



# CONDITIONS OF WORK, CONDITIONS OF CARE

Submission to the Parliamentary Secretary to the  
Minister of Health for Seniors, Dr. Darryl Plecas

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# Executive summary and recommendations

The Hospital Employees' Union (HEU) welcomes the opportunity to share our views and recommendations on long-term care (LTC) staffing for consideration by Parliamentary Secretary to the Minister of Health for Seniors, Dr. Darryl Plecas, in his review on the matter.

Through this process, the B.C. government has an opportunity to become a leader in the delivery of high quality seniors' care by addressing a key determinant of care quality – a stable and adequately resourced team of care staff.

Since 2002, legislative and regulatory changes in B.C. have undermined this team by enabling extensive privatization and contracting out of seniors' care services. These practices in turn lowered wages, increased staff turnover, and compromised the continuity of care delivery.

Thirty-four per cent of total LTC beds are now in the for-profit sector – a 42 per cent increase since 2000. Health authority and non-profit operated beds have decreased by 10.8 per cent over this period. Despite evidence that for-profit care is lower quality, the expansion of for-profit LTC operators in the sector continues unabated.

As a consequence of privatization and inadequate public funding, LTC facilities have insufficient staffing, high turnover, and lower quality care. The B.C. Seniors Advocate recently found that four out of five health authority funded LTC facilities received funding for less than the recommended provincial staffing minimum of 3.36 hours per resident day. The Advocate also noted that 74 per cent of those LTC facilities that fell short of the Ministry's guidelines were operated by for-profit businesses.

In a recent survey, more than half of HEU care aides reported that they did not have enough time to adequately meet the needs of residents. Nearly 66 per cent were forced to rush seniors through basic activities of daily living (bathing, eating etc.).

Furthermore, inadequate staffing levels exacerbate high rates of musculoskeletal injury and resident-on-worker aggression, leading B.C.'s LTC sector to have the highest injury rate (8.9 of every 100 workers injured) of any workforce sector in the province.

This comes with significant social costs to seniors and care workers, as well as a financial cost to employers through higher WorkSafeBC premiums.

Based on the academic research and the experience of HEU members, it is clear that the conditions of work are the conditions of care. Therefore, by increasing staffing levels and improving working conditions, the B.C. government can significantly improve the quality of seniors care.

The B.C. government should adopt promising practices from other jurisdictions, and the experience in Nordic long-term care facilities is particularly compelling. Generally in Nordic countries, a greater share of GDP is spent on LTC, resulting in higher staffing levels and better individualized resident care.

Clinical and financial accountability in the LTC sector is in need of improvement, especially with regard to monitoring the growing number of privately operated care homes and contracted out services.

Establishing legislated minimum staffing levels plus enhanced staffing based on higher levels of acuity is long overdue. These legislated standards must be enforceable through strong accountability measures including robust reporting requirements and regular monitoring and audits.

In summary, HEU offers the following recommendations for action by the B.C. government:

1. *Conduct a comprehensive review, involving leading health policy and long-term care experts, and key stakeholders, to establish an appropriate legislated minimum staffing level necessary to provide quality care. Such a review should:*
  - *Examine acuity levels and their variance by facility characteristics and ownership type across all health authorities and consider enhanced staffing levels in relation to acuity;*
  - *Examine how to enhance and implement person-centred and relational care models in publicly funded LTC facilities;*
  - *Examine and recommend a funding formula and accountability measures for LTC operators;*
  - *Recommend measures to increase financial accountability; and*
  - *Examine the impact of contracting-out and privatization on working conditions and quality of care.*
2. *As an urgent interim measure before an appropriate legislated level is determined, immediately increase funding so all publicly funded LTC facilities at a minimum meet the Ministry's 3.36 hprd guideline. This immediate staffing increase should be supported by new funding to health authorities and include:*
  - *Recruitment of more care aides;*
  - *Accountability requirements to ensure new funding is directly applied to care;*
  - *Standardization of the calculation, collection, and reporting of staffing levels;*
  - *Standardization of musculoskeletal and violence prevention programs including training across health authorities, bargaining associations, and employers; and*
  - *A joint assessment of "peer coach" injury prevention training and program expansion.*
3. *Improve continuity and quality of care by reducing staff turnover:*
  - *Adopt measures mitigating the impact of contracting out including restrictions on such practices in commercial contracts between health authorities and service providers;*
  - *Establish meaningful successorship rights for collective bargaining to ensure continuity of care; and*
  - *Require health authorities to track and report staff turnover and retention, contracting out, and contract flipping and other data necessary to enhance evidence-based decision making.*

# Introduction

The Hospital Employees' Union is the oldest and largest health care union in British Columbia, representing 46,000 members working for public, non-profit and private employers.

Since 1944, HEU has been a strong and vocal advocate for better working conditions for our members and improved caring conditions for British Columbians who access health care services including long-term care.

HEU members work in all areas of the health care system – acute care hospitals, residential care facilities, community group homes, outpatient clinics and medical labs, community social services agencies, and First Nations health agencies – providing both direct and non-direct care services.

Approximately 19,000 of our members work in residential care and home care as Care Aides, Community Health Workers, Activity Aides, Licensed Practical Nurses, Dietary Aides, Housekeepers and others. About 15,000 of these are Care Aides and Community Health Workers -- the largest occupational group within HEU.

It should be noted that the vast majority of care aides are women and a high proportion are represented by racialized or immigrant workers as compared to the HEU membership as a whole. And like other health care workers, many are aging with almost 70 per cent over 45 years of age<sup>1</sup>.

Our members demonstrate an unwavering commitment to the residents they work with. They entered the field to enhance the lives of seniors and these workers derive great satisfaction when they are able to do that. Increasingly though, stories of insufficient numbers of staff resulting in an inability to meet even the basic needs of residents, have become common. Inadequate staffing levels coupled with higher acuity rates compound this situation. HEU members face unmanageable workloads and regularly go home feeling distressed from being constrained from delivering the kind of care they want to provide.

Low staffing levels contributed to an injury rate of 8.9 per cent in B.C.'s LTC sector in 2015 (8.9 of every 100 workers experience an injury)<sup>2</sup>. Fatigue, and being rushed with residents contribute to high levels of musculoskeletal injuries (MSIs) and high numbers of injuries due to violence.

HEU has been working with its members, other unions, health and safety agencies, academics, and community organizations for many decades to establish improved care for seniors. We believe that a robust review of staffing levels is necessary. Stakeholders and experts must be engaged not only to determine an appropriate minimum legislated staffing level, but also to establish what a quality resident- focused model of care looks like.

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<sup>1</sup> Viewpoints Research, "HEU Care Aides Survey" Hospital Employees Union (HEU), Oct 2014, 24.

<sup>2</sup> WorksafeBC, "Injury Rate." Industry Safety Information Centre (ISIC). <https://online.worksafebc.com/anonymouse/wcb.ISR.web/IndustryStatsPortal.aspx?c=2> (retrieved July 15, 2016).

A mandated staffing level is only effective to the extent that care facility operators will be held accountable to implement it. Reporting methods for staffing, clinical accountability as well as financial accountability are currently lacking and need to be improved upon if the Ministry/health authorities intend to enforce staffing levels.

Continuity of care is another integral aspect of providing quality care however staff turnover disrupts continuity. While increased staffing levels will help to mitigate the day-to-day turnover in the sector, the large scale staff turnover that accompanies contracting out and contract flipping will continue to undermine care unless these practices are also addressed.

Our union welcomes the opportunity to participate in the review process and assist in developing staffing levels that result in the delivery of appropriate and quality care. The ensuing discussion and recommendations are limited in scope to the most pressing issues touching on staffing levels.

Should a broader review be undertaken, HEU will have more recommendations on related aspects of care delivery including education requirements, the oversight and functions of the B.C. Care Aide and Community Health Worker Registry, and the role of support staff in LTC facilities.

## Long-term care restructuring, 2000-2016

Legislative, regulatory, and policy changes over the last 14 years have led to more fragmentation in the residential care system, deteriorating working conditions, and lower quality of care for seniors in B.C.

On January 28, 2002, the B.C. government introduced Bill 29, the *Health and Social Services Delivery Improvement Act*, legislation that removed contracting out protections in collective agreements between health care unions and the Health Employers Association of B.C. (HEABC) -- the bargaining agent for the provincial government.

Bill 29 cleared the way for contracting out and privatization of many non-clinical services in both the acute care and residential care sectors and resulted in the layoff of more than 9,000 HEU members. In LTC, Bill 29 enabled HEABC members to contract out both direct care and support services and also facilitated the closure of many care homes by health authorities.

In 2003, Bill 94, the *Health Sector Partnership Agreement Act*, was passed. It extended the provisions of Bill 29 to designated private operators in health care who have built new care homes (as well as other health infrastructure) under agreement with health authorities.

Virtually all new care home operators in B.C. since 2003 are designated under this legislation and are not subject to HEABC membership or the main master collective agreements in the sector.

Bills 29 and 94 also eliminated successor obligations under the B.C. *Labour Relations Code* that would bind private sector contractors and subcontractors to an existing collective agreement if “a business or a

part of a business ... is sold, leased, transferred or otherwise disposed of”.<sup>3 4</sup> The lack of meaningful successorship protections in the sector has facilitated widespread contracting out and contract-flipping of care and support services, leading to lower wages, greater staff turnover and lower quality of care.

Additionally, Bills 29 and 94 eliminated the *Labour Relations Code* provision that allows several businesses to be constituted as one employer when “associated or related activities or businesses are carried on by or through more than one corporation, individual, firm, syndicate or association, or a combination of them under common control or direction”.<sup>5 6</sup>

Furthermore, Bill 94 ensures that the subcontractor (“private sector partner”) is the “true employer” and their staff may not be considered employees of the primary contracted operators (referred to as the “health sector partner”).<sup>7</sup> In essence, this prevents subcontracted employees to be considered part of the same bargaining unit as those employed by the primary contracted service provider at the same worksite. This excludes employees working for the subcontractor from the master collective agreement that may include employees of the primary contractor (health sector partner).

It should be noted that the Supreme Court of Canada struck down the prohibition on contracting out language contained in Bill 29 and Bill 94 in a 2007 decisions that established collective bargaining as a Charter-protected right. The SCC did not, however, restore those provisions in public sector contracts.

Contracting out of care and/or support services has occurred in 50 LTC facilities where HEU currently has active certifications – representing 17 per cent of all funded facilities in B.C.. However, it is important to note the number of facilities with contracting out is likely higher since this figure does not include facilities where other unions have certifications.<sup>8</sup>

## The shift to for-profit service delivery

Bills 29 and 94 have significantly fragmented and reduced the quality of seniors’ residential care by facilitating greater private, for-profit delivery of services. The weight of the peer-reviewed research evidence has found that for-profit residential care is inferior to care delivered in public or non-profit facilities, and numerous studies have demonstrated that facility characteristics (i.e. ownership) are the

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<sup>3</sup> The Health and Social Service Delivery Improvement Act, [SBC 2002] c. 2, s. 6(5); The Health Sector Partnerships Agreement Act, [SBC 2003] c. 93, s. 5(5).

<sup>4</sup> Labour Relations Code, [RSBC 1996] c. 244, s. 35(1).

<sup>5</sup> The Health and Social Service Delivery Improvement Act, [SBC 2002] c. 2, s. 6(6); The Health Sector Partnerships Agreement Act, [SBC 2003] c. 93, s. 5(6).

<sup>6</sup> Labour Relations Code, [RSBC 1996] c. 244, s. 38(1).

<sup>7</sup> The Health Sector Partnerships Agreement Act, [SBC 2003] c. 93, s. 3.

<sup>8</sup> Data retrieved June 8, 2016, from HEU database.

primary predictors of staffing levels.<sup>9</sup> In B.C., the shift to private residential care is evident by examining the growth in the number of for-profit facilities and beds.

### Growth of for-profit residential care beds

Since 2000, 2,082 health authority and non-profit operated LTC beds have closed. Between 2000 and 2016, the vast majority of all new residential care beds have been created in the for-profit sector. In fact, beds in health authority and non-profit operated facilities have decreased by 10.8 per cent, from 19,209 beds in 2000 to 17,127 beds in 2016. Beds in the for-profit sector have increased 42.2 per cent, from 6,211 beds in 2000 to 8,832 beds in 2016. Thirty-four (34) per cent of total LTC beds are now in the private, for-profit sector.

**Table 1. B.C. residential care facilities by ownership (long-term only), 2000-2016**

	FACILITIES							
	2000 facilities	% of total	2008 facilities	% of total	2016 facilities	% of total	Change in # of facilities, 2000-2016	Change in share of total, 2000-2016
<b>For-profit</b>	83	26.9%	100	33.8%	107	36.6%	24	28.9%
<b>Health authority and non-profit</b>	225	73.1%	196	66.2%	185	63.4%	-40	-17.8%
<b>Total</b>	308		296		292			

<sup>9</sup> L. A. Ronald, M. J. McGregor, C. Harrington, A. Pollock, and J. Lexchin, "Observational Evidence of For-Profit Delivery and Inferior Nursing Home Care: When Is There Enough Evidence for Policy Change?", *PLoS Med* 13(4), 2016.



Table 2. B.C. residential care beds by ownership (long-term only), 2000-2016

	BEDS						Change in # of beds, 2000-2016	Change in share of total, 2000-2016
	2000 beds	% of total	2008 beds	% of total	2016 beds	% of total		
For-profit	6,211	24.4%	7,588	30.8%	8,832	34.0%	2,621	42.2%
Health authority and non-profit	19,209	75.6%	17,028	69.2%	17,127	66.0%	-2,082	-10.8%
Total	25,420		24,616		25,959			

Sources: M. Cohen, J. Tate, and J. Baumbusch. (2009). *An Uncertain Future for Seniors: BC's Restructuring of Home and Community Health Care, 2001-2008*. Vancouver: Canadian Centre for Policy Alternatives; Office of the Seniors Advocate. (2016). *British Columbia Residential Care Facilities Quick Facts Directory*. Victoria: Office of the Seniors Advocate; HEU database.

## Legislative changes and de-accreditation erode working conditions, wages and quality of seniors' care

By opening the door for contracting out and contract flipping, Bills 29 and 94 have significantly eroded working conditions, wages, and the quality of seniors' residential care. The Canadian Centre for Policy Alternatives' 2005 study *The Pains of Privatization: How Contracting Out Hurts Health Support Workers, Their Families, and Health Care* found that "conditions of work for privatized workers are unacceptably harsh" and that "[c]ontracting out not only endangers the health of these workers, but the well-being of their families and the patients they serve".<sup>10</sup> With the passage of this legislation, wage rates fell by around 40 to 60 per cent in the initial wave of privatization, and rolled back more than 40 years of pay equity gains for women in health support occupations.<sup>11 12</sup>

A significant wage gap between "independent" facilities (not part of the Health Services & Support Facilities Subsector master agreement) and "direct" or "affiliated" facilities (part of the master agreement) persists.

<sup>10</sup> J. Stinson, N. Pollak, and M. Cohen, *The Pains of Privatization: How Contracting Out Hurts Health Support Workers, Their Families, and Health Care*. Vancouver: Canadian Centre for Policy Alternatives, 2005. Accessed June 8, 2016, at: [http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC\\_Office\\_Pubs/bc\\_2005/pains\\_privatization.pdf](http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC_Office_Pubs/bc_2005/pains_privatization.pdf).

<sup>11</sup> Stinson et al., 2005.

<sup>12</sup> M. G. Cohen and M. Cohen, *A Return to Wage Discrimination: Pay Equity Losses Through the Privatization of Health Care*. Vancouver: Canadian Centre for Policy Alternatives, 2004. Accessed June 8, 2016, at: [https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC\\_Office\\_Pubs/bc\\_pay\\_equity.pdf](https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC_Office_Pubs/bc_pay_equity.pdf).

For example, care aides employed at Inglewood Care Centre – a facility with a history of persistent contract flipping – earn \$17.93/hour (Table 2), while care aides working in facilities covered by the master agreement earn \$22.95/hour – a difference of \$5.02/hour. Put another way, Inglewood care aides earn 22 per cent less than fellow care aides with the same training employed in facilities covered under the master agreement.

In 2009, the B.C. government began allowing Health Employers Association of BC (HEABC) members to de-accredit, meaning that unions would be required to negotiate collective agreements directly with the individual facility operators. Twenty-four facilities with HEU members have left HEABC through de-accreditation. As a result, there have been wage and benefit rollbacks, leading to greater staff turnover and lower quality of seniors' care. For example, care aides at Beacon Hill Villa, even after 1,950 hours of employment, earn \$19.85/hour or \$3.10/hour less than the \$22.95/hour that care aides earn under the master agreement – a wage gap of 14 per cent. De-accreditation has also facilitated contracting out since de-accredited operators are not bound by contracting out quota limits established in the master agreement. HEU and other health sector unions are consistently negotiating “new” collective agreements with different employers at the same facility, preventing collective agreements to mature over time and artificially suppressing wage rates.

Notably though, care aide wages are closer to the collective agreement in independent facilities (not part of the master agreement) that do not have a history of contracting out and flipping. Royal City Manor wages are higher than Inglewood Care Centre and Beacon Hill Villa, although slightly below the master agreement. Contracting out, contract flipping, and de-accreditation erodes wages, contributes to higher staff turnover and undermines resident care.

The erosion of working conditions and instability created in the sector impact the care that seniors experience, and will be described further along in this submission. First, it seems worthwhile to examine promising practices from other jurisdictions to establish a vision of what is possible in the world of long-term care.

## What does good care look like?

### Quality care is built on relationships

“Like other areas of paid care work, such as home care, work in residential long-term care homes is often viewed through the lens of tasks, and lacks an important connection to the affective and relational dimensions of the work.”<sup>13</sup>

The work of caregiving is intimate. Seniors are bathed, toileted, fed, and groomed by their care staff in their last years. They share their fondest and their darkest memories with staff. They are held and

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<sup>13</sup> Tamara Daly and Marta Szebehely, “Unheard Voices, Unmapped Terrain: Care work in long-term residential care for older people in Canada and Sweden,” *International Journal of Social Welfare* 21 2012, 139.

consoled by their caregivers in their final hours. These are acts that would have most people receiving them, feeling potentially vulnerable, somewhat powerless, and understandably apprehensive. It is relationships of mutual trust, dignity, and respect that help to mitigate vulnerability, but these types of relationships can only be created when there is ample time and space permitted to form them.

In B.C. and most of the North American context, caregiving in long-term care homes has become focused on the physical and medical aspects of residents' health. The term 'warehousing' has come to be used to refer to an assembly line approach to ensuring that seniors have a roof over their head and have their basic physical needs attended to. Facilities are institutional in appearance, house large numbers of residents, and are typically unable to accommodate much diversion from an established schedule of care to suit individual wants and needs.

## Promising practices

Looking to Nordic care homes by way of comparison, an alternative experience and greater possibilities for the last years of life are made evident. Scandinavian facilities are typically more home-like than hospital-like. Facilities are smaller. In Denmark and Sweden, almost all seniors have their own room or small apartment. As of 2005/2006, Swedish facilities housed 34 residents on average, while Canadian facilities housed 96.<sup>14</sup> Meals are served in a combined kitchen/dining area rather than a dining hall.<sup>15</sup>

A scene described by Banerjee and Braedley in *Promising Practices in Long Term Care* details the authors' visit to a Swedish facility. The facility was large for Sweden but divided into units of nine, capitalizing on economies of scale while still personalizing the space and care. The home was a non-profit and thus able to be attached to a charitable foundation. Money generated through the foundation was used to hire additional staff exceeding the numbers stipulated by the home's funder. Workers had time to get to know the residents and their interactions were usually unhurried. Each unit had a complete kitchen. This feature allowed residents to wake and eat when they wished. A nursing assistant put simple breakfast ingredients out on a tray and assisted residents as needed to prepare their meals.

Staffing is such that two nursing assistants were able to spend half or more of their shifts planning activities for the seniors. There was time to discuss resident care among the staff throughout the day and even time for special touches like baking. Each resident was attached to a designated contact, who was usually a nursing assistant who got to know the resident's needs and advocated for them.<sup>16</sup>

Staffing ratios are key to providing the type of care Swedish facilities offer. Sweden spends 2.07 per cent of its gross domestic product on residential eldercare as compared to Canada which spends 1.06 per

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<sup>14</sup> Ibid.

<sup>15</sup> Pat Armstrong et al., eds., *They Deserve Better: The long-term care experience in Canada and Scandinavia* (Ottawa: Canadian Centre for Policy Alternatives, 2009), 35.

<sup>16</sup> Albert Banerjee and Susan Braedley. "*Promising Practices in Long Term Care: Ideas Worth Sharing*, eds. Donna Baines and Pat Armstrong. , *Sweden:Big City* (Ottawa: CCPA, 2015/2016), 60-62.

cent.<sup>17</sup> The hours per resident per day (hprd) for direct care (equivalent of RN, LPN and Care Aide) is 5.2<sup>18</sup> compared to B.C.'s funded average of 2.98.<sup>19</sup>

Staff care for residents is carried out in a manner that addresses both their physical needs and social needs. The care team is comprised of the equivalent of Licensed Practical Nurses (LPNs) and Care Aides with fewer Registered Nurses (RNs) than what are utilized in the Canadian staff mix. The division of duties is less rigid and less hierarchical with the work days of Care Aides and LPN equivalents looking very similar with the exception that the LPNs give injections.

Both engage in the physical 'bodywork' of caregiving but also do the activity planning. Daly and Szebeheley analyzed survey data that found Swedish care workers are more often able to give social care, reporting that they are more frequently able to have coffee with a resident or run an errand with them outside of the facility. The number of residents Swedish workers reported helping in a typical day was 8.8, a stark contrast to the 19.9 reported by their Canadian counterparts.<sup>20</sup>

While Canada has fewer facilities utilizing practices as promising as those found in the Scandinavian countries, they do exist here. Ruth Lowndes lists components that supported the quality care offered at a Manitoba facility that provided the basis for her case study, also in *Promising Practices in Long Term Care*. They include management's strong vision of 'resident first' care, staff being empowered to work autonomously, stable, permanent employment with good working conditions, and permanent shifts and units facilitating continuity of care.<sup>21</sup>

## Inadequate staffing and high turnover

### Impact of staffing levels on seniors

Conditions at all long-term care facilities in B.C. might not have met all of the criteria Lowndes outlines, but there was a time in the not so distant past that staff were able to do more for their residents. There was far greater stability in the sector, with fewer sites being closed down to move residents into new for-profit homes, and the large scale staff turnover that comes with contracting out, did not exist.

Beyond the staff, are the residents – the reason we are there. They are the ones who really suffer from not enough workers. There are times in my day when only the residents with the greatest of needs are getting most of the attention and others wander about looking lost and I want to reach out to them and I can't because I'm needed more elsewhere. We

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<sup>17</sup> Daly and Szebeheley, "Unheard Voices, Unmapped Terrain", 140.

<sup>18</sup> Armstrong et al., *They Deserve Better*, 55.

<sup>19</sup> Office of the Seniors Advocate. *British Columbia Residential Care Facilities Quick Facts Directory*. Victoria: Office of the Seniors Advocate, 2016.

<sup>20</sup> Daly and Szebeheley, "Unheard Voices, Unmapped Terrain", 141-143.

<sup>21</sup> Ruth Lowndes, *Promising Practices in Long Term Care: Ideas Worth Sharing*, eds. Donna Baines and Pat Armstrong. , (Ottawa: CCPA, 2015/2016), 41-43.

don't have enough eyes on the floor either. We clearly need more permanent care aide staff for the safety of residents and staff and for the well-being of residents. – quote from HEU care aide<sup>22</sup>

Our members are the first to acknowledge that care in B.C. long-term care facilities is getting worse for seniors. Those that are more seasoned recall earlier years in their career with pride. They typically worked with lower acuity residents and speak about having had time in their schedule to talk with residents, to assist their residents with walking to keep them ambulatory, and to help their residents with styling hair and similar grooming that impact residents' self-esteem.

The seniors entering care today are indeed older, less physically independent and closer to the end of life.<sup>23</sup> This places greater demands on staff. A 2015 survey of 602 HEU members undertaken by Viewpoints Research and commissioned by HEU illustrates the current context, one in which care aides do not have time to carry out even basic care. According to those surveyed:

- More than half said they do not have enough time in a typical shift to adequately meet the needs of those in their care.
- Nearly three-quarters said they are forced to rush seniors through basic care routines. That includes getting dressed, toileting, bathing, and eating.
- More than 70 per cent reported that they don't have the time to comfort or reassure someone who may be confused, agitated or afraid.
- The same number said residents do not receive enough attention or stimulation.

The majority of care aides surveyed said that they were not always able to toilet residents in a timely manner. Residents become incontinent, losing dignity and independence when this occurs. Sixty per cent of care aides did not always have enough time to provide support for feeding.<sup>24</sup> Nutrition of course, is key to good health and preventing disease, particularly for more frail seniors. The B.C. Ombudsperson's report found that it is common in facilities for seniors to be bathed only once a week and that in some cases, they do not even receive that due to staff shortages.<sup>25</sup>

The average number of residents in B.C.'s long-term care homes on anti-psychotics *without* a diagnoses in 2010 was 50 per cent.<sup>26</sup> In 2012-13, the new average was 34 per cent.<sup>27</sup> The rate declined but the Ministry had not met its own goal of reducing its earlier average in half.<sup>28</sup>

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<sup>22</sup> Hospital Employees Union (HEU) Care Aide, email submitted to HEU as part of Care Aide Testimonials gathered in April and May 2016.

<sup>23</sup> Margaret J. McGregor et al., *Trends in long-term care staffing by facility ownership in British Columbia, 1996 to 2006* (Statistics Canada, Catalogue no. 82-002XPE Health Reports Vol 2, no.4, 2010).

<sup>24</sup> Viewpoints Research, "Care Aides Survey." Burnaby, B.C.: commissioned by the HEU, 2014.

<sup>25</sup> Best of Care, Part 2, Volume 2, (274).

<sup>26</sup> *Vancouver Sun* (Vancouver). 6 April 2015.

<sup>27</sup> Office of the Seniors Advocate. *British Columbia Residential Care Facilities Quick Facts Directory*. Victoria: Office of the Seniors Advocate, 2016.

<sup>28</sup> *Vancouver Sun* (Vancouver). 6 April 2015.

Anti-psychotics, are prescribed legitimately in many instances, but have more commonly come to be used as a chemical restraint to manage delusion, agitation and aggression, particularly for residents with dementia. The risks of these drugs can be as severe as heart attacks or death, and common side effects include falls, sedation and movement disorders.<sup>29</sup>

Clinical guidelines developed by the Ministry of Health and the B.C. Medical Association advise physicians to exercise caution when prescribing these drugs and recommends “environmental and behavioural modifications and psychosocial interventions for first line management of behavioural and psychological symptoms of dementia”.<sup>30</sup>

The B.C. Ministry of Health’s review of the use of anti-psychotics in residential care found agreement among stakeholders that best approaches to dementia care were one-to-one interactions such as taking a resident for a walk or having tea together in familiar surroundings. “However, these approaches take time, and the present staffing ratios in care facilities were thought insufficient to ensure this type of attention.”<sup>31</sup>

## High turnover

High turnover and low retention in staffing obstructs the delivery of quality care. Studies have consistently offered evidence that high turnover is associated with poor quality of care.<sup>32</sup> One large U.S. study (8,023 nursing homes) found less use of restraints, catheters and fewer pressure sores in homes with less turnover (when staff stayed 5 years or more).<sup>33</sup>

Another study that looked at over 5,000 facilities in the U.S. saw a strong relationship between nursing assistant retention (U.S. equivalent to care aides) and whether a facility fell into the worst 10 per cent of those studied for quality measures.<sup>34</sup>

As noted previously, for most seniors in care, the nature of the assistance they depend on means that they require familiarity and relationships with their caregivers. This is of even greater importance when working with seniors with dementia, which is three in five residents in care facilities.<sup>35</sup> The Alzheimer’s

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<sup>29</sup> *The Star* (Toronto). 15 April 2014.

<sup>30</sup> Ministry of Health and the British Columbia Medical Association, *Cognitive Impairment in the Elderly, Recognition, Diagnosis and Management*, 2007, revised in 2008. (12).

<sup>31</sup> Ministry of Health, *A Review of the Use of Antipsychotic Drugs in British Columbia Residential Care Facilities*, Dec 2011. Accessed July 9, 2016 at: <http://www.health.gov.bc.ca/library/publications/year/2011/use-of-antipsychotic-drugs.pdf>

<sup>32</sup> Nicholas G. Castle and Ruth A. Anderson. “Caregiver Staffing in Nursing Homes and their Influence on Quality of Care,” *Medical Care* 49, no.6 (June 2011): 546.

<sup>33</sup> Nicholas G. Castle and John Enberg, “Further examination of the influence of caregiver staffing levels on nursing home quality,” *Gerontologist*, 48, no. 4, (2008): 464. Accessed July 9, 2016 at: <http://gerontologist.oxfordjournals.org/content/48/4/464.long>

<sup>34</sup> Marvin Feuerberg, *Report to Congress: Phase II Final Report*. (Baltimore: Centers for Medicare and Medicaid Services, 2001), MD 21244-1850, p 3-31.

<sup>35</sup> Canadian Institute for Health Information, *Caring for Seniors With Alzheimer’s Disease and Other Forms of Dementia* (Analysis in Brief, Aug. 2010), 1.

Society of Canada promotes consistency of staff assignments as a best practice in providing dementia care.<sup>36</sup>

Ramage-Morin's examination of factors influencing seniors' self-perception of health found that social network and social involvement were not surprisingly, influential. Seniors in institutions who reported being close to one staff member had higher odds of having positive self-perceived health.<sup>37</sup>

The quality of relationship that comes with continuity of care is well established as being critical and aids caregivers to learn about a residents' preferences, triggers, and typical state of health. The more information that is available, the better. The ongoing connection between a caregiver and resident also reduces the confusion and heightened agitation that can accompany change for these seniors.

Reasonable workloads, fair compensation, open communication, respectful management, and a stable sector all factor heavily in maintaining cohesive, consistent care teams, and quality care conditions. The sector as discussed earlier, however, is no longer stable. Contracting out and contract flipping have become prevalent in B.C. as has the more recent and increasing trend of moving residents out of public facilities and into privately operated sites. Facilities undergo large scale staff replacement and a severing of continuity of care when either of these events occur. This practice stands firmly in contradiction to what is deemed a cornerstone of quality, resident-focused care.

## Impacts of low staffing on care workers

Care Aides are an older, predominantly female workforce. A recent study of workers in this occupation in Canada's Prairie provinces found that of those in urban centers, half were born outside of Canada and English was not their first language.<sup>38</sup> A total of 1,381 care aides were surveyed in the study. Almost all had a high school diploma and most had a college certificate, 57.4 per cent were between 40 and 59 years old and 92.5 per cent were female. They had typically worked for 10 years or more as a care aide.<sup>39</sup>

Burnout is a key impact of low staffing on this workforce. The environmental factors that precipitate burnout such as frequent exposure to dementia-related responsive behaviours, high workload, high acuity of residents, and little time to perform tasks for residents were all present in the Estabrooks study.<sup>40</sup>

Their reported job efficacy however was unusually high, that is, they felt strongly that their work was meaningful and with purpose. This combination seems especially hazardous to women who face

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<sup>36</sup> Alzheimer's Association Campaign for Quality Residential Care, *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes* (Chicago: The Alzheimer's Association, 2009), 7.

<sup>37</sup> Pamela L. Ramage-Morin, *Successful Aging in Health Care Institutions*, (Statistics Canada, Catalogue no. 82-003 Supplement to Health Reports Vol 16, 2005), 52.

<sup>38</sup> Carole A. Estabrooks et al., "Who is Looking After Mom and Dad? Unregulated Workers in Canadian Long-Term Care Homes" *Canadian Journal on Aging*, 34, no. 1 (2015): 53.

<sup>39</sup> Ibid., 52

<sup>40</sup> Ibid., 54

enormous pressure to adopt caregiving and nurturing as significant aspects of their gendered roles, and who in turn come to measure their own value as a person by their ability to provide these things to others.

HEU's 2015 survey of our care aide members found that only 38.5 per cent were able to say that they always took their breaks. One in five surveyed in Armstrong et al. missed half or more of scheduled breaks (2009, 71). Confronted with the reality of insufficient time and the seniors they care for being in need, many staff sacrifice their own needs.

The care team routinely works short staffed. Failure to replace workers for vacations and sick time has become the norm. When asked what single change would most improve working conditions, "more staff" was the response from 55 per cent of members surveyed. Another expression of the same issue, "workload", was the response chosen by 9.5 per cent. Six out of ten workers cited workload as the number one reason they would leave their job.<sup>41</sup>

Despite a consistent trend of short staffing in long-term care facilities, workers are often in a position of not having access to enough hours. Many hold positions at two or more LTC homes to assemble enough hours to make ends meet. They face the burden of trying to make last minute arrangements to accept a shift on short notice, or sometimes having to cancel with one employer to accept a set of shifts from a different employer that will generate greater income.

Armstrong et al. found that over 40 per cent of Canadian LTC workers in their survey worked part-time hours and that 48 per cent of those wanted more hours.<sup>42</sup> A more recent poll of HEU LTC Care Aides in B.C. found that 31 per cent worked part time and 22 per cent worked as casuals.<sup>43</sup> Increasing the number of full-time positions in the sector would be beneficial in increasing staff retention, and enhancing continuity of care.

## Mental and emotional impact

The work of caregiving is emotionally and mentally draining. In addition to the sheer volume of work, the nature of the job is taxing. It requires skilled and constant communication in a high pressure environment. It is the work of nurturing and loving within human relationships. Deep attachments are formed and care aides grieve these relationships regularly when the residents they have cared for, die. It is a regular part of the job but there is no support or space offered to deal with this grief.

In addition, care aides experience a moral distress when they are unable to comfort a resident, particularly at the end of the residents' life. As expressed by one HEU member, "it is no longer possible to hold the hand of a scared resident."<sup>44</sup>

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<sup>41</sup> Daly and Szebehely, "Unheard Voices, Unmapped Terrain", 145.

<sup>42</sup> Armstrong et al., *They Deserve Better*, 83-84.

<sup>43</sup> Viewpoints Research, "Care Aides Survey." HEU, 2014.

<sup>44</sup> HEU Care Aide, Care Aide Testimonials, April and May 2016.



Workers feel inadequate when they are unable to deliver the care they feel seniors deserve. Almost 40 per cent of Canadian care aides reported feeling inadequate all or most of the time. Seventeen per cent said that work almost always kept them awake at night.<sup>45</sup> In another worker's words, "I feel such guilt for not being able to do more, [I] see my co-workers stressed and irritated as they try and meet basic needs of people they care about. We are constantly being asked to do more, without additional staff. This is putting everyone at risk."<sup>46</sup>

## Physical injuries and related impacts

Injury rates in the long-term care sector are four times as high as the provincial average in B.C.. In 2015, the sector's injury rate was 8.9 per cent (8.9 in 100 workers were injured that year) and much greater than 2.2 per cent provincial average.<sup>47</sup> Long-term care workers are at the greatest risk of being injured on the job, and at greater risk than police officers, construction workers or forestry workers. Care aides account for the majority of workers in LTC making injury claims.<sup>48</sup> Almost 3,000 time loss claims occurred in 2015. The average duration was 35 days with claim costs in the year of injury totalling more than \$12 million.<sup>49</sup>

Most injuries fall into the category of over-exertion from patient handling.<sup>50</sup> Care aides are the group most likely to experience MSI injuries such as back and shoulder strains because they perform the bulk of the work that involves moving and handling patients.

A B.C. study by WorkSafeBC and partners compared high injury rate facilities (HIRFs) and low injury rate facilities (LIRFs), examining the relationship between both MSI and violence-related injuries, and risk factors including workload, and staffing levels. The research included ergonomic indicators of physical workloads which demonstrated higher spine compression, strongly correlated with low back pain, among care staff at the HIRFs (2003, 11).<sup>51</sup> The relationship between staffing levels and injury rates was significant with HIRFs averaging 16:1 residents to staff compared with 12:1 residents to staff at LIRFs (average day shift across all units).<sup>52</sup>

The runner up to MSI injuries in LTC are injuries due to violence. Between 2011 and 2015, 15.3 per cent of the time loss injuries experienced in long-term care in B.C. were due to violence, yet time loss claims

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<sup>45</sup> Armstrong et al., *They Deserve Better*, 113.

<sup>46</sup> HEU Care Aide, Care Aide Testimonials, April and May 2016.

<sup>47</sup> WorkSafeBC, "Injury Rate." Industry Safety Information Centre (ISIC). <https://online.worksafebc.com/anonymouse/wcb.ISR.web/IndustryStatsPortal.aspx?c=2> (retrieved July 15, 2016).

<sup>48</sup> *Vancouver Sun* (Vancouver). 2 January 2016.

<sup>49</sup> WorksafeBC, "Claim Costs." ISIC. <https://online.worksafebc.com/anonymouse/wcb.ISR.web/IndustryStatsPortal.aspx?c=6> (retrieved July 15, 2016).

<sup>50</sup> *Vancouver Sun* (Vancouver). 2 January 2016

<sup>51</sup> Marcy Cohen et al. "Reducing Injuries in Intermediate Care: Risk factors for musculoskeletal and violence-related injuries among care aides and licensed practical nurses in Intermediate Care facilities" (Vancouver, B.C.: WorksafeBC, et al., 2003), 11.

<sup>52</sup> *Ibid.*, 48.

can only reveal part of the story, since not all incidents result in time loss, nor are they always reported.<sup>53</sup>

In the Viewpoints Research survey of HEU care aides, 83 per cent of those contacted reported being “struck, scratched, spit on or subjected to other acts of violence or aggression from a resident/patient/client.”<sup>54</sup>

These findings echo research carried out with care aides in the long-term care sector across Canada which found 43 per cent of care aides experienced physical violence “by a resident or their relative” on a daily basis and 23 per cent on a weekly basis.<sup>55</sup> Verbal violence including racial slurs were found to be common. Unwanted sexual attention was experienced on a daily or weekly basis by one third of care staff surveyed.<sup>56</sup> This unwanted attention took the form of sexist comments but also sexual violence from male residents toward female care aides in the form of groping or in some instance, attempted assaults while the care aide was bathing or showering residents.

It is also important to note that it has been estimated that no more than 15 per cent of violent incidents can be viewed as random or unexpected attacks. Evidence shows that the majority of violent incidents occur at the point of care, where staff are in direct contact with a patient, resident or client.<sup>57</sup>

Given the potential for violence that exists in the provision of personal care, it is necessary for members of the care team to have established familiar, trusting relationships with those they are assisting. Inadequate staffing levels obstruct relationship building by preventing care aides from having the time they need to provide respectful, safe and dignified care. The lack of staff and time is a significant contributory factor in triggering aggression on the part of frustrated, sometimes frightened residents. In other words, given sufficient time within a shift, many of the situations and conditions that trigger aggressive behaviours could be anticipated and reduced, if not prevented altogether.

The impact of violence on care staff comes at a high cost and cannot be underestimated. Violent incidents can leave staff demoralized, traumatized, anxious and exhausted. It is not uncommon for those who have experienced a violent incident to internalize trepidation, fear, and diminished confidence which compromise their ability to provide quality care going forward. And then there are the financial costs. Claims costs in B.C. between 2011 and 2015, as a result of violence-related injuries in LTC, amounted to \$2.2 million, accounting for over one third of violence related claims costs in the Health and Social Services sector on a whole.<sup>58</sup>

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<sup>53</sup> WorksafeBC, “Claim Characteristics: Top 10 Accident Types” ISIC.

<https://online.worksafebc.com/anonymous/wcb.ISR.web/IndustryStatsPortal.aspx?c=5> (retrieved July 15, 2016).

<sup>54</sup> Viewpoints Research, “Care Aides Survey.” HEU, 2014.

<sup>55</sup> Banerjee et al., “Structural violence in long-term, residential care for older people: Comparing Canada and Scandinavia” *Social Science & Medicine* xxx 2012, 4.

<sup>56</sup> Armstrong et al., *They Deserve Better*, 131.

<sup>57</sup> Neil Boyd, *Gently into the Night: Aggression in Long-Term Care*, (British Columbia: Worker’s Compensation Board of British Columbia, 1998), 21.

<sup>58</sup> WorksafeBC, “Claim Costs: Top 10 Accident Types” ISIC.

<https://online.worksafebc.com/anonymous/wcb.ISR.web/IndustryStatsPortal.aspx?c=5> (retrieved July 15, 2016).

A number of initiatives have occurred in B.C. in developing tools, training, and systems to address violence in health care including WorksafeBC's High Risk Strategy plan that offers detailed inspection plans and audits. The strategy has been implemented in various health authorities, but this has happened unevenly. Training modules to help equip health care staff and their managers with the knowledge and skills that they need to prevent violence were recently updated in conjunction with B.C.'s Provincial Occupational Health and Safety and Violence Prevention Committee (POHSVPC). Care staff employed directly by the health authorities will receive this training accompanied by classroom time.

It is questionable though whether or not those workers employed by non-profit and for-profit operators will benefit from the new modules, and unlikely that they will receive the in-class education component that accompanies the modules. In addition, our members repeatedly express frustration at not having time or the encouragement from management that would facilitate utilizing these new techniques.

For example, in order for a care aide to be able to cease care if a resident becomes agitated and return later, she requires a flexible schedule of care and supportive management. But these working conditions are not widespread. While this training initiative has potential to be beneficial, it is only useful to the extent that workers are given the time and support to implement what they have learned. The training must also be standardized and delivered in the same manner across health authorities and across employer types.

The POHSVPC until recently included stakeholders from WorkSafeBC, health authorities, the Ministry of Health and each of the health sector bargaining associations representing various members of the health care team. In recent negotiations with the Nurses Bargaining Association however, the Ministry agreed to a separate committee for RNs and LPNs with a separate funding framework from the PHOHSVPC.

It is alarming that the Ministry has allowed the dismantling of a system-wide prevention program and adopted in its place, a patchwork approach. Controls and standardization of programs, and training must be established across health authorities, bargaining associations, and all employer types, if the Ministry and other vested parties intend to address violence related injuries in a serious fashion.

Injury prevention programs that utilize 'peer coaches' constitute a promising practice that should be expanded in LTC facilities. Care aides at a number of sites in some health authorities have received training, primarily in MSI and violence related injury prevention, to learn how to model and share injury prevention with their peers. Care aides are paid to receive this training. They then return to their facility and are released from their regular duties for a day in their work week to coach others on injury prevention.

When these programs were introduced in the Vancouver Coastal Health Authority LTC sites, the results included a 22 per cent drop in MSI claims at those sites utilizing peer coaching.<sup>59</sup> This approach should

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<sup>59</sup> Worksafe Magazine, July/August, 2010, 15. (Retrieved July 15, 2016).

be jointly assessed, collaboratively by stakeholders including unions, and expanded upon where it has been successful.

## Recommended minimum staffing levels

Appropriate staffing levels are critical in helping to prevent injury to workers, preventing poor health outcomes for residents and improving the quality of life for seniors and quality of working conditions for care staff. Establishing the precise levels that are 'appropriate' is a labour intensive research process. It is advisable to draw on the comprehensive studies that exist and are described below in conjunction to consulting with an expert panel to determine what will be appropriate in the current context in B.C..

Staffing levels of care aides specifically, where they fall below 2.04-2.06 hours per resident day (hprd), have been associated with a four times higher likelihood of high hospitalization rates for LTC residents.<sup>60</sup>

Horne et al. found that residents who received 2.25 hprd of care aide time were 41 per cent less likely to develop pressure ulcers than those receiving less than 2.25 hprd.<sup>61</sup> In a comparison of 21 care homes, Schnelle et al. found that the facilities with the highest staffing levels performed better in 13 of 16 outcomes.<sup>62</sup> The study found that:

- Residents at high staffed facilities received a greater number of walking assists and had greater ability to bear weight
- Residents received seven minutes on average of feeding assistance compared to low staffed facilities in which they received 2.5
- Thirty-one per cent of residents responded yes to having to wait too long for toileting assists in high staffed facilities compared to 49 per cent at low staffed homes<sup>63</sup>

There are no Canadian studies that attempt to establish the level of nurse (RN, LPN, and care aide) staffing levels required to maintain or improve quality of care/health outcomes. Two notable studies conducted in the U.S. however, have made recommendations.

A review of On Line Survey, Certification and Reporting System data for all certified nursing homes in the United States used regression analysis to examine the relationship between staffing hours, nursing home deficiencies and quality of care and quality of life issues. Fewer Nursing Assistant hours were

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<sup>60</sup> Kramer A. et al. Effects of nurse staffing on hospital transfer quality measures for new admissions. In *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Report to Congress, Phase I* (U.S. Department of Health and Human Services, ed.). Health Care Financing Administration, Washington DC, 9.1-9.22

<sup>61</sup> Horn et al. , "RN Staffing Time and Outcomes of Long-Stay Nursing Home Residents: Pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care." *American Journal of Nursing* 105, 2005, 58-70. In Janice M. Murphy, *Residential care quality: A review of the literature on nurse and personal care staffing and quality of care*, (British Columbia: Nursing Directorate, British Columbia Ministry of Health, 2006), 22.

<sup>62</sup> Schnelle et al., "Relationship of Nursing Home Staffing to Quality of Care." *Health Services Research* 39, 2004, 225.

<sup>63</sup> Schnelle et al., "Relationship of Nursing Home Staffing to Quality of Care." 2004, 241-242.

associated with greater deficiencies and poorer outcomes for measures of quality of care and quality of life. Harrington et al. recommended a total *minimum* of 4.55 hprd, adjusting upward for acuity and with care aides constituting 2.7 of the hprd.<sup>64</sup>

And in what is considered the most comprehensive study on this matter, commissioned by the US Congress, the Center for Medicaid and Medicare Services (CMS) concluded that a minimum level of 4.1 hprd was necessary to avoid deterioration of health in residents and 4.55 to improve outcomes. It looked at data from over 5000 facilities across 10 states. The study utilized regression analysis of empirical data and a simulation analysis on nurse aide time (equivalent of Canadian care aides) reviewing 5 key activities in addition to routine care: 1) dressing/grooming, independence enhancement 2) exercise 3) feeding-assistance, 4) changing wet clothes and repositioning residents and 5) toileting and repositioning residents.

The staffing levels required of care aides *alone* as a necessary condition for optimal care was determined to be between 2.8 and 3.2 hprd with the variation being dependent on staff's workload related to the acuity of a specific facility's residents.<sup>65</sup>

It must be noted that this study was carried out in 2001. Acuity levels of residents entering long-term care have risen significantly since that time, with residents currently entering North American facilities at later stages in their lives, with more complex care needs, and with increasing incidents of cognitive disorders such as dementia.

The B.C. Ombudsperson's report on seniors' care, issued in 2012, determined staffing level standards as they currently exist, to be subjective and therefore impractical to enforce. She points to the contrasting standards found in regulations set for childcare facilities which are clearly stated and make it easy for a parent or family member to know if the standard is being met and can provide them a basis from which to make a complaint.<sup>66</sup>

A standard that is quantifiable and relatively easy to identify, must also be audited by inspectors. The Ministry currently has had a guideline of 3.36 hprd for several years, but it is just that, an un-enforceable *guideline*. The Ombudsperson recommended that The Ministry of Health establish the appropriate staff mix needed to meet residents' needs, the minimum number of direct care staff required at different times of the day, and the minimum number of hours required per resident per day.<sup>67</sup>

Figures released by the Office of the Seniors Advocate indicate that 232 of 292 facilities are not funded to meet the existing guideline. Of these 232 facilities, 74 per cent are operated by for-profit businesses.<sup>68</sup> This discrepancy points to a need for substantial improvements to the accountability in our long-term care sector. A strengthened requirement including a legislated and enforceable staffing level

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<sup>64</sup> Charlene Harrington et al. "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States", *The Gerontologist* 40, No. 7, 2000, 13.

<sup>65</sup> Marvin Feuerberg, *Report to Congress: Phase II Final Report, Volume I*. (Baltimore: Centers for Medicare and Medicaid Services, 2001), MD 21244-1850, 6.

<sup>66</sup> Best of Care, Part 2, Volume 2, 298.

<sup>67</sup> *Ibid.*, 299.

<sup>68</sup> *Vancouver Sun* (Vancouver). 6 April 2016.

is necessary but also accountability with respect to the clinical and financial aspects of operating long-term care are also needed.

## Accountability

### Financial accountability

Health care privatization and contracting out often lead to reduced transparency and accountability of how public dollars are spent – a problem with contracted residential care in B.C.. Charlene Harrington, a leading health policy scholar, has extensively examined the problems associated with financial accountability in the residential care sector. In a 2016 peer-reviewed article, Harrington concluded that:

Countries with growing marketization and privatization levels of nursing homes need to develop mechanisms for reporting how public resources are spent and adopting appropriate cost controls on administration and profits to assure value for expenditures. Within each country, poor quality and nursing home scandals have been identified that may possibly have been avoided or minimized, if governments were providing stronger financial oversight.<sup>69</sup>

Compared to other jurisdictions including the US, England, Norway, and Ontario, B.C. could significantly improve financial accountability and transparency.

In B.C., residential services agreements between health authorities and contractors require that operating budgets, semi-annual financial reports, and independently audited annual financial statements are submitted to health authorities. Although these requirements are intended to ensure financial accountability, these measures provide limited transparency and oversight. There are no requirements that contracted operators adopt cost controls on administration and profits or that public dollars are only expended on improved staffing and direct care. In fact, contracted operators are not required to allocate public funds by cost centre.

Furthermore, the Ministry of Health and health authorities do not regularly conduct financial or operational audits to determine whether public funds (and funding increases) are being allocated to direct care and staffing levels or to administration and profits.

Financial accountability could significantly improve by adopting key recommendations from the B.C. Ombudsperson's *Best of Care* report as well as by examining the potential effectiveness of envelope funding for contracted residential care operators. In the 2012 report, B.C.'s Ombudsperson recommended that the Ministry of Health provide the public with a clear and accessible annual report on the allocation and expenditure of public dollars by health authority for home and community care,

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<sup>69</sup> C. Harrington et al. (2016). Comparison of nursing home financial transparency and accountability in four locations. *Ageing Int* 41, p. 34.

and an assessment of the efficacy of the funding in meeting prescribed goals.<sup>70</sup> This recommendation was accepted by the Ministry of Health, but as of June 2015, there has been no progress towards this recommendation.<sup>71</sup>

However, improving accountability through envelope funding and enhanced financial reporting requirements, for example, are only partial measures. From the US experience, Harrington found that “cost reports are often inaccurate or incomplete because they are not audited and penalties are not issued for reporting problems.”<sup>72</sup> In Ontario, LTC facilities are required to perform cost reporting but data are not publicly available.<sup>73</sup> Therefore, B.C. should consider implementing a funding model that provides greater transparency while also enhancing accountability through regular financial and operational audits.

Finally, HEU strongly believes that health authorities need to implement more stringent reporting and accountability measures in their contractual relationships with contracted residential care service providers. This could include tighter reporting requirements as outlined above and restrictions on operators to mitigate the impact of contracting out and the sale of facilities on staff, and therefore, on the continuity of care for seniors.

These measures could include restrictions on contracting out (through health authority review or an outright ban) and enhanced reporting requirements on operational budgets.

## Staffing and clinical accountability

Staffing is a key part of clinical accountability and an important structural measure of care.<sup>74</sup> Improving clinical accountability requires that staffing levels are appropriately defined and publicly reported.

Currently, contracted operators must comply with the Ministry of Health’s Minimum Reporting Requirements (MRR), and must submit facility activity reports and patient information through the Resident Assessment Instrument – Minimum Data Set, Version 2.0 (RAI-MDS 2.0). While some of RAI-MDS 2.0 measures are publicly reported at the facility level through the Canadian Institute for Health Information (CIHI), the MRR and facility reports are not openly reported. As well, the Office of the Seniors Advocate is now reporting paid nursing hours (care aide, RN, LPN) and allied health per resident

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<sup>70</sup> B.C. Ombudsperson, *The Best of Care: Getting It Right for Seniors in British Columbia (Part 2)*. Volume 1. Public Report No. 47. Victoria: Office of the Ombudsperson, 2012, p. 34. Retrieved June 8, 2016, at: <https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf>.

<sup>71</sup> B.C. Ombudsperson, *Update on Status of Recommendations: The Best of Care: Getting It Right for Seniors in British Columbia (Part 2)*, 2015. Retrieved June 8, 2016, at: <https://www.bcombudsperson.ca/sites/default/files/Best%20of%20Care%20%28Part%202%29%20-%202015%20Updates%20%28All%29.pdf>.

<sup>72</sup> C. Harrington et al., “Comparison of nursing home financial transparency and accountability in four locations”, 2016. p. 34.

<sup>73</sup> Ibid.

<sup>74</sup> I. Jansen, *Residential Long-Term Care in Canada: Our Vision for Better Seniors’ Care*. (Ottawa: Canadian Union of Public Employees, 2009), 39-40.

day. However, employers routinely fail to backfill vacation and sick days. This means that the current calculation of hprd, based on funded hours, is higher than the actual time spent with residents. In B.C., it is estimated that hours worked range 15-30 per cent lower than hours paid.<sup>75</sup>

Furthermore, contracted operators are required to submit staffing plans as part of their service agreement with health authorities. Improving clinical accountability of minimum staffing levels requires that contracted operators publicly report direct care hours worked, not paid hours, and that health authorities regularly audit payroll to ensure accountability.

Consistent with the research literature, direct care hours should be defined as care aides and regulated nurses (RNs, LPNs) but not allied occupations. In order to ensure a consistent minimum standard of staffing across B.C., it should be only adjusted upward for acuity and never reduced. Publicly reporting acuity levels by facility through RAI-MDS 2.0 data, in addition to worked hours, would significantly enhance transparency and accountability of how acuity informs health authority funding and LTC staffing levels.

For health authority-operated facilities, payroll information is accessible through a centralized database. In order to improve staffing level accountability, contractors' payroll information (showing worked hours) should be submitted to health authorities and the Ministry of Health for the purposes of compliance, planning and analysis. Health authority and Ministry of Health information management systems should be standardized and fully integrated to include payroll information for direct and affiliated operators.

Staffing levels, retention levels, and patient caseload/acuity will illuminate the conditions of care at facilities, but staff turnover, as cited earlier is also a significant determinant of quality of care and should be used to inform decision making.

Two forms of turnover/retention need to be tracked and reported out: 1) the day to day turnover that occurs through individual staff leaving their employment, and 2) the large scale turnover that occurs through contracting out and contract flipping. Currently there appears to be no requirement to report either of these.

Significant restructuring has occurred in the LTC sector since 2000. With the growth of independent operators outside the main public sector collective agreement, and with expansion of sub-contracted care and support service providers, it is important that the Ministry of Health acknowledge the links between ownership and contracting out, staffing levels, and quality of care.

In upholding its stewardship responsibility, the Ministry of Health should track and report on contracting out. This would allow the Seniors Advocate, CIHI, system managers, and researchers analyze the links between contracting out, staffing levels, and clinical outcomes.

The contracting out of care has created an arms-length relationship between health authorities and facility operators. If the B.C. government intends to hold contractors accountable to a high standard of

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<sup>75</sup> Hospital Employees Union, *Quality of care in B.C.'s residential care facilities: Input to the Office of the Ombudsman on Seniors' Care*, January 12, 2009



care, they should be prescriptive about staffing levels and equally important factors that contribute to high quality care.

The *Adult Care Regulations* when they initially came into force in 1980 had quantifiable and specific standards for staffing. In keeping with regulatory trends of the last two decades, the language has been transformed to a flexible and highly subjective standard. The current *Residential Care Regulation* reads “the employees on duty are sufficient in numbers ... to meet the needs of persons in care and assist persons in care with activities of daily living. ... In a manner consistent with the health, safety and dignity of persons in care”.<sup>76</sup> This new standard is indicative of a growing ‘hands off’ outcomes approach which fails to set a model for delivery of care and is practically unenforceable.

Facility inspections provide a further means of monitoring quality and compliance but in B.C. they are not utilized often enough nor in a manner that maximizes their effectiveness. The Seniors’ Advocate 2016 report *Monitoring Seniors Services*, found that almost all of the facilities that had received inspections within the last year were for issues identified as falling into the Care and Supervision category of the regulations. Neither of the acts, the *Community Care and Assisted Living Act* or the *Hospital Act*, governing LTC facilities in B.C. stipulate the frequency with which inspections are to occur.<sup>77</sup>

The B.C. Ombudsperson found that between the years of 2004 and 2011, the Director of Licensing ordered audits or investigations exactly four times.<sup>78</sup> In the same examination of inspection practices, it became apparent that the majority of inspections were scheduled, and that most occurred during regular business hours.

The Ombudsperson deemed this practice unreasonable and made the recommendation that the “Ministry of Health require all the health authorities to conduct a set number or percentage of unscheduled facility inspections and inspections outside of regular business hours.”<sup>79</sup> Many seniors experience cognitive impairments and live with advanced dementia, and a portion of these do not have family members or advocates.

Monitoring the conditions of care for a population as vulnerable as frail, elderly seniors must not be left to a complaint driven process.

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<sup>76</sup> Best of Care, Part 2, Volume 2, 98.

<sup>77</sup> Ibid., 20-21.

<sup>78</sup> Ibid., 321.

<sup>79</sup> Ibid., 333.

## Conclusion and recommendations

The Hospital Employees' Union appreciates the opportunity to provide the perspective of front-line staff on the challenges B.C. currently faces in the provision of high quality long-term care services and makes the following recommendations to the Government of B.C. in the area of staffing levels and staffing mix:

1. *Conduct a comprehensive review, involving leading health policy and long-term care experts, and key stakeholders, to establish an appropriate legislated minimum staffing level necessary to provide quality care. Such a review should:*
  - *Examine acuity levels and their variance by facility characteristics and ownership type across all health authorities and consider enhanced staffing levels in relation to acuity;*
  - *Examine how to enhance and implement person-centred and relational care models in publicly funded LTC facilities;*
  - *Examine and recommend a funding formula and accountability measures for LTC operators;*
  - *Recommend measures to increase financial accountability; and*
  - *Examine the impact of contracting-out and privatization on working conditions and quality of care.*
2. *As an urgent interim measure before an appropriate legislated level is determined, immediately increase funding so all publicly funded LTC facilities at a minimum meet the Ministry's 3.36 hprd guideline. This immediate staffing increase should be supported by new funding to health authorities and include:*
  - *Recruitment of more care aides;*
  - *Accountability requirements to ensure new funding is directly applied to care;*
  - *Standardization of the calculation, collection, and reporting of staffing levels;*
  - *Standardization of musculoskeletal and violence prevention programs including training across health authorities, bargaining associations, and employers; and*
  - *A joint assessment of "peer coach" injury prevention training and program expansion.*
3. *Improve continuity and quality of care by reducing staff turnover:*
  - *Adopt measures mitigating the impact of contracting out including restrictions on such practices in commercial contracts between health authorities and service providers;*
  - *Establish meaningful successorship rights for collective bargaining to ensure continuity of care; and*
  - *Require health authorities to track and report staff turnover and retention, contracting out, and contract flipping and other data necessary to enhance evidence-based decision making.*