A PROMISE BROKEN

CUPE Ontario's analysis of Shirlee Sharkey's long-term care report

Ontario needs minimum standards of care in nursing homes that give seniors the "dignity and respect" they deserve, Premier Dalton McGuinty says…Legally binding minimum standards of care could be in place within three months of the next government taking office, thanks to legislation the Liberals passed earlier this year, Smitherman said.

- Nursing home changes coming, McGuinty says, *Toronto Star*, October 5, 2007

"We are not recommending that there should be a regulation under the Long-term Care Homes Act 2007 that provides a provincial staffing ratio or a staffing standard."

- *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes*, Shirlee Sharkey, June 2008, page 9

CUPE SCFP Ontario

Overview

In *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes*, government-appointed facilitator Shirlee Sharkey was mandated to propose a comprehensive health human resources framework for long-term care facilities. Instead, the report contains an overt rejection of the minimum care standard regulation advocated by CUPE Ontario and all of the major health care unions and community groups involved in long-term care homes. The report provides little to replace a minimum care standard.

In fact, Sharkey goes beyond rejecting the care standard regulation to reject the notion of a strong provincial approach to all aspects of human resources planning, enforcement and regulation. She proposes several unclear initiatives that will actually delay the achievement of a regulated staffing standard, proposals that might be worse than what is currently in place. These proposals include vaguely attaching funding to "outcomes" rather than enforceable standards of care; increased funding with "guidelines" as opposed to regulations, compliance and enforcement; and committees for each long-term home whose task will be to come up with plans regarding health human resources and levels of care for their own home.

The report makes no concrete recommendations and proposes no provincial strategy to improve staffing shortages – these are all downloaded to the individual homes' committees. There are other crucial aspects to rejuvenating the long-term care sector that are notably absent from this long-awaited report, and, unfortunately, the list is long. Omissions include: no regulations or enforcement to improve hours of care; no improvements for training, education and credentials; no improvements in workplace safety; no recognition of high rates of violence, accident and injury; no concrete proposals to improve working conditions and access to supplies; no restrictions on downloading of more acute patients; and no improved access to information.

Finally, Ms. Sharkey has changed the types of staff calculated when determining care measurement to include allied health professionals. This has confused the media – leading to stories that she is calling for 4 hours of care – and will not work in favour of increasing access for residents to either the daily care staff (RN, RPN, PSW) nor the allied health professionals.

Perhaps the only slightly positive aspect of this report is that Sharkey supports increasing nursing and personal care up to 3.5 hours (as a ceiling, not an average) but, again, without calling for enforcement or regulation. In fact, prior to this report, the government had made public its intention to get the homes up to 3.25 hours of nursing and personal support as an average by the end of this term in government. So Ms. Sharkey's recommendation may provide an escape from even this promise.

The McGuinty government has announced that it has adopted all of Ms. Sharkey's recommendations in principle. Ms. Sharkey is now heading an "implementation committee" to implement her report with limited labour representation.

What CUPE wanted & what Sharkey recommended:

CUPE Ontario proposed:

1. Regulate the facilities with a minimum staffing standard contoured to case mix – requiring them to provide 3.5 hours of daily hands-on care for an average acuity home, with increases of care for those in higher acuity homes, and less care required for those in lower acuity homes.
2. Create special care units for those with cognitive impairment and/or behavioural problems staffed with an adequate number of staff trained to work with residents with these high needs.
3. Improve access to employment in long-term care homes by recognizing experience as qualifications and by eliminating the food services course requirement, which is prohibitively costly.
4. Recognize and take seriously the high rates of violence, accident and injury in long-term care homes. Take measures to reduce these – in addition to the regulated minimum care standard.
5. Other workplace improvements, such as improved access to supplies (stop rationing incontinence products); replacement of staff who are absent; time to talk with, connect and support residents and their families.
6. Consult on the new classification system, including getting feedback from CUPE.
7. A provincial funding model, attached to the regulated staffing standard, to provide clear provincial standards across all LHINs with improved transparency and accountability.

Sharkey recommended:

1. Sharkey recommends *explicitly against* a minimum staffing standard. She proposes that funding be increased with "guidelines" as opposed to regulation, compliance and enforcement. She suggests that care levels increase *up to* 3.5 hours (not as an average and with no enforcement).
2. No mention of special care units, no concrete measures to deal with the influx of residents with cognitive impairment and/or behavioural problems.
3. No provincial staffing plan and no concrete measures or proposals to improve access to employment and training. Responsibility for dealing with shortages is downloaded to committees to be set up in each home, despite the fact that they have no power over provincial funding levels and do not have the power to increase the pool of available staff.
4. No mention of high rates of violence.
5. No mention of improved access to supplies or replacement of absent staff. She does mention improving time to spend with residents but provides no concrete measures that would enable this to happen.
6. No consultation on the new classification system.
7. Vague suggestion that funding be attached to outcomes, without specifying what those outcomes might be and how they might be attached to funding. In general, the report is based on a clearly anti-regulation approach and a strong anti provincial-standards approach. No proposals to increase transparency and accountability.

We Need *More* Accountability, Not Less

Ontario's long-term homes sector is now owned and operated by a majority of for-profit corporations, a number of which are multinational companies with histories of extremely poor practices in the United States as well as Ontario. It has been the trend across the United States – particularly in the Clinton era with some rollbacks under George W. Bush – to improve accountability and regulation of the homes in response to scandals, preventable deaths and poor practices, similar to those that have been widely reported in Ontario.

Shirlee Sharkey's recommendations call for increased funding to the homes, without more rigorous accountability – chiefly a minimum care standard regulation and enforcement of that standard. She recommends devolving responsibility for improving care levels to individual homes and creating committees to discuss issues related to human resources and care levels.

Instead of regulation and enforcement, she proposes resident and family satisfaction surveys, despite the fact that more than 70 percent of all residents have some form of cognitive impairment, and an untold number do not have family support. While rejecting outright a connection between required staffing levels and improvements in care, Ms. Sharkey suggests that a more difficult-to-prove connection be made between funding levels and outcomes (without specifying what these outcomes might be). The prospect that these methods will hold homes accountable is undermined by the government's announcement, upon the release of the Sharkey report, that the Ontario Health Quality Council – not the Ministry of Health and Long-term Care – will be mandated to report on the sector (without specific requirements in that reporting) rather than improved transparency and accountability for the Ministry of Health and Long-term Care.

In recent years, enforcement of improved levels of daily care in Ontario's long-term care homes has relied upon the envelope funding system and supporting regulations. Of the four envelopes of funding available to the homes, facilities are allowed to take profit only from the accommodation envelope – into which flow provincial per diem funding and residents' fees for their beds. The homes have responded by making more room for profit by shifting costs out of that funding envelope into the Nursing and Personal Care envelope which is meant to fund the daily care (RN, RPN, PSW) for residents. Items like incontinence products, security systems and others have been moved to make room for profit-taking. The provincial government has not forced homes to move these costs back into the accommodation envelope. Ms. Sharkey made no recommendation to stop these practices.

In addition, our members have complained in many homes that numbers of management staff – who do not provide hands-on care – have been increasing disproportionately in recent years. We raised this issue repeatedly. Ms. Sharkey made no recommendation to limit this.

Although the province has increased long-term care homes funding by more than $1 billion since the McGuinty government took office, recent figures revealed through a Freedom of Information request show that hours of daily hands-on care have not

increased since 2005 – even using the measures of hours of care reported by the facilities themselves.

The Sharkey approach – a total rejection of provincial standards, compliance and enforcement regimes – is based on the assumption that homes will work in partnership with stakeholders to increase care levels on their own without actual requirement to do so. Sharkey suggests increasing funding with "guidelines" rather than regulations, compliance and enforcement regimes. On an individual home level the absence of regulations leaves no enforcement mechanism whatsoever. The recommendations do not increase provincial government accountability for improving care.

Myth Versus Fact

Sharkey asserts that studies provided limited evidence on staffing standards and links to quality of care (pp. 9). This is untrue.

- The major "best practice" research, conducted by the U.S. Health Care Financing Administration, used a decade of concrete evidence-based research – including multivariate analysis and time motion studies to correlate exact levels of care (to the hour and minute) by each of the daily hands-on care classifications to specific health outcomes – to recommend specific hours of care that reduce harm and improve quality outcomes.
- We provided Shirlee Sharkey with additional studies plus the Coroner's Jury Recommendations in the Casa Verde inquest that link hours of care to outcomes, including specific hours of care that lead to measurable decreases in injury rates for nurses and support workers. CUPE also presented evidence-based relationship between staffing levels and quality of care as measured by a number of outcome indicators.

Sharkey suggests that if "available resources" were used to increase staffing and care levels, other areas such as staff education, leadership development and team building would be affected (p. 9).

- This implies that "available resources" are not already allocated to increase staffing and care levels every year based on measured acuity (measured resident need). Yet, according to a formula arranged between the MOHLTC and the facility operators, funding is increased every year based on the measured increase in acuity, ostensibly to improve care levels to meet higher need. However, though the money goes up every year, the care levels are not increasing. There is no requirement for increasing care levels as a pre-condition for the increased funding. Available resources are already being flowed to the sector – more than $1 billion (according to former health minister George Smitherman) since the McGuinty government took office. But they have not resulted in any measured increase in care levels since 1995. In fact, care levels dropped in 1996, recovering to 1995 levels in 1997 according to the government's figures.
- In the end, unless the funding formula is changed (and so far, neither Sharkey nor the Ministry have recommended this) we will be paying for an average 3.5 hour care level but will not be receiving that level of care.

Sharkey holds out complaints about paperwork to recommend against standards and compliance, but then applauds the new RAI-MDS 2.0 assessment tool (which, though CUPE supports it with the caveat that it requires consultation on the evaluation of the pilot projects, requires much more charting and paperwork). She makes no recommendations to reduce less important paperwork or to prioritize administrative reporting. She simply uses this to support her rejection of daily care standards.

- Staff are complaining that they are "charting for dollars" since the weighty charting requirements are used to measure increases in acuity to get more funding for the homes but are not tied to increases in actual care. Thus, charting has resulted in annual funding increases, but actual daily care levels remain stagnant.
- Since staff already chart for acuity and homes already have to report actual staffing levels (and there is no proposal to change these requirements), it is hard to see how a standard would place prohibitive additional paperwork requirements on homes.

Debunking Key Recommendations

Sharkey suggests a number of initiatives that are light on detail and clear planning steps, including:

1. **Provincial "guidelines" (unspecified) to support funding increases over the next four years.**
    - But the MOHLTC already issued a directive to facilities to increase their staffing levels. It is hard to imagine how a "guideline" approach with no teeth – no compliance and enforcement – would achieve what this directive has not.
    - The MOHLTC, through the Local Health Integration Networks (LHINs), already has Accountability Agreements (formerly Service Agreements) with each long-term care home. It is not clear if this "guideline" approach might be less than what is already in place.
    - This approach to enforcement is lax, given the experience in Ontario's long-term care homes and in the for-profit chains in other jurisdictions. To date, the nurses are reporting a failure to enforce the regulated requirement for an RN to be present 24/7, and 98 of the 603 homes have failed to report their actual staffing levels, according to the government in the latest response to a Freedom of Information request on care levels. In the U.S. this information is available on a home-by-home basis on the web. In Ontario, this information is not being provided openly by the Ministry – successive Freedom of Information requests have been required to obtain it.

2. **Development of annual staffing plans at each long-term care home – including an unspecified process for input from staff, residents, families and LHINs.**
    - The MOHLTC used to require homes in their Service Agreements to report on staffing levels, to adhere to planned or budgeted levels of staffing

(eliminated by the Harris government) and to increase the average staffing per resident as a condition for eligibility for new funding (eliminated by the McGuinty government). Thus, Sharkey's report recommends less accountability than was previously in place.
    - Sharkey does not elaborate on what these "staffing plans" might achieve since the homes will simply claim they don't have enough money to increase staffing. And potentially use these meetings to campaign for more funding with no accountability as they have been doing for years.

3. **Annual evaluations to "validate" that funding is addressing resident care needs and to inform decisions about staff enhancements.**
    - This is substantively less than CUPE's recommendation for inspections to ensure that homes are compliant with required staffing and care levels. Inspection compliance reports have an escalating process to ensure enforcement. This unspecified evaluation process – based on an RNAO framework that would have to be re-written to fit the context of long-term care homes – does not.

4. **Provincial guidelines designed to achieve up to 4 hours of care per resident per day over the next four years.**
    - This "4 hours" is very deceptive. It includes allied health professionals plus personal support workers, registered nurses and registered practical nurses (PSWs, RNs and RPNs). There appears to be no justification in the literature for changing the regular measure of care per resident per day to include these classifications. This is unwarranted, since no jurisdiction measures allied health professional hours/day in a daily-care staffing standard (because the need for social workers, therapists and so on is highly variable).
        - Though CUPE supports improving access to these important health professionals, they do not belong in a daily care measure. This inclusion will not improve access to daily care nor to allied health professionals' care, in fact it is more likely to achieve the opposite. The report includes no clear proposals to improve access to allied health professionals.
    - According to Statistics Canada, Ontario was at 3.8 hours per resident per day for total long-term care staff in 2005-06; the second lowest level in the country. Though many different staffing categories are important, daily hands-on care is provided by only a portion of those staff – the RN/RPN/ PSW. According to CUPE Ontario research, staffing standards in homes located across the province indicate a hands-on standard of care between 1.9 to 2.7 hours per resident per day. The staffing standard CUPE called for is an average – tied to acuity – of 3.5 hours of care provided by RNs/RPNs/ PSWs, specifically because these are the hands-on daily care staff who provide turning, feeding, bathing and other care functions for daily living. These staff are covered by the nursing and personal care funding envelope, and these are the staff covered by daily care regulations in all other jurisdictions. The reporting that the MOHLTC has been using for several years includes the same range of staff, plus a minute amount of time for Nurse Practitioners. There are already staffing standards for the following classifications in Ontario: Administrator; Director of Nursing; Food Services

Supervisor; Therapy Services Coordinator; Registered Dietician; Recreation and Leisure Services.
    - Sharkey also asserts that with the new staff announced (but not yet flowed) the number of hours will increase to 3.5 hours. Again, this number inappropriately includes allied health professionals. It also appears to be based on the existing number of beds divided by the total number of staff (including announced new staffing that has yet to materialize) but fails to take into account the bed increase which totals, according to the health minister today, another 2,500 beds that are announced but not yet on stream. Thus, this number is likely incorrect.
    - Linking resources to resident outcomes by developing quality measurement tools and satisfaction surveys.
    - It should be noted that, by the figures used in Sharkey's report 73% of residents have some form of cognitive impairment, including Alzheimer disease or dementia, and the utility of resident surveys is constrained by this reality.
    - There are no concrete proposals for what "quality measurement tools" might be developed, but it is clear that actual standards with enforcement and compliance regimes as we have repeatedly recommended are specifically rejected in Sharkey's recommendations.
    - It is not clear what "linking resources to resident outcomes" might mean.

What's Missing

- There are no concrete proposals to deal with severe shortages across several staff categories, including PSWs and other support staff, nurses, health professionals and doctors. These shortages exist in all areas of the province and leave homes working "short staffed" regularly. They are a serious barrier to improving quality of care. This is a provincial policy responsibility and requires a clear provincial health human resource plan. The report calls for strategies to be developed to improve recruitment and retention without giving any actual proposals (we thought that was what Shirlee Sharkey was supposed to do) and leaves individual homes and regions to strategize about how to deal with the shortages, amounting to the status quo.

- There are no concrete proposals to improve reporting about actual care levels, nor to ensure concrete accountability for increased funding. The MOHLTC press release states that the Health Quality Council will be "tasked" with reporting on quality of care and resident satisfaction. It is the government, not the Health Council, that is accountable for reporting on care levels and compliance and for ensuring that funding reaches its intended goals. This provision should not be used as a means to reduce government reporting and accountability for actual daily hands-on care levels in the homes.

- To date, the Ministry itself is not keeping its undertaking to report publicly on staffing levels. A very critical Provincial Auditor General's report was required to force the government to require homes to start reporting on actual care levels after the Harris government removed this regulatory requirement. Under the McGuinty

government two “Freedom of Information” requests have had to be filed to obtain information that the government collects on actual care levels. The June 2007 report indicates that 98 of 603 homes failed to report their staffing levels. For the 22,000 of 75,000 residents now covered by the new resident assessment system (calls RAI/RUGSIII), data on their measured care needs is not being released. The Sharkey report provides no assurance of any improvements to transparency that could provide greater accountability.

- Though the report recognizes the increasing acuity of residents, it neglects to propose any clear recommendations to prevent downloading of patients with care needs too great for homes to meet. It does not propose any concrete steps to reduce violence, illness, accidents and injury in the homes. It rejects the recommendations of the Coroner’s Inquest in the Casa Verde homicides.

CUPE Ontario

The Canadian Union of Public Employees is Canada’s largest union representing more than half a million workers across Canada including over 200,000 in Ontario. CUPE Ontario members are employed in Health Care, Education, Municipalities, Libraries, Universities, Social Services, Public Utilities, Transportation and Emergency Services. Our members include service-providers, white-collar workers, technicians, and labourers, skilled trades people and professionals.

Across Ontario’s long-term care sector, CUPE represents 24,000 workers in 217 long-term care homes. CUPE represents workers at 35 charitable homes, 69 homes for the aged, 71 nursing homes and 42 retirement homes. Forty-seven per cent of CUPE members work in the non-profit sector and 53 per cent working in for-profit sector. In addition, CUPE members are residents and users of Ontario’s health system. Many of us have family members, colleagues and friends living in Ontario’s nursing homes.

Appendix

On Financing: Clarifying the Numbers

The Minister reported that the government has introduced 6,100 new front-line staff, including 2,300 nurses, to long-term care since the government was elected in 2004. He announced that the government is committing to increasing the number of PSWs by 2,500 over the next four years.

- The problem with these numbers is that they *fail to take into account the dramatic and ongoing increase in the number of beds and residents*. From 2004 to May 2007 the McGuinty government increased the number of long-term care beds by 4,912. In the press conference to release Shirlee Sharkey's report, the Minister stated that the government is creating another 2,500 long-term care beds.
- The government is relying on overall increases in funding to automatically improve levels of care for residents. Provincially, the last Freedom of Information release showed that care hours increased by only 0.001 hours per resident per day from March 2006 to June 2007. During the same period, resident care need increased by 3.15% – from an average "Case Mix Measure" of 93.39 to 96.66. During the same period, funding increased by 8.1% – from $68.19 to $73.69. Clearly, just transferring increased funding to the homes does not translate into increased care levels.
- Since 2005, according to government figures, the amount of care per resident per day has not increased, despite increased funding and increased acuity. In the previous several years, increased numbers of staff have likely gone to the increasing number of beds, not to improving care in existing beds.
- Since the reinstitution of reporting actual care levels, the for-profit homes have had the least increase in actual hours of care/day and the public homes have had the greatest increase in hours of care/day. This points to a requirement for more accountability in the use of public funds, not less.
- The previous announcement of increased PSWs has not yet come to pass.