thank you for looking into long term care! It has been neglected and often not viewed as a priority. Long term nurses are often viewed as secondary not as “real” nurses. With increasingly aging population it should be a priority. Public needs education on long-term care and role of the nurse and why we are an important part of nursing. We take care of their parents and often love them like our own.”

“The resident should be allowed to sleep in in the mornings and not gotten out of bed early. This is their home! Should not be made to get up till after 7:00 am.”

“I am convinced we would decrease meds by 50-75%. Nobody looks at discontinuing, just adding other meds to disguise side effects.”

“I don’t think nurses who are involved in direct care with residents should be spending time replacing sick calls.”
“We are so bothered with filling in loads of paper work and computer, that I don’t really feel like a nurse anymore.”

“One tub bath per week whether needed or not! One HCA should be walking people – toileting everyone who can sit after breakfast and changing diapers of those who can’t – We need 1 person extra on days and evenings on each ward.

Nurse has to help put patients to bed after lunch – nurse should be doing treatments missed in AM because pts were up before she could get to them; looking up new meds, reading charts of new pts, supervision HCA’s I would like to see 1 HCA or nurse on days and evenings trained to mobilize pts.

No physical activities for men. They don’t like folding laundry, etc. What about an old car or motor to tinker with. Thanks for the opportunity and good luck with getting us more staff!”

“Paper work is phenomenal. Something needs to be done, as is DEFINITELY taking away from resident’s care!!”

“Increase number of nurses. As I am responsible for 31 residents, the ever increasing paper work increased time on phone talking to very demanding families – never mind MD’s. I have so little time to spend with residents.

The residents are rushed – meal time is stressful. HCA’s on my unit are very caring, well trained aids whom I depend heavily on to keep the unit going. They try so hard to keep the level of care standards we had in yrs gone by.

“Less paperwork or more nurses, no time for hands on patient care, especially in smaller facilities with no ward clerks, social workers, OT, etc.”
“We desperately need 2 night nurses. We presently have 1 nurse for 120 residents.”

“That the responsible nurse on eve not be doing security checks for the building instead of being on his or her own unit providing resident care.”

“Staff morale is poor. Our facility is short nurses, HCA’s, many empty positions. More staff is needed to fill vacancies.”

“HCA – designated for bathing and mobility of residents, allowing more time for psychological support of residents.”

Nursing staff need to have more input into what supplies are needed and readily available! Often, especially weekends, we are short of linens, soap, gloves etc. We do not “shut down” on weekends and need to have our supplies! Family members usually visit in larger numbers on weekends and notice when supplies are short!”

“More assistance with feeding at mealtimes! People are not being adequately hydrated as mealtimes are rushed, workloads are heavier and if people can’t get fluids easily, they don’t get them!

Increased staff to deal with patient and family attention seeking, bored, lonely, or who need answers to questions. We need more hands-on care, people are less mobile, more contractured, more incontinent and existing longer than they were years ago, med passes are heavier, meds need to be crushed, coaxed, etc, also, more people on multiple inhalers, eye gtts, insulin’s, than they were years ago as these people are being medically maintained longer and are often sicker than ever before!”
“There is only 1 nurse on night shift for 91 residents and 4 HCA’s there should be another nurse with same # HCA’s.”

“Freely supply gloves! And isolation equipment. Freely supply dressing supplies and cath trays etc.”

“To have to proper supplies ie: treatments and dressing supplies and also food seems to be less and less not enough supplies to last 1 week.”

“Foam mattresses for every resident – all frail and prone to O/A’s – we have beds that are as hard as sleeping on the floor.”

“Shortage of supplies – includes peri wash, Nasg tx supplies, having hot water and peri towels etc.”

“More availability of supplies, dressing supplies for treatments, towels/bed linens, incontinent products.”

“New beds verses old stuff donated by the hospital that is no longer adequate for Acute Care but good enough for elderly with frail bones and tissues.”

“Do not mix severe dementia/Alzheimers with the more cognitively well elders. Elderly are very unsympathetic and un-empathetic toward these wandering, hollering, spitting, fighting peers.”

“Better quality of food – more variety and improve taste. Sometimes we have to guess at what is being served.”