



There are not enough hands

CONDITIONS IN ONTARIO'S LONG-TERM CARE FACILITIES

July 21, 2004

Dr. Pat Armstrong and Dr. Tamara Daly



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1.0 Executive Summary

There are not enough hands

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In May 2004, the Ontario Minister of Health and Long-Term Care released its consultation report based on Parliamentary Assistant Monique Smith's investigation of long-term care facilities. *Commitment to Care: A Plan for Long-Term Care in Ontario* makes recommendations about the quality of life in care facilities, public accountability, new standards for inspection and compliance, increased staffing and continuity of care and new legislation and funding models.

This study, resulting from a survey of employees in long-term care, provides further support for Monique Smith's findings. It highlights the issues from the perspective of the nurses, personal support workers, maintenance staff, homemaking staff, dietary workers, therapists and recreational workers who are involved in caring for residents on a daily basis. As the recent report of the Federal Task Force on Pay Equity explains, those who do the work "have the direct knowledge of the numerous requirements of their jobs and they can speak with conviction of the difficult and demanding aspects of those jobs." Because it is based on workers' knowledge, our survey reveals additional issues that must be addressed in order to meet the ministry's objective of providing quality care.

i) Staffing

Like Monique Smith's investigation of long-term care in Ontario, this survey identifies staff shortages as a central problem. Increasing acuity levels, combined with reductions in the numbers of employees, have resulted in overworked staff and under-cared-for residents. Unlike the Ministry report, however, this survey also indicates that shortages in every occupational category are critical to care. While shortages in nursing, therapy and personal care staff are important, so too are shortages in laundry, dietary, clerical, recreational, housekeeping and maintenance. If the dietary and housekeeping staff are not there, nursing staff end up doing cleaning and feeding. And, housekeeping staff end up doing nursing work if there are no nurses available for care. Each job is critical to care and cutbacks in one area have an impact on all workers and residents.

This survey also indicated that shortages result not only from the failure to employ enough staff but also from the failure to replace absent staff members. Formal staffing levels are low, as Smith makes clear, but actual staffing is often even lower.

Smith's investigation also suggests that more training is required for personal support workers and managers. This survey indicates that the majority of employees do have formal training that is relevant for their current work and this training should be recognized. They also have extensive experience in care that should be recognized as a way of developing skills for care. However, changing acuity levels and resident needs do mean that many could benefit from support for more education programs. Like Smith's report, many of those writing in comments saw a need for more managerial training not only in directing personnel but also in care.

And, like Smith's report, this survey indicates that there will be critical shortages in the future. These future shortages result not only from the pay inequities and poor conditions that Smith and this survey identify, but also from the aging of the workforce. Most current workers are middle-aged and older. Many stay because they remember the days when care was there and hope to see those days return. The rewards come from their commitment to care and their extra work to make up for the care deficit. When this generation retires, the next may be unwilling to take on work that seems to provide few rewards in terms of pay, security or resident satisfaction.

ii) Quality of Life

In addition to the lack of baths, appropriate food and recreation identified by Smith, this survey also revealed fundamental inadequacies in 1) workers' ability to complete tasks in the time allotted and 2) in the physical environment within homes.

First, like the Smith report, this survey reveals a troubling lack of care. Heavy workloads mean there is not enough time to complete tasks in a way that complies with standards. Nearly one-fifth (18.1%) report they are able to complete their tasks to established standards less than half the time. Another 14.3 per cent report that they are never able to do so (Figure 7). In some cases, tasks are simply left undone.

We asked workers to indicate whether specified tasks were completed or left undone in the seven-day period prior to responding to the survey. What we found is disturbing and goes far beyond a lack of baths, appropriate food and recreation. The survey reinforces the claim that the workload is simply too heavy to allow for a safe and healthy workplace for providers or a home space for elderly, frail residents. Chatting with residents is 69.3 per cent of the time the task most frequently "undone" (Figure 8). Nearly 60 per cent of the time, workers don't have the time to provide emotional support (59.8%), while walking and exercising of residents is not done more than half the time (52.3%). More than 40 per cent of the time, recording, foot care, and providing support to co-workers is left undone. Nearly 30 per cent of the time common room cleaning and keeping in touch with families is overlooked. More than 20 per cent of the time, turning of residents, bed changing, room and bathroom cleaning, learning necessary skills and other unspecified tasks remain to be done. Bathing and building maintenance are left undone nearly 20 per cent of the time. Nearly 15 per cent of the time (14.7%), workers are unable to attend to clothing changing. Finally, referral to outside medical support is left undone more than 10 per cent of the time. Nearly ten per cent of the time (8.5%), feeding is left undone!

Second, the physical environment within homes is simply inadequate. According to these workers, stairs and dining rooms, bathroom and recreation spaces are too often inappropriate for current care needs or simply inadequate and sometimes even dangerous. But perhaps the most important lack identified by this survey is social and emotional support. People need providers who have time for chatting, walking and exercising as well as hair, foot and mouth care. These supports are as important to health as direct nursing care. Yet they have been, for the most part, defined out of the time available for providers to do their jobs.

Unlike Smith, this survey also explores the quality of life for workers. It reveals alarming rates of violence among residents and against workers and of both illness and injury. Within the most recent three-month period, almost three-quarters of workers have experienced some form

of violence directed at them from one or more individual residents (73.3%). The combination of rising acuity, inadequate staffing and facilities creates conditions that are dangerous for workers' health. A stunning number (96.7%) in our survey reported having been ill or injured as a result of work in the past five years (1999 – 2003). More than 50% report that work caused illness or injury more than 11 times during this time period.

Not surprisingly, these conditions in long-term care have a negative impact on workers' personal lives. Given that most of these workers are women, they go home at night to another job. But their comments reveal how difficult it is to do this job when they are tired and stressed from their paid work. Stressed at their paid work, they are stressed at home. Stress in either place promotes poor health.

iii) Standards and Compliance

Like Smith's report, this survey indicates that standards are both too low and too minimally enforced. This applies to everything from resident care to physical environments, from staffing levels to nutrition and recreation. There is too much work and too little time to care. Inspections happen infrequently and inadequately, as Smith suggests. But these workers also say that governments do not listen and that inspectors fail to meet with the workers when they seek advice on the services.

iv) Accountability

Like Smith's report, this survey suggests that there is little public accountability in long-term care. The majority of these respondents would not feel comfortable reporting unsafe practices to their employer and almost nine out of 10 would not feel comfortable reporting such practices to the government.

Unlike Smith's report, this survey also asked about workers' autonomy and the extent to which workers are consulted. A majority indicate they do not have a say in their schedules and just over half have control over what they do, when or how they do it. Yet autonomy is known to be a critical component in health and both the workplace and the residents could well benefit from workers' knowledge.

In short, this survey reinforces many of the observations set out in the Smith report. However, it also identifies absences. The Smith report focused on only one side of the long-term care population. This report focuses on the other. It identifies some of the conditions that are undermining workers' health and their capacity to care. For residents to enjoy quality of life, workers must too.

In brief, STAFFING

- ☞ Staff shortages are critical in every occupational category, undermining teamwork for care
- ☞ Staff shortages are greater than official numbers would suggest because absent workers may not be replaced
- ☞ Employees have considerable knowledge and experience but need more formal training in order to respond to patients with new and heavier needs
- ☞ Staff shortages will increase dramatically in the near future both because many are nearing retirement and because those currently employed have been working hard to overcome gaps in care, a pattern that is less likely in the future

QUALITY OF LIFE

- ☞ Employees report an alarming number of tasks left undone because there is no time for appropriate care
- ☞ The physical space is often inadequate, inappropriate or even dangerous for current resident needs
- ☞ Employees report high levels of violence among residents and against staff
- ☞ Conditions have a strong negative impact on employees' personal lives
- ☞ Conditions are reflected in the very high rates of illness and injury

STANDARDS AND COMPLIANCE

- ☞ Standards are low
- ☞ Standards are minimally enforced

ACCOUNTABILITY

- ☞ Employees do not feel comfortable reporting unsafe practices to governments or employers
- ☞ Employees are seldom consulted in ways that influence practices, even though they are in a position to know the residents
- ☞ Employees have little control over their schedules or the order in which they complete tasks

2.0 Introduction

Long-term care facilities have been an essential component in Ontario health care since the nineteenth century. Health care reforms over the last decade have made these facilities even more critical to care. In Ontario, Liberal, Conservative and New Democratic governments have acknowledged their importance through both regulations and funding. The majority of the money for care in these facilities comes from the public purse, although their share of funding is small relative to other sectors in health care.

A 1997 survey of care providers concluded that changes to minimum standards of care and to the funding system, as well as to hospital services, were having a significant negative impact on both providers and residents. Research conducted three years later revealed “the multiple, varied and often invisible ways workloads are expanding” as a result of reform strategies in and outside these facilities. Yet, the recent Royal Commission on Health Care – more commonly known as the Romanow Report – failed to consider long-term care.

However, this spring a nurse employed in long-term care blew the whistle on conditions. Subsequent media coverage dramatically revealed examples of resident neglect and mistreatment. In response, the Ontario Minister of Health and Long-Term Care appointed Parliamentary Assistant Monique Smith to study the issues raised by the coverage. In May this year, the ministry released the consultation report based on her investigation. *Commitment to Care: A Plan for Long-Term Care in Ontario* makes recommendations about the quality of life in care facilities, public accountability, new standards for inspection and compliance, increased staffing and continuity of care, and new legislation and funding models.

In order to prepare her report, the Parliamentary Assistant toured facilities, spent a shift following a Registered Practical Nurse on the job, and consulted with a range of those concerned about care in these facilities. Her primary focus was residents and the quality of care they receive, although this focus necessarily involved consideration of working conditions in care.

Our report, resulting from a survey of workers in long-term care, provides further support for Monique Smith’s findings. It highlights the issues from the perspective of the nurses, personal support workers, maintenance staff, homemaking staff, dietary workers, therapists and recreational workers who are involved in caring for residents on a daily basis. As the recent report of the Federal Task Force on Pay Equity explains, those who do the work “have the direct knowledge of the numerous requirements of their jobs and they can speak with conviction of the difficult and demanding aspects of those jobs.” Because it is based on workers’ knowledge, our survey reveals additional issues that must be addressed in order to meet the ministry’s objective of providing quality care.

“There are not enough hands to effectively, and with dignity, feed these residents as they deserve to be fed. There are not enough hands to provide the care these elderly residents require and deserve”

Respondent 99314

“There are times that I want to change jobs. However, I care very much for the elderly and would miss them.”

Respondent 99336

This report is framed by two central assumptions:

1. Long-term care facilities are residents' homes. They should provide comfort, security, and care for vulnerable and dependent adults. As homes, they need to include all aspects of a good home, including privacy and personal space, public space, safety, entertainment, recreation, health, and well-being.
2. Long-term care facilities are also places of work. Workers are entitled to health and safety, freedom from violence and abuse, proper work supplies, appropriate physical conditions and sufficient staff resources and support.

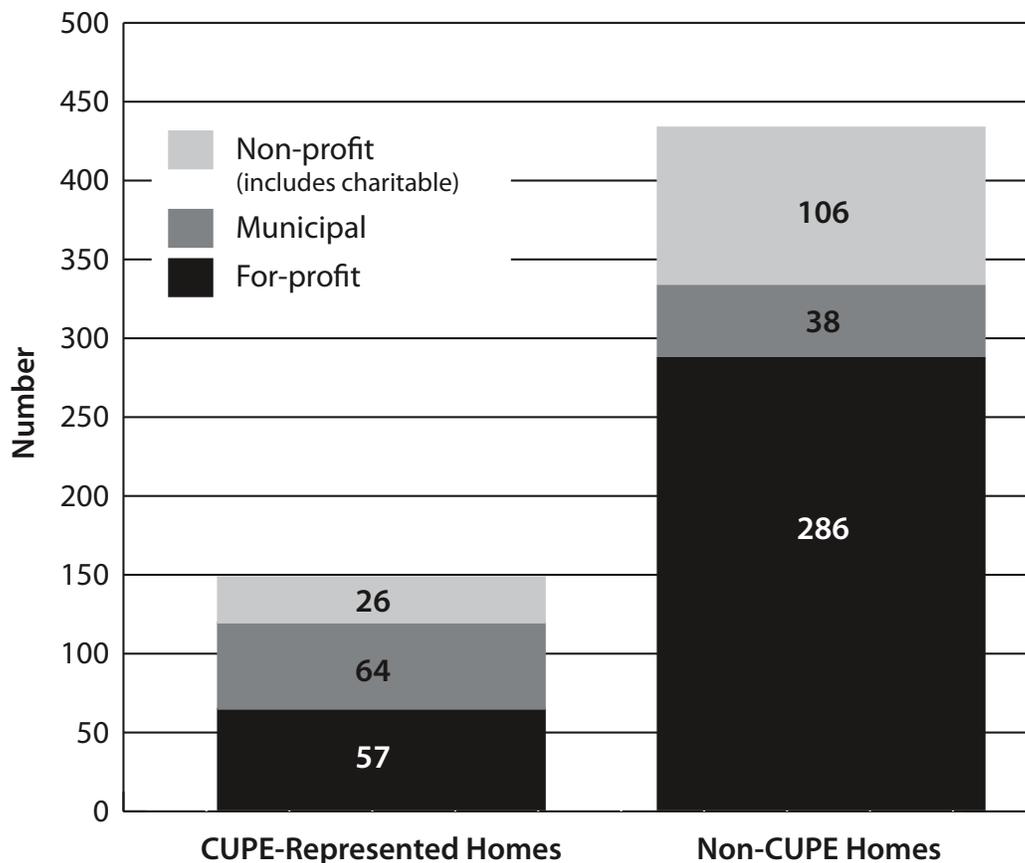
In other words, issues such as worker safety, staff shortages, employment security, reasonable working conditions and hours of work are as important as ensuring the privacy and personal space, entertainment, recreation, health and well-being of residents. Indeed, these issues can only be adequately understood and addressed together. When providers have poor working conditions, it is difficult not to provide poor care.

Successful reform requires recognition of the dual nature of facilities as sites for receiving care and for providing care. Our conclusion is simple: good quality care requires good working conditions.

3.0 Method

In March 2004, the Canadian Union of Public Employees (CUPE) Ontario Division in conjunction with the National Research Department commissioned an independent study of Ontario’s long-term care workplaces represented by CUPE, to be conducted by researchers at York University. Across Ontario’s long-term care sector, CUPE represents 18,000 workers in 187 long-term care facilities. Of these, 39 facilities (20%) are for-profit retirement homes that do not receive government funding. The following is the breakdown of CUPE representation in Ontario’s long-term care sector homes receiving public funding: 31 per cent are for profit homes, 34 per cent are municipal homes and 14 per cent are charitable and non-profit homes. Figure 1 compares the number of CUPE and non-CUPE represented publicly-funded homes across the province by facility type. There are currently 70,100 long-term care beds available across the province. Excluding retirement homes, CUPE workers are responsible for nearly one-third of the beds in the province (29.8%).

Figure 1: CUPE and Non-CUPE LTC Homes in Ontario, 2004



Source: *Commitment to Care: A Plan for Long-Term Care in Ontario and CUPE Ontario Data*

The study is based on a sample survey questionnaire. The purpose is to assess long-term care workplace issues, including staff training, workload, perceptions of resident care, worker health and safety and the relationship between work and family life. In March and April of 2004, it was sent by mail to 2,322 individuals working in 18 CUPE nursing home workplaces across the province.

A probability sample design was used to randomly select workplaces, which were selected by type, according to their status as either private non-profit, public municipal, or private for-profit, and by location based on size (small, medium and large centres).

A total of 917 surveys were returned by mail to the Institute for Social Research (ISR) at York, representing an overall response rate of 39.5 per cent. Data were input by ISR and descriptive statistics were analysed by York researchers using the statistical package SPSS.

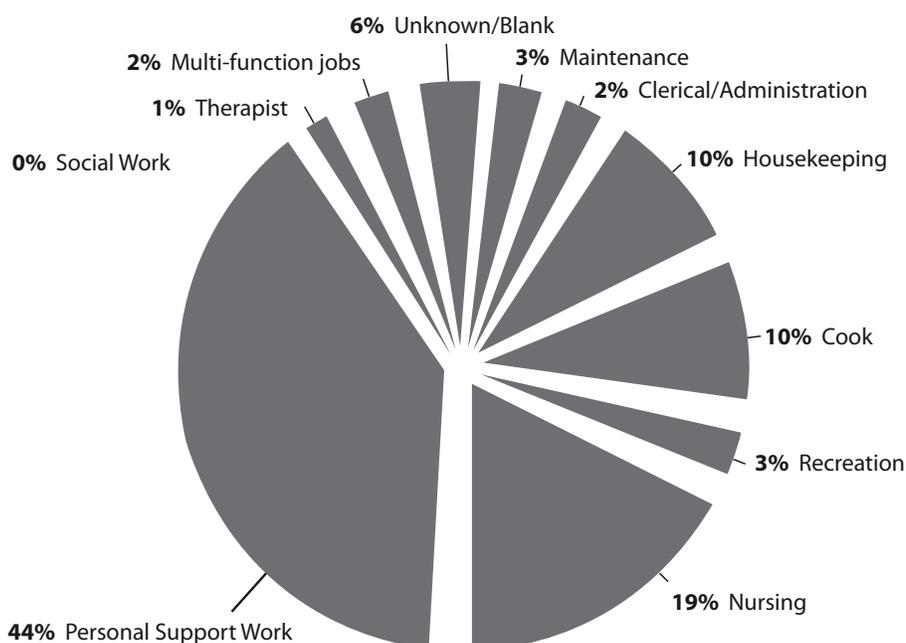
The survey uses five-point scales and open-ended questions to ask workers about their employment, workload, resident care, worker health and safety and work and family life. Three of the survey's open-ended questions probed workers to identify whether they faced particular problems with meeting their other responsibilities as a result of their work schedule, to identify what other influences their job places on their personal life and space to add additional comments.

Of the 917 responses returned, the type of institution is identified in 511 returns. In this report, data are reported for the survey responses overall (n=917). In places, data are also presented by type of worker (e.g. nurse, cook). The survey also analyses the responses to open-ended questions provided by 48 per cent of respondents (n=443).

4.0 Who Works in Long-Term Care?

The people in our sample covered the full range of jobs in long-term care. A hundred different job titles are represented. For the purpose of analysis, we have divided them into the 10 broad job classifications indicated in Figure 2. The employees do nursing and personal support work, social work and recreation work. Some cook and others clean while significant numbers do maintenance and clerical work. All are critical to care, as the research on the determinants of health makes clear. While the majority of our respondents (72.2%) work directly with residents in patient care, it should be recognized that clean floors are as critical to residents' health as clean bottoms.

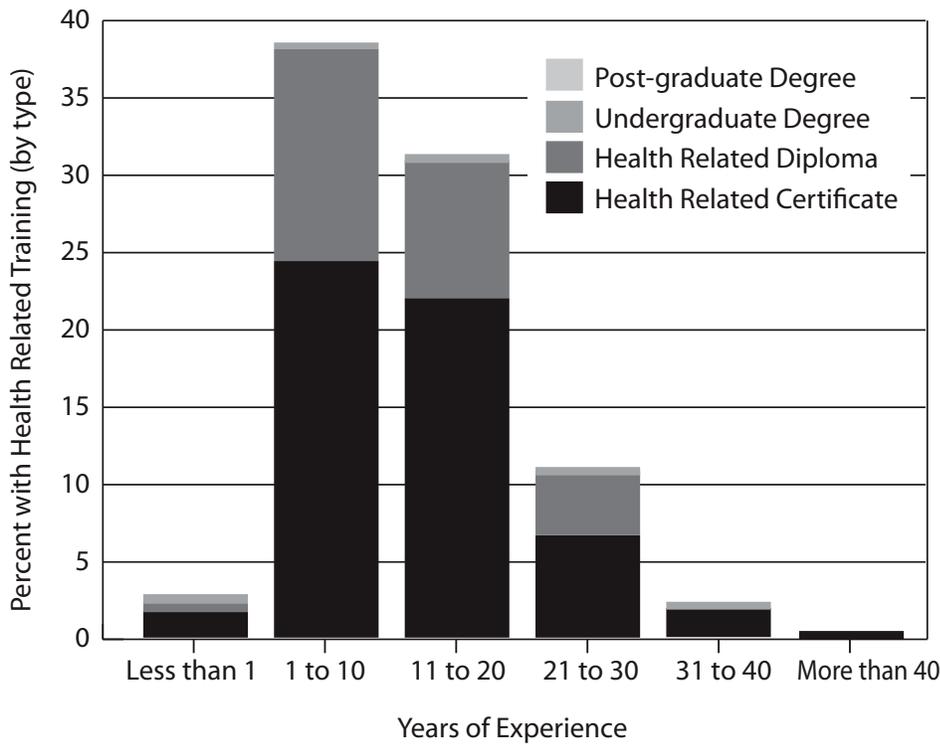
Figure 2: Workers' Job by Category



Half of the workers in our sample were born before 1959. In other words, a majority are over forty-five years of age. The workforce, then, is no longer young. Like the population as a whole, this workforce is aging

However, partly as a result of age, this is a highly experienced labour force. Nearly 60 per cent of them have been doing this type of work for more than 10 years. Just over 20 per cent have been on this kind of job for more than 20 years, with 10 per cent putting in a quarter century or more. They not only bring skills acquired through experience. They also bring skills learned through formal training processes. A majority (55.8%) have a health care related training certificate while a quarter (26.1%) has completed a diploma in health care (Figure 3). Of those with formal educational training, three-quarters (75.0%) say this training has prepared them well or very well for their current work. Another 18 per cent (17.5%) felt somewhat prepared while 6 per cent did not think their formal training had prepared them for their job. This still leaves a significant number without appropriate training for their current work.

Figure 2: Health-Related Training and Years of Experience



Most of these workers have been quite loyal employees. Half (49.5%) have been with their current employer for 10 years or more. This does not necessarily mean they have full-time, full-year work, however. Just over half (51.9%) have full-time employment. Most of the rest work part time (44.5%), while some are employed on a casual basis. Many of these part-time people have more than one job in order to cobble together full-time pay. Twenty per cent (19.9%) of our sample worked at more than one facility. While this means that more than one institution benefits from their labour, it also means that those traveling between sites may carry germs with them and that providers have to work with two different populations.

In sum, this is a labour force that brings both experience and formally recognized skills to the work and to their assessment of conditions in long-term care. Their commitment to their work is evident in their long years with the same employer, even if some have to do more than one job in order to create full-time work. However, some still need additional training in order to meet the skills required by the changes in the nature of care required in these facilities. And there may well be a crisis looming, given that the majority is set to retire within the next 20 years. There has been a great deal of talk about nursing shortages but the shortages may extend to the entire range of workers in care.

“I have been here for six-and-a-half years. And I can honestly say that for about the first two to three years, I really enjoyed my work, but with all the cutbacks and layoffs in the last few years, it has really taken a toll on me and my co-workers.”

Respondent 99310

“I know I can’t speak for anyone else, but all I want is some stability and security in a job...”

Respondent 99310

5.0 Commitment to Residents

Demographic information on age and experience only tells part of the story about this labour force. What we did not ask about was their commitment to care, about why they worked in these facilities and about why they stayed in spite of the conditions reported in the media. However, the answers to these questions were evident in their written comments. What they reveal is a labour force that stays because they care.

In their comments, the respondents to this survey mainly wanted to talk about the gap between the care they want to give and the care they can give. They are committed to providing the best care possible and suffer when the patients suffer because they can see the care deficit that continues in spite of all the providers' efforts to ensure care is there.

They stay in the job in spite of its conditions because they are committed to the residents. One spoke for many when she said: "There are times that I want to change jobs. However I care very much for the elderly and would miss them." (Respondent 99336). The respondents feel torn between work they want to do and work they cannot do. One six-year veteran said "I am 30 years old, living on my own and barely have time for a normal social life." Yet she went on to make it clear she was there because "I enjoy working with the elderly. I feel bad for them. They are getting ripped off. As well, we are over-worked, tired and under-paid. Our residents are not getting the top quality care that they deserve and especially for what they pay for." (Respondent 99310). In the words of another, "I enjoy my job except that it's extremely hard and stressful. This place or home has a dark cloud over it. I would like to see this home shine like it used to." Or as another put it, "I do try and give the best care I can in the time allowed, it's just too bad it's not enough. The residents have the right to the best care." Yet another reported that, "I enjoy my job, the residents and some of my peers. At times my job can be stressful due to working short and no support from management. I feel that at times residents do not get the quality of care these people deserve."

In spite of conditions, these respondents continue to find rewards in their work.

I love my job. These people are like family. It's too bad the Ministry of Health doesn't understand. Maybe they will one day, when they live in a home, require care and don't understand why they can't have what they want right now. It's terrible not having time to spend 5 minutes with someone to say goodnight or good morning. It's always a mad dash from the beginning of the shift to the end of the shift. Hopefully no one from the Ministry of Health will grow old. (Respondent 99339)

One respondent eloquently brought together the twin concerns of worker health and resident care:

Watching my co-workers... try to meet the residents' needs is overwhelming. A

"I loved the elderly before working here at the workplace. But after working with the elderly, I love them more and think they're sweethearts."

Respondent 97032

couple of pairs of extra hands would give these people maybe a little sense of someone cares because then we could spend a little one on one time with them. Being old doesn't mean you don't have feelings anymore or don't get lonely. Or maybe just having someone sit and hold your hand. Shame on our government for treating these people, who have done so much for this country all their lives, to be treated with such disrespect. I hope they realize, one day, they will be old, unable to take care of themselves. Maybe there will not be anyone to take care of them. (Respondent 99299)

In sum, the problem is not lack of commitment among the staff working in long-term care. Rather, it is a lack of attention to both the needs of residents and the needs of the staff. History, and these workers, tell us it is not the nature of the work but rather the way the work is organized that creates the care deficit and health consequences for workers in care. "Because of all these cutbacks, we have to work sometimes doing the job of five people and we're tired and stressed out because there is more work put on us than should be there. All this makes it hard to enjoy the work. I remember the time when we enjoyed our job. Now you have hardly any time to even say hello to the residents."

6.0 Work/Life Balance

Balancing Work and Family Life

Research over the last several decades has demonstrated that paid work can have a negative impact on family life. This is particularly the case for women because they continue to bear the primary responsibility for work in the home. And most of those employed in long-term care are women. However, both women and men bring their paid work home in the sense that it can have an important impact on family life. In light of this research, we asked respondents whether their current job made life at home better or worse and whether it had an impact on their personal life.

More than one in ten (13.2%) said their work schedule often causes problems or makes it quite difficult to complete other activities. But it was in the written comments that the conflicts created by demands at work were made visible.

Several issues related to work-life balance appeared frequently in the open-ended responses. When asked about problems with meeting other responsibilities resulting from their work schedule, difficulty with coordinating childcare was frequently cited. Single parents were not alone in reporting not being able to see their children. Those with shift-working spouses reported difficulty coordinating family time: “[m]y husband and I both work shift work. It often causes problems with babysitting schedules for our son. It’s very rare that all three of us are at home together.” (Respondent 99348) Elderly parents, also in need of care, create other work schedule issues. Some respondents reported the dual challenges of scheduling work around child and parental care responsibilities. Others who frequently work weekends noted problems with meeting their own spiritual, personal and social needs. One respondent (99286), in checklist fashion, noted her work schedule causes problems for the following “other” responsibilities:

- ☞ Younger child at home
- ☞ Sick father
- ☞ Dependent neighbour’s spouse has recently passed away
- ☞ Working husband

Clearly, her care work does not end when her shift does. According to Lesley Doyal, “[w]orkers who have direct responsibility for the fate of others often report more distress than those dealing only with the manipulation of inanimate objects.” The stress increases along with the workloads. Indeed, worker after worker wrote in “stress,” “child care” and “my relationships” in response to the questions about work schedule and other responsibilities and whether the job has any other influence on their personal life. Liz Lloyd notes that, for people who do care work, “[t]heir stress is exacerbated when

“I am scheduled 3 out of 4 weekends and have little family time as a whole. I want to pick up extra shifts; they tend to fall on my weekend off, therefore I get no weekends off with my family.”

Respondent 99333

they are unable to provide a good standard of care because of inadequate resources.” The workers in this survey substantiate her claim.

Tiredness was another recurring theme in response to this question. As one put it, “I find most days when I am finished I am exhausted both physically and mentally. It is hard for me to do things outside work as I know there is another day of work tomorrow.” Another said it somewhat differently. “Because of low morale and harder workload, I have no energy and enthusiasm at home.”

Not all the responses were negative. The most typical positive responses were related to the benefits of working with seniors. For example, “It has given me a better outlook on seniors and how someone can make a difference just by a touch or a smile.” However, even these positive aspects of the work are being undermined by the increasingly heavy workloads. The following quote sums up the responses of many: “The job does provide good experiences. But on a stressful day I go home tired and irritable. Home life can suffer.”

Work Schedule

The difficulty of balancing paid work and family life is made worse by scheduling. Of course shift work is necessary in care so there is some inevitable disruption. However, there are choices about when and how shifts are scheduled, choices that could make paid work more compatible with individual personal lives. Moreover, research by Karasek and Theorell and others have demonstrated that lack of control over work has a negative impact on worker’s health.

It is for these reasons that we asked employees about their schedules and the control they have over them. We found that work schedules are highly structured by employers, and it is difficult to switch shifts. Nearly 40 per cent (38.8%) report that their work schedule is decided wholly by their employer or manager and that they lack choice about how their schedules are organized. A further 41.2 per cent report that they are able to make small changes to their schedule once it has been decided on by their employer or manager. Given the way that work schedules are typically set, it is not surprising that work and life commitments are sometimes at odds.

Workers’ own health care needs can fall victim to inflexible schedules. Many respondents cited difficulty scheduling and/or making scheduled appointments with doctors and dentists without scheduling holiday days to ensure protected time. Others reported repeatedly missing outings with family and friends as a result of consistently working three out of every four weekends. Many of these same respondents complained of difficulty with trying to trade shifts to accommodate personal obligations.

Nor do they have much control over shift changes. Yet work schedule changes, especially those that are accompanied by layoffs, can have multiple impacts on people’s work satisfaction, work role(s) and personal lives. As

“The job has influenced my life as far as extreme tiredness due to workload. It was not like this when I started 10 years ago. As well, we have had in the past 2 years I’ve been there, 3 schedule changes due to lay-offs. This has disrupted many lives of the employees as the schedule changes affect the holidays they have applied and planned for, as well as routine within our lives. There is extreme uncertainty in whether or not you will be working in the future there.”

Respondent 99307

the quote that introduced this section illustrates, shift changes can have a negative impact on both personal lives and individual health.

Even though less than half of the respondents indicated that they work part-time (44.5%), when asked about the previous seven-day period, 64.1 per cent said they worked less than 40 hours, while 27.7 per cent worked between 40 and just under 60 hours. Thus employees lack choices not only in scheduling shifts, but also in deciding how many hours they work. Up to two-thirds have fewer hours than they would prefer while more than a quarter work more than the hours of a usual work week. This means some do not have enough money to live on while others do not have enough time to live.

Both the way work is scheduled and the lack of control over schedule have an important influence on the health and home life of providers. While shifts are necessary in care, the lack of choice over how shifts are organized and assigned is not.

Workloads

Lack of choice in scheduling is linked to the lack of staff and workloads. It is harder to give people alternatives when resources are already at a minimum. Indeed, the woman whose quote begins the previous section on scheduling went on to say:

The pressure at work is also evident, as many duties are being downloaded as nursing aide duties (i.e. we had a recent cut in our activation department, laundry and kitchen staffing). As such, nurses aides will now be required to assist with activation of residents (i.e. walking exercises). We are required to serve dining rooms at meal times and put away all residents' laundry and linen daily. This is difficult as there are many residents who require additional assistance, "extras," as we call them, and we are simply not able to meet that need, which is a stress on the resident, as well as on us. Other than basic personal care that is about all that is available for residents now. (Respondent 99307)

It is clear from the research that has been done on reforms in long-term care that workload is the central issue in both patient care and provider health. As Monique Smith's report clearly states, "Both the public and the industry view nursing and personal care hours (staffing) as a proxy for quality care." We would add that staffing in dietary, housekeeping, laundry and maintenance is equally important, as is the quality of life for providers. This is why we included questions about workload in the survey.

The responses are uniform. Workload has increased to the point where both care and workers' health are suffering. One simple sentence by a respondent perfectly sums up not only her own enormous workload pressure but also that of all those employed in long-term care: "56 rooms to clean, 16 bathrooms, 2 tub rooms on first floor, 2 tub rooms on second floor in 8 hours." (Respondent 99312, emphasis ours) From this spare list we can see how enormous and daunting her task is and how dangerous it is to all

"We are always supposed to have 2 staff for transfers, but most of the time, we do it alone because our partner is busy or on a break. There are too many residents and not enough staff to meet all of the residents' needs.

Respondent 99339

"...Basic personal care... is about all that is available for residents now."

Respondent 99307

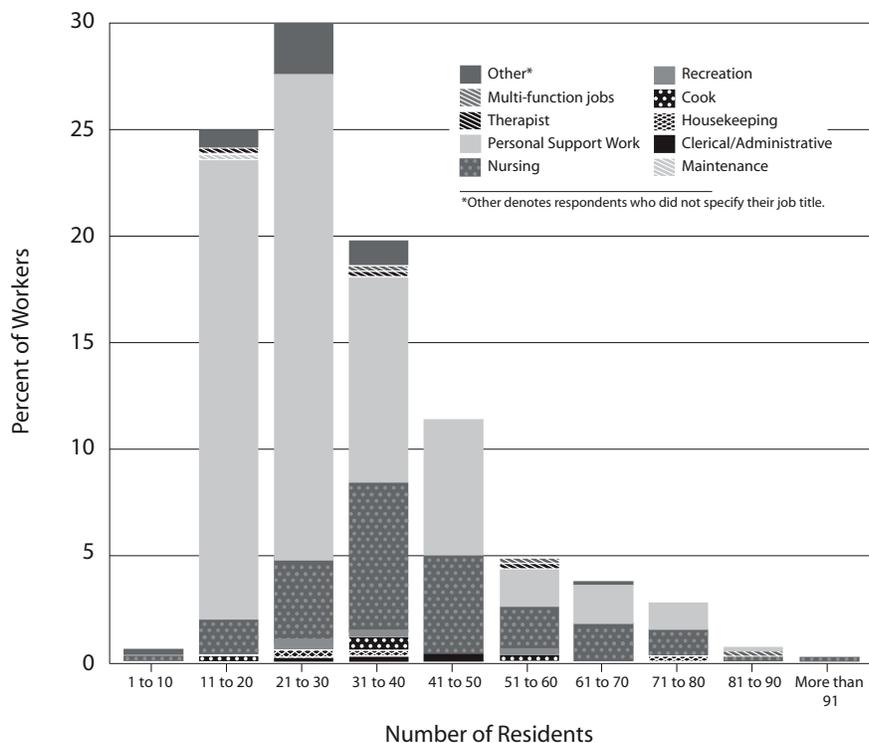
residents, particularly those with one frailty or another, to be surrounded by an environment cleaned in such a hurry. Quite simply put, improper hygiene in a long-term care facility is a life-threatening issue because residents live with immune-compromised systems. Saving money by skimping on cleaning – and maintenance and dietary staff for that matter – in no way contributes to residents’ health and well-being.

When asked how many different residents they had worked with on their usual morning shift, an amazing 10 per cent (10.5%) reported they had worked with between 40 and 70 and 7.4 per cent said they had worked with more than that. Another 10.9% had worked with between 30 and 40 residents. It must be remembered that the morning shift is the heaviest because it involves getting people up, dressed, fed and perhaps washed.

Afternoon shifts change the distribution somewhat. While, for example, 23 per cent (22.8%) report working with between 1 and 10 residents in the morning, this is the case for only 16 per cent of those in the afternoon shift. One in five work with more than 40 patients in the afternoon. By the evening shift, only 11.7% are assigned to between 1 and 10 residents.

Figure 4 shows that most personal support workers dealt with between 11 and 30 workers on their “last” shift. As one nurse so succinctly put it, “So the ration will be one nurse for 32 patients. That is outrageous!” Yet not unusual. Most nurses in our survey cared for between 21 and 50 residents. It is hard to imagine that it is possible to provide adequate care when so many different residents are involved.

Figure 3: Number of Residents Cared for on the Last Shift, by Job Category

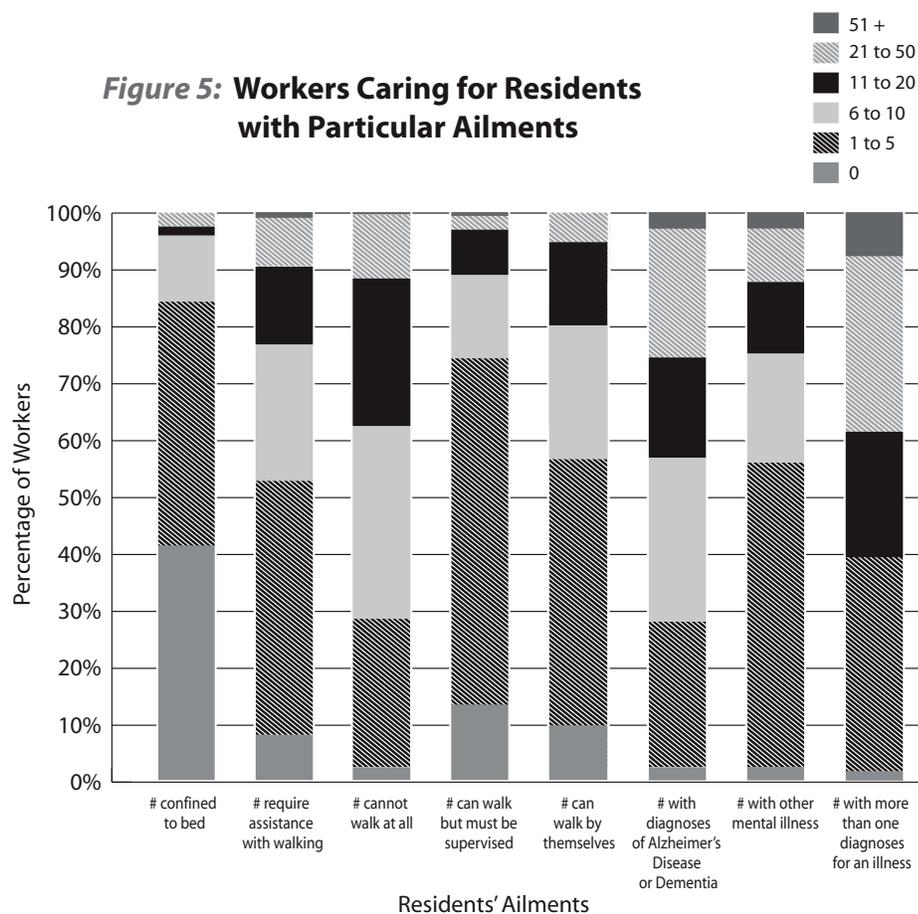


“We have lack of staff. Sometimes we go without workers. We have no time to talk to residents and do the little things that count. We have no social contact with the residents because we have no time due to lack of staff. I would like to see more time with the residents and just taking time out to socialize with them. They are humans and they need contact just like we do.”
Respondent 99340

This is the case in the kitchen as well as in the bedrooms and shortages in one area have an impact on the other. As one nurse explained:

“Too much nursing time taken up doing work in dietary, passing juice, cleaning tables, passing snack cart. Nursing on evening shift in my facility get 3.5 hours per shift for nursing care. The rest is kitchen work, supper breaks and paperwork. Tic sheets are four pages long and it takes 4-5 minutes per shift to do. When floor is in quarantine because of illness outbreak, no extra help is offered. My floor is working three staff for 48 people.” (Respondent 99292)

This nurse raises another issue that appears repeatedly in the comments and that is evident in response to our question on patient needs. Workloads have increased not only because there are fewer staff in all areas but also because each resident requires more care. Most long-term care facilities in the past provided primarily for the frail elderly, most of whom were women. When residents became ill, they went to the hospital. Now, residents are admitted only if they have multiple physical problems or severe mental problems, often combined with physical ones. Yet the staff numbers have declined just as those requiring catheters, intravenous, and with Alzheimer’s, have moved into these facilities. Put simply, “They are heavier and require more care.” (Respondent 99333)

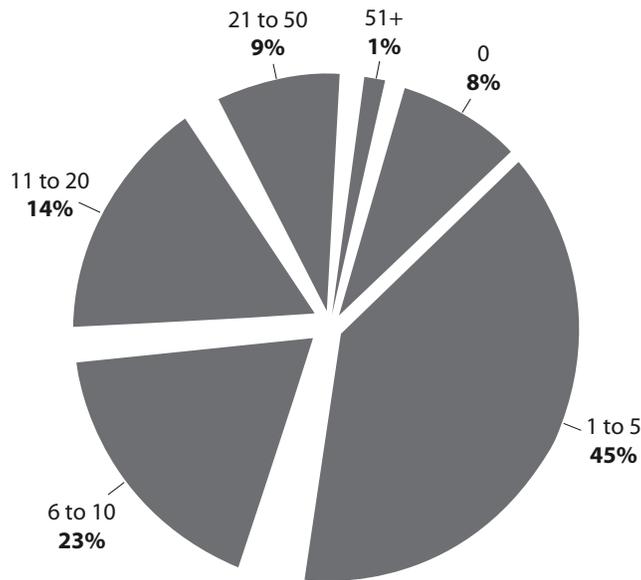


“These wonderful residents we care for 24/7 need more nursing care today, not 10 years from now.”
Respondent 97034

There is a general consensus that individuals entering homes are more in need of assistance than even five years ago. Figure 5 shows the number of residents workers cared for with particular ailments. The majority of workers care for between one and five residents who are completely confined to bed (44.1%), require assistance with walking (45.5%) or can walk but must be supervised (61.4%). Few workers (10%) deal exclusively with patients able to walk by themselves. Many workers deal with between six to 10 residents who cannot walk at all (34%) and/or have a diagnosis of Alzheimer’s disease or dementia (28.5%).

Figure 6: Residents that Cannot Walk Without Assistance

Of residents that you cared for on your most recent shift, what is the number of residents that cannot walk without assistance?



Nearly half of workers report that they care for between one and five residents who cannot walk without assistance. Just under one-quarter (23%) care for six to 10 residents and 14% care for between 11 and 20 residents unable to walk without assistance (Figure 6).

The residents we are admitting now are of much greater need of activities of daily living. They are heavier and require more care. (They are more) “time consuming” and as the time goes by more ... staff (are cut). We don’t have time to “hit chat” with residents anymore because we are on the run, off our feet trying to get our work done. Therefore, we’ve had an increase of work-related injuries, more off sick with stress. (Respondent 99333)

Another respondent also provided concrete examples of the more general issues.

The tasks that are not completed are...due to lack of staff and time. In my unit, there are 32 dementia/Alzheimer residents that require partial to full care. The 32 residents are cared for by 4 Health care Aides. Eighty per cent of these residents are incontinent and require full care. Seventy per cent also do not walk and require more than one staff for transfers. Seven out of ten residents require some kind of assistance at mealtime. Some require full feeding, some require monitoring, and some require partial assistance, and some require intermittent encouragement. (Respondent 99314)

Fewer scheduled staff, combined with residents with increasing needs, is not the only factor contributing to increasing workloads. When staff call in sick, they are not always replaced. Asked about replacements, only a quarter (25.5%) said that their employer always replaced absent employees. Another 40 per cent (41.2%) reported that staff was replaced more than half the time, leaving a third saying that absent providers were replaced less than half the time.

Staff shortages also mean a surprising 40.3 per cent work alone when tending residents. One worker noted the following: “We are always supposed to have two staff for transfers, but most of the time we do it alone because our partner is busy or on a break. There are too many residents and not enough staff to meet all of the residents’ needs.” (Respondent 99339) When asked to reflect on their situation five years ago, overall only 11.7 per cent reported working alone with residents. However, of all nurses and personal support workers, 17 per cent and nine per cent respectively reported doing so five years ago.

The inflexibility of the work schedule and lack of time to do extras for residents are issues tied to worker shortages. Many respondents wrote in comments about how they feel more is expected from them, in less time. Care suffers as a result. One respondent put it this way:

“We probably spend only twenty minutes max with a resident per shift...Also with cutbacks, us health care aides are expected to serve food, put laundry away and do some cleaning while serving the dining room. By the time we get to feed our total care residents, their food is cold. Much to our dismay, the standards are going downhill fast.” (Respondent 99321)

Many also said they exhaust themselves trying to make up for the care deficit.

As well, many workers described their experiences with job layoffs, cutbacks and an overall sense of job insecurity. This was the case even with those who had a great deal of job seniority.

“I work in the kitchen, it’s a pretty busy place at most times. We have had a lot of cutbacks. People (are) losing their jobs after working for 22 years. I myself may lose mine after working for 19 years. Because of all these cutbacks we have to work sometimes doing the job of five people and we’re tired and stress(ed) out because there is more work put on us than there should be. All of this makes it hard to enjoy our work. I remember the time when we enjoyed our job. Now you have hardly anytime to even go to say hello to residents.” (Respondent 99334)

Workplace layoffs also result in (mostly unwelcome) changes in job roles and responsibilities. This is particularly the case when workers are already overburdened.

It is not surprising then that the chief issue registered by respondents is stress and discontent with many aspects of their workplaces primarily caused by workloads. But this is coupled with a real love of the elderly. Inflexible work schedules and the burden of having to do more with fewer hands and less time, combined with a sense that residents are “not getting what they deserve,” likely contribute to the problems of stress, low morale and feelings of lack of support from management. These issues are made worse by the fact that workers, typically women, hold multiple care responsibilities in addition to their workplace responsibilities.

In the words of one worker, “most of the staff work themselves to death because, regardless of how understaffed we are, we don’t want to let the residents suffer because of it.” But the impact on workers is not good. “So we are prone to injury because we rush around.”

Workloads have increased because each person looks after more people, because each of those residents requires more care, because each person is taking on more – and more varied – tasks

and because there are no replacements for the growing number of workers absent as a result of illness or injury. The result is overwork for the workers and, in spite of their best efforts, often poor care. Working overtime to fill shortages may also have deleterious effects. For instance, studies point out that overtime affects nurses' health by increasing the risk of injury – a problem that is more acute with the advancing average age of nurses.

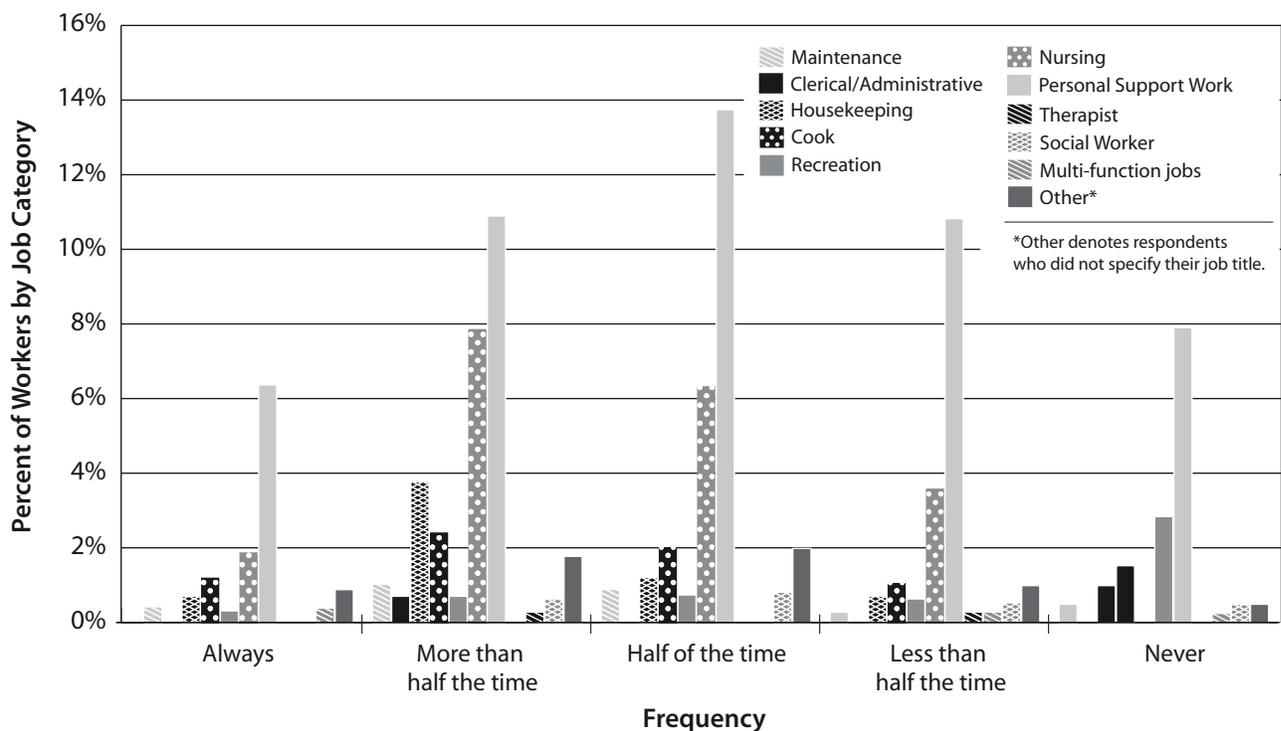
Quality of Life for Residents

Of course, workloads and staffing levels are directly linked to the quality of life for residents. Because they are there every day, employees are in a position to provide an informed perspective on the quality of care. While staffing levels provide perhaps the most important indicator of care quality, written standards are increasingly assumed to provide a critical indicator of care quality. So we asked staff about the written standards and how they are realized in practice.

Three-quarters (74.6%) indicated that their workplace has written standards pertaining to how much time can be spent on a task and how it should be done. But written standards tell us little about either appropriateness or compliance. Thus workers were asked to assess the appropriateness of written standards to meet the needs of residents. The majority of respondents feel either that written standards meet needs of all residents (26.8%) or meet the needs of more than half of the residents (25.5%).

However, heavy workloads mean there is not enough time to complete tasks in a way that complies with standards. Nearly one-fifth (18.1%) report they are able to complete their tasks to established standards less than half the time. Another 14.3 per cent report that they are never able to do so (Figure 7).

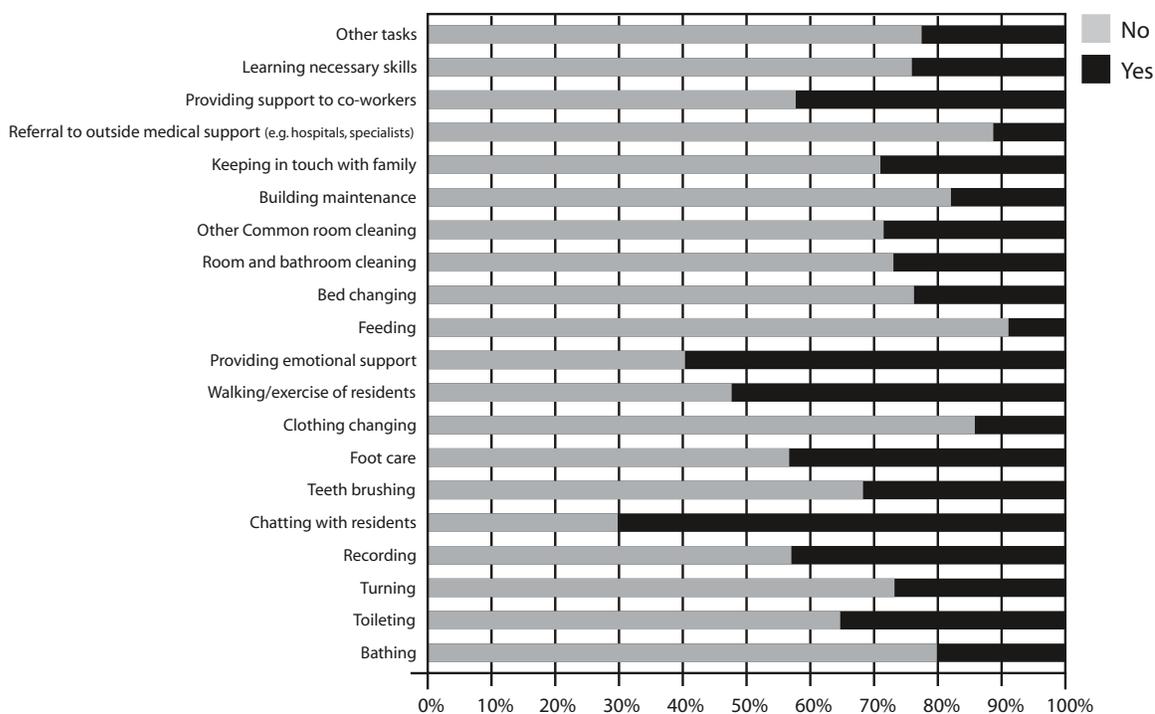
Figure 7: Time to Complete Tasks to Standards



In some cases, tasks are simply left undone. We asked respondents to indicate whether specified tasks were left undone in the seven-day period prior to completing the survey. What we found is shocking and reinforces the claim that the workload is simply too heavy to allow for a safe and healthy workplace for providers or home space for elderly, frail residents.

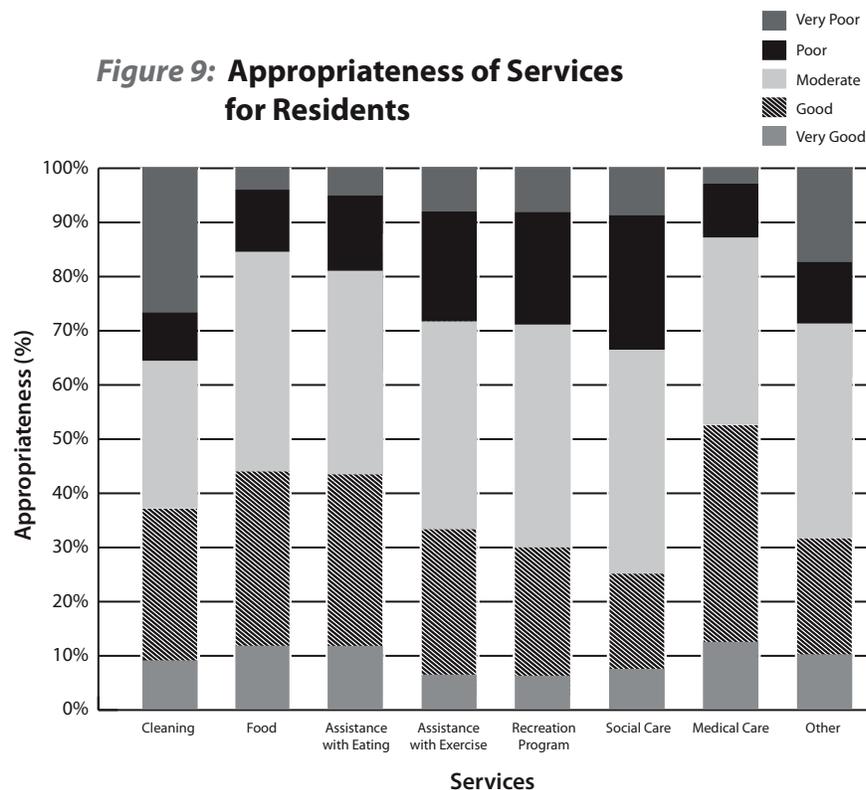
Chatting with residents is the task most frequently “undone” 69.3 per cent of the time (Figure 8). Nearly 60 per cent of the time, workers don’t have the time to provide emotional support (59.8%), while walking and exercising of residents is not done over half the time (52.3%). More than 40 per cent of the time, recording, foot care and providing support to co-workers is left undone. Nearly 30 per cent of the time, common room cleaning and keeping in touch with families is overlooked. More than 20 percent of the time, turning of residents, bed changing, room and bathroom cleaning, learning necessary skills, and other unspecified tasks, remain to be done. Bathing and building maintenance are left undone nearly 20 per cent of the time. Nearly 15 per cent of the time (14.7%), clothing changing is not attended to. Finally, referral to outside medical support is left undone more than 10 per cent of the time. Nearly 10 per cent of the time (8.5%), feeding is left undone!

Figure 8: Tasks Left Undone in Past Seven Days



Respondents were asked to rate which services are appropriate for current residents’ needs. With the exception of medical care services, the majority find that most services are moderate at best and very poor at their worst (Figure 9). Nearly two-fifths (35.8%) reported that cleaning services are moderate, but 15.1 per cent find cleaning services are either poor or very poor. Only 12.3 per cent noted that cleaning services are very good. A majority (55.5%) reported food service as moderate, poor or very poor. Just over one-tenth of respondents (12.2%) felt that food

service quality is currently very good in terms of appropriateness. Services to assist residents with eating were described as poor or very poor by nearly one-fifth (19.1%) while a further 35.7 per cent feel it is only moderately appropriate. Nearly one-third (27.8%) said that assistance with exercise is either poor or very poor. Likewise, nearly one-third (28.9%) consider their facility's recreational program to be either poor or very poor. More than one-third (32%) considered social care is poor or very poor. Only 7.2 per cent thought it is very good. Three quarters (75.6%) find medical care services to be moderate or good, but only 12.7 percent considered it is very good. One-third indicated that "other services" are poor or very poor.



Without doubt, the extreme workload pressures result in tasks left undone.

Worker Autonomy

Karasek and Theorell, among others, have demonstrated that autonomy is critical to workers' health. Workers need to have some control over their own work, not only for the sake of their own health but also so they can adapt their work to the individual needs of residents.

Thus we asked workers about their autonomy in relation to their control over what and how tasks are accomplished. Ontario's nursing homes appear to be highly structured and hierarchical workplaces. We questioned workers about what they do, and how they do it in a day. Nearly one-fifth of respondents (18%) reported that they infrequently or never have control

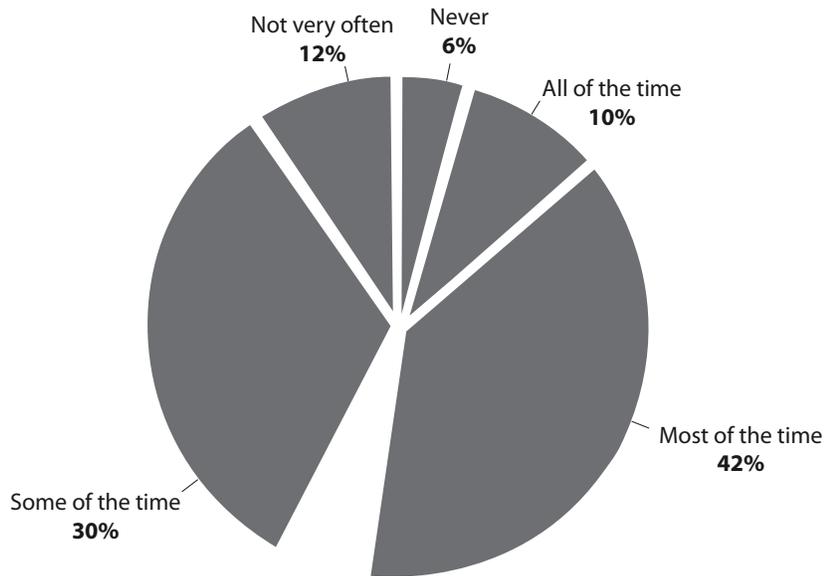
"Ninety-five percent of the time, the employer fails to bear in mind that residents' needs change. They may walk into the home on the day of admission, as time goes by, either they fall or their form of dementia worsens, therefore staff must spend more time with their residents."

Respondent 99319

over what they do during the day. Just over half reported mostly controlling (41.8%) or always controlling (9.9%) what they do. (Figure 10)

Figure 10: Worker Control over Tasks

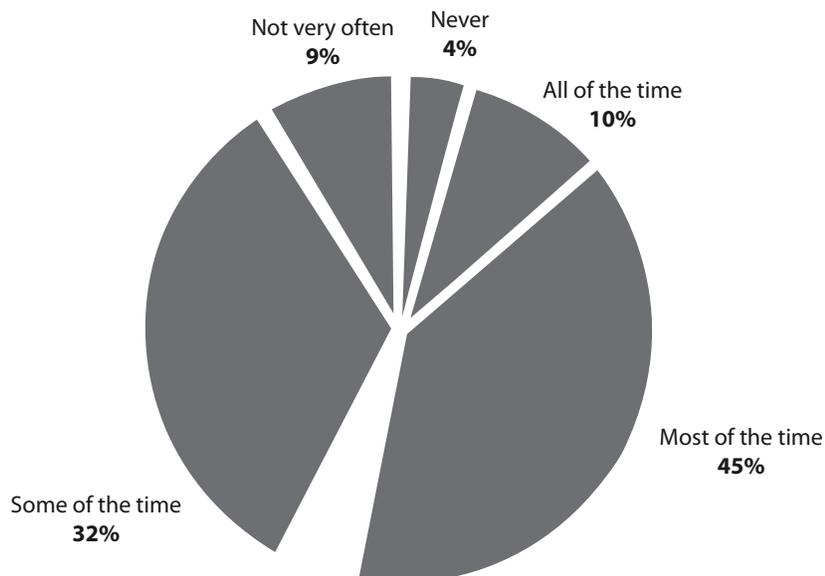
Given the responsibilities of your job, do you have control over *what* you do during the day?



When asked if they retain control over how they do things, 55.2% reported that most of the time or always they are able to make decisions about how to carry out their work. (Figure 11) Fewer reported frequent or complete inability to control how they do their jobs (12.9%) compared with what they do (18%).

Figure 11: Worker Control over How Tasks are Done

Given the responsibilities of your job, do you have control over *how* you do things during the day?



Respondents frequently indicate their enjoyment and satisfaction working with seniors, but consistently cite lack of time to complete tasks to a standard seniors “deserve.” They specifically pointed out a lack of time and hands available to assist residents at meal times.

Directly linked to the question of control is the right to report unsafe practices. If workers can feel confident in reporting unsafe practices they can help protect themselves and the residents. If they do not feel comfortable reporting them, the workers and residents may be at risk. It is reassuring to see that three-quarters would feel comfortable reporting unsafe practices to their supervisor and half to their peers. However, two-thirds would not feel comfortable reporting to an employer. Given that employers have the final say, this is a disturbing response. Only a small minority (14.2%) would feel comfortable reporting to the Ministry of Health and Long-Term Care. Given that the ministry makes important policy and funding decisions, this response may indicate a critical gap in public accountability.

Although we did not ask respondents to rate their managers, multiple comments raised problems with managers. For example, one respondent said managers make “unilateral decisions.” Another reported: “[t]hey have no management skills whatsoever. They have a lack of compassion for staff that work here and the job they do.” Like several others, one respondent emphasized the manager’s failure to understand care work. Managers don’t “understand our workload or understand how hard we work or care at times when we feel a need should be met.” Or as another put it, “There is often unreasonable expectation from management.” More than one thought their managers were burned out from trying to organize the care with limited resources.

We did, however, ask if workers are consulted about changes. Only 8.3% said always while 29.4 per cent checked ‘never.’ A majority (62.3%) indicated that they were sometimes consulted but a number of comments suggested that advice offered in consultation was frequently ignored.

Workers have important experience with the daily practices in care. They are the ones who are there. When employers fail to consult them they lose valuable information on care. When workers do not feel comfortable reporting unsafe practices to those with power, such practices can go unchecked. When workers have little control over their work, their health suffers and, as a result, so does that of those for whom they provide care.

“I enjoy my job, the residents and some of my peers. At times, my job can be very stressful due to working short and no support from management. I feel that at times residents do not get the quality of care these people deserve.”

Respondent 99303

“I wish that when inspectors came in to audit the home they would speak with the workers not management.”

Respondent 99283

7.0 Worker Health & Safety: *Illness, Injury and Violence in the Workplace*

Illness and Injury in the Workplace

Health care is dangerous work. According to the Canadian Institute for Health Information, individuals working in health care were one-and-a-half times more likely to be absent from work due to illness and disability compared with workers in other sectors in 2000. Canada's Health Care Providers (2001) notes higher weekly absentee rates for health care reasons with health care workers averaging 7.2 per cent compared with 4.8 per cent for all other workers. Also, health workers tend to be absent for longer periods for illness and disability (11.8 days on average) compared with other workers (6.7 days on average).

Shamian and Villeneuve (2004) report greater differences in nurses' rates compared with the rest of the workforce than does CIHR. For instance, they note that overtime is highly predictive of increased "lost-day injury claim rates" among nurses. They make three points. First, the rate of RN illness and injury-related absenteeism, which includes sick leave, was 8.6 per cent. This is a much higher rate than the 1987 figure for RNs of 5.9 per cent, compared with the lower rate of 4.7 per cent for all workers. Second, they also report that between the years 1997 and 2002, absenteeism rates for RNs increased by 16.2 per cent. The rate for full-time workers was almost 50 per cent higher compared with part-time workers. Third, the 2002 absenteeism rate for RNs working full time was 83 per cent higher than for the general labour force.

Our survey confirms that health care work contributes to worker ill health. A stunning number (96.7%) in our survey reported having been ill or injured as a result of work in the past five years (1999 – 2003). More than 50 per cent report that work caused illness or injury more than 11 times during this time period.

The vast majority of nursing home workers (65.8%) report suffering from one or more of the following common illnesses or injuries resulting from their work: flu and other communicable diseases (56.7%), stress (53.8%), back injury (50.8%), and arm, ankle or knee sprain (32.4%). Nearly 30 per cent (27.8%) reported other injuries or illnesses (Figure 12).

When asked how many weeks their work has caused them to be ill or injured, almost two-thirds of workers (63.6%) reported illness or injury lasting for six or more weeks in the past five years.

The rising injury and illness rates are no mystery. As one respondent put it, "Staff now are wearing themselves out with stress, shoulder injuries and back injuries." They work harder, faster and often alone because there are fewer people to help. Moreover, "Vacation or sick time are often denied due to staff shortages," further risking the health of both providers and residents. Although it is clear that injury and illness rates are primarily the result of working conditions, "Anytime you injure yourself, you're questioned and

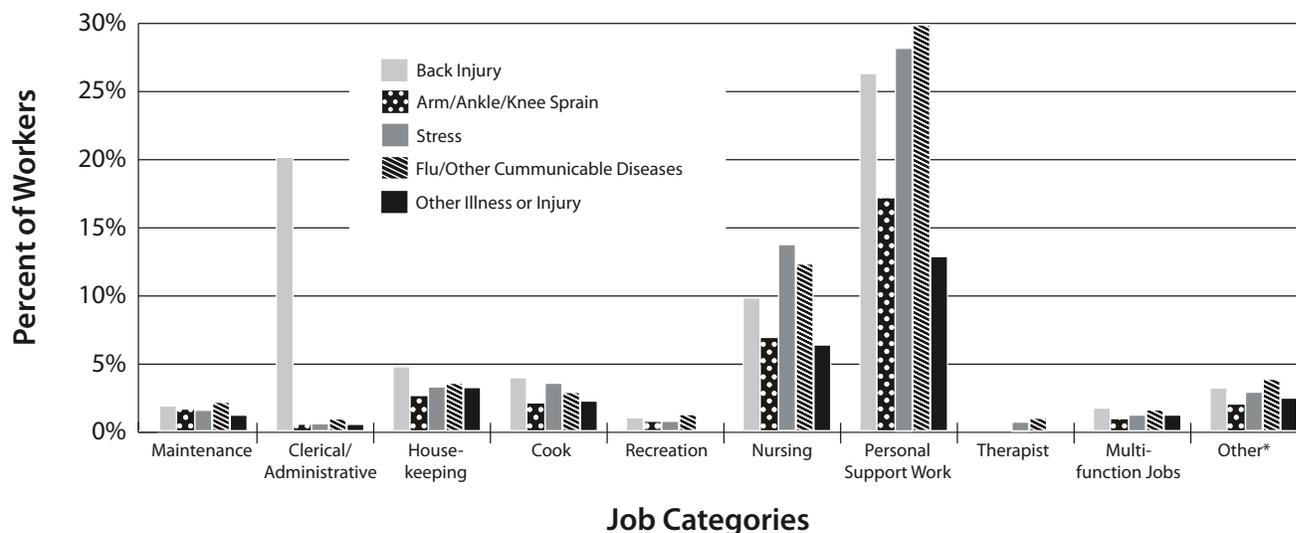
"More health care aides needed per shift. There (aren't) enough workers to fully care for all the residents. Longer hours for housekeeping, rushing too much, and (it) causes injury."

Respondent 99309

"We don't have time to "chit chat" with residents anymore because we are on the run off our feet trying to get our work done. Therefore we've had an increase of work-related injuries, more off sick with stress."

Respondent 99333

Figure 6: Residents that Cannot Walk Without Assistance



made to feel it's your fault." This respondent went on to say, "I wish that when inspectors came in to audit the home they would speak to workers not management. They are clueless about what actually goes on in a home."

Violence in the Workplace

Violence occurs frequently in nursing homes. Attention has recently focused on worker-to-resident violence, shining light on the conditions in long-term care homes, but leaving the suggestion that the only issue is what workers do to residents. Our survey focused on the prevalence of other types of violence, namely resident-to-worker and resident-to-resident violence.

Results show that violence of all types is common and occurs frequently within long-term care homes. Almost all workers (96.3%) indicated that some type of violent incident had occurred in their nursing home in the previous three-month period. The majority of workers (54.9%) reported that some form of violence occurred 11 or more times in the three-month period preceding the survey distribution. Nearly 10 per cent reported daily incidents of violence (8.4%). Within the most recent three-month period, almost three-quarters of workers have experienced some form violence directed at them from one or more residents (73.3%). The highest percentage of respondents (39.7%) indicated that violence was directed at them, from between two to five individual residents over the three-month period.

Over this same time period, the majority of workers (81.2%) have dealt with patients who have directed their violence towards other patients. Just under half of the workers surveyed (43.4%) reported that between two and five residents had been violent towards another resident in the previous three months. As well, nearly half (43.6%) report dealing with between two and five residents that were violent towards a co-worker. In total, more than 80 per cent (82.6%) of workers indicated dealing with one or more residents violent towards a co-worker.

Controlling violence of all types is a key issue that policy makers and employers must address. Improving conditions for residents and for workers in long-term care homes is a necessary first step.

8.0 Work Environment: How Workers Rate the Facilities

The respondents were asked to rate the facilities in terms of how well they meet the current residents' needs. The questions prompted them to answer in terms of specific areas of the facilities and on a scale from very good to very poor.

The hallways, the parts of facilities most visible to visitors, are rated better than other areas. Almost half (48.5%) rated the hallways as either good or very good. Only 17.2% rated the hallways as poor or very poor in meeting residents' needs. While the proportion is relatively small, hallways that are too narrow for wheel chairs, for example, can be a major impediment to care and any poor rating can be understood as a hazard to care.

Stairs seem to be more problematic. Although nearly half (47.0%) rated the stairs as good or very good, almost one in five (18.9%) said they were poor or very poor. Like hallways, stairs can be a health hazard if not appropriately structured to meet the needs of the frail.

Dining rooms are seen as inadequate by a significant number of the respondents. More than a quarter (27.7%) rated the dining rooms as poor or very poor in terms of meeting residents' needs. Only 36.6 per cent thought the dining rooms were good or very good. Given that food is critical both to survival and well-being, as well as often being the high point in a resident's day, poor facilities can contribute to poor health.

Bathrooms are not simply critical to care. They are also places that can produce particular risks or constitute particularly important barriers to care if they are inappropriately structured. More than two-fifths of respondents (41.4%) rated the bathrooms as poor or very poor while only a quarter (25.3%) rated them as good or very good.

Long-term care facilities are residents' home. Dinner is, or can be, a social event but most need help and stimulation for other kinds of activities and social interactions to make their homes not just bearable but also comfortable places to live. Moreover, recreation can provide the stimulation necessary to keep minds and bodies functioning. This is why facilities have recreation programmes. Yet, only a minority of respondents (24.4%) rated their recreation facilities as good or very good. Over a third (28.3%) rated them as poor or very poor. Outdoor recreation spaces seemed particularly inadequate, with 39.3 per cent assessing them as poor or very poor. Similarly, many of the residents are long-time smokers and want their homes to accommodate their preferences. However, 43.1 per cent of respondents say that the facilities have poor or very poor smoking rooms. The ratings are somewhat better for places to meet families and friends. Just over a third (36.4%) rated them as good or very good, with 28.1 per cent rated them as poor or very poor.

The more obviously medically-related aspects of facilities are not rated

“Due to the unreal amount of cutbacks, the rooms look dirty, the food is horrible because it is mostly processed food, and residents that need extra care, are not receiving it.”

Respondent 99321

very well either. Although a growing number of residents have dementia, Alzheimer's or other mental illnesses that require surveillance, less than half the respondents (45.1%) rate their facilities as having good or very good locked areas. Another 23 per cent rate their locked areas as poor or very poor. Only 30 per cent (29.8%) rated the medical equipment as good or very good compared to 27.6 per cent rating it as poor or very poor.

Ventilation also seems to be an important issue. More than half (57.4%) rate the ventilation as poor or very poor while only 18 per cent rate it as good or very good. Clean air and comfortable conditions matter to us all but they are primarily important to those who are already in weakened states of health. Privacy too can be an issue and can be particularly important if residents have special needs or are especially disruptive. Nearly a third (21.6%) thought that facilities rated poorly or very poorly in terms of the availability of private rooms. In spite of the growing number of people in care who cannot walk or need assistance with walking, these respondents say there are not enough appropriate elevators to meet their needs. Well over a quarter (27.8%) rate elevator access as poor or very poor.

Those in our sample are also worried about the standards of services, although some services were rated more highly than physical facilities.

Standards of cleanliness are, in their view, being maintained in a bare majority of facilities. Almost half (49%) rated the cleaning as good or very good with only 15% grading cleaning as poor or very poor. Food services were similarly rated as was assistance with eating. This does not suggest a high quality of life but at least only a small minority ranked these items as very poor.

Assistance with exercise was rated as more inadequate, however. More than a quarter (27.8%) of respondents said the level of assistance was poor or very poor, in spite of the clear benefits of exercise to health and well-being. Only a third (34%) rated such assistance as good or very good. Recreation programs rated just below assistance with exercise, with 30.5% calling them good or very good and 28.9% giving a poor or very poor rating. The ratings for social care were even worse. A third saw social care as poor or very poor at meeting resident needs while only 25.9% rated social care as good or very good. Medical care was better. Indeed, this was the only service that the majority (51.4%) rated as good or very good. However, it is still the case that 11.7 per cent rated the medical care as poor or very poor.

In sum, facilities are not adequate for the needs of the residents and, by extension, for the needs of the employees. According to our sample, bathrooms in particular are a problem, followed by recreation facilities, meeting rooms, smoking rooms and dining rooms. Such facilities are important to health and when they are in poor condition, they can threaten health. Medical facilities, although more obviously connected to health, do not rate much better. Around a quarter rate the medical equipment as well as access to patient lifts and locked areas as poor or very poor. Services are somewhat better rated than physical facilities. The most obviously health related services – cleaning, cooking and feeding – are the most highly rated although 15 per cent define these services as poor or very poor. And, while medical care is more highly rated, none of us would like to be in the facilities where staff say such care is poor or very poor.

9.0 Conclusions

i) Staffing

Like Monique Smith's investigation of long-term care in Ontario, this survey identifies staff shortages as a central problem. Increasing acuity levels, combined with reductions in the numbers of employees, have resulted in overworked staff and under-cared-for residents. Unlike the ministry report, however, this survey also indicated that shortages in every occupational category are critical to care. While shortages in nursing, therapy and personal care staff are important, so too are shortages in laundry, dietary, clerical, recreational, housekeeping and maintenance. Nursing staff end up doing cleaning and feeding if the dietary and housekeeping staff are not there. And housekeeping staff end up doing nursing work if there are no nurses available for care. As one respondent put it, "We are a health team...everyone has a positive contribution to make." Each job is critical to care and cutbacks in one area have an impact on all workers and residents.

This survey also indicated that shortages result not only from the failure to employ enough staff but also from the failure to replace staff members who are absent. Formal staffing levels are low, as Smith makes clear, but actual staffing is often even lower.

Smith's investigation also suggests that more training is required for personal support workers and managers. This survey indicates that the majority of employees do have formal training that is relevant for their current work and this training should be recognized. They also have extensive experience in care that should be recognized as a way of developing skills for care. However, changing acuity levels and resident needs do mean that many could benefit from support for more education programmes. Like Smith's report, many of those writing in comments saw a need for more managerial training not only in directing personnel but also in care.

And like Smith's report, this survey indicates that there will be critical shortages in the future. These future shortages result not only from the pay inequities and poor conditions that Smith and this survey identify, but also from the aging of the workforce. Most current workers are middle-aged and older. Many stay because they remember the days when care was there and hope to see those days return. The rewards come from their commitment to care and their extra work to make up for the care deficit. When this generation retires, the next may be unwilling to take on work that seems to provide few rewards in terms of pay, security or resident satisfaction.

ii) Quality of Life

Like the Smith report, this survey reveals a troubling lack of care. As one respondent so nicely summed it up:

I finally can voice that this LTC system sucks. These residents deserve better. They often get neglected because of our workload and that isn't fair. Sometimes they don't get their baths and have to sit in their urine because we have so many people to care for in a shift. They never get mouth care because we don't have time to do it for them. I would never put my parents in LTC and I would never want to myself knowing the lack of staffing for these poor people. I hope one day it changes. They deserve better care! We can only do what our time allows.

In addition to the lack of baths, appropriate food and recreation identified by Smith, this survey also revealed fundamental inadequacies in the physical environment. According to these workers, stairs and dining rooms, bathroom and recreation spaces are too often inappropriate for current care needs or simply inadequate and sometimes even dangerous. But perhaps the most important lack identified by this survey is social and emotional support. People need providers who have time for chatting, walking and exercising as well as hair, foot and mouth care. These supports are as important to health as direct nursing care. Yet they have been, for the most part, defined out of the time available for providers to do their jobs.

Unlike Smith, this survey also explored the quality of life for workers. It revealed alarming rates of violence among residents and against workers and of both illness and injury. The combination of rising acuity, inadequate staffing and facilities create conditions that are dangerous for workers' health.

Not surprisingly, these conditions in long-term care have a negative impact on workers' personal lives. Given that most of these workers are women, they go home at night to another job. But their comments reveal how difficult it is to do this job when they are tired and stressed from their paid work. One listed the following as influenced by her job: marriage, family well-being and personal time. These workers have "little family time" and when they do have time, they are "always fatigued." They are "too tired to do some things after work but have to do them anyway."

Stressed at their paid work, they are stressed at home. Stress in either place promotes poor health.

iii) Standards and Compliance

Like Smith's report, this survey indicates that standards are both too low and too minimally enforced. This applies to everything from resident care to physical environments, from staffing levels to nutrition and recreation. There is too much work and too little time to care. Inspections happen infrequently and inadequately, as Smith suggests. But these workers also say that governments do not listen and that inspectors fail to meet with the workers when they seek advice on the services.

iv) Accountability

Like Smith's report, this survey suggests that there is little public accountability in long-term care. The majority of these respondents would not feel comfortable reporting unsafe practices to their employer and almost nine out of 10 would not feel comfortable reporting such practices to the government.

Unlike Smith's report, this survey also asked about workers' autonomy and the extent to which workers are consulted. A majority say they do not have a say in their schedules and just over half have control over what they do, when or how they do it. Yet autonomy is known to be a critical component in health and both the workplace and the residents could well benefit from their knowledge.

In short, this survey reinforces many of the observations set out in the Smith report. However, it also identifies absences. The Smith report focused on only one side of the long-term care population. This report focuses on the other. It identifies some of the conditions that are

¹ Pay Equity Task Force Final Report, *Pay Equity: A New Approach to a Fundamental Right*. Ottawa: Department of Justice Canada, 2004, p.221.

² Pat Armstrong, Laura Sky, Ellen Long, Hugh Armstrong, Jacqueline Choiniere, Eric Mykhalovskiy, Jerry P. White and Ivy Bourgeault, *The Consequences of Government Policy Changes in Long Term Care in Ontario*. A report prepared for the Canadian Union of Public Employees and the Service Employees International Union, Toronto, July 1997.

³ Pat Armstrong, Irene Jansen with Mavis Jones and Erin Connell, "Assessing the Impact of Restructuring and Work Reorganization in Long-Term Care". pp. 175-217 in Penny Van Esterik, ed. *Head, Heart and Hand. Partnerships for Women's Health in Canadian Environments*. Toronto: National Network for Environments and Women's Health, 2003

⁴ Commission on the Future of Health Care in Canada, *Building on Values. The Future of Health Care in Canada* (Romanow Report) Ottawa: Commission, 2002.

⁵ Monique Smith, *A Commitment to Care: A Plan for Long-Term Care in Ontario*. Ministry of Health and Long-Term Care. Toronto: Spring, 2004

⁶ Pay Equity Task Force Final Report, *Pay Equity: A New Approach to a Fundamental Right*. Ottawa: Department of Justice Canada, 2004, p.221.

⁷ This survey does not include responses from managers or owners of nursing homes.

⁸ No data were collected in the large, municipal category.

⁹ Doyal, L. *What Makes Women Sick*. New Brunswick, New Jersey, Rutgers University Press, 1995 p. 165.

¹⁰ Lloyd, L. *The Wellbeing of Carers: An Occupational Health Concern. Health and Work Critical Perspectives*. N. Daykin and L. Doyal. London, MacMillan Press, 1999.

¹¹⁻¹² R. Karasek and T. Theorell, *Healthy Work: Stress, Productivity and the Reconstruction of Working Life*. New York: Basic Books, 1990

¹³ Monique Smith, *A Commitment to Care: A Plan for Long-Term Care in Ontario*. Ministry of Health and Long-Term Care. Toronto: Spring, 2004, p.21.

¹⁴ J. Shamian and M. Villeneuve, "Better Working Conditions: Meeting the Growing Demand for Nurses", Health Policy Research Bulletin, Issue 8. May 2004. Available at: <http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/rmdd/bulletin/ehuman.html>

¹⁵ R. Karasek and T. Theorell, *Healthy Work: Stress, Productivity and the Reconstruction of Working Life*. New York: Basic Books, 1990

¹⁶ Canadian Institute for Health Information, *Canada's Health Care Providers*, 2001. Available at: www.cihi.ca

¹⁷ J. Shamian and M. Villeneuve, "Better Working Conditions: Meeting the Growing Demand for Nurses", Health Policy Research Bulletin, Issue 8. May 2004. Available at: <http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/rmdd/bulletin/ehuman.html>



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