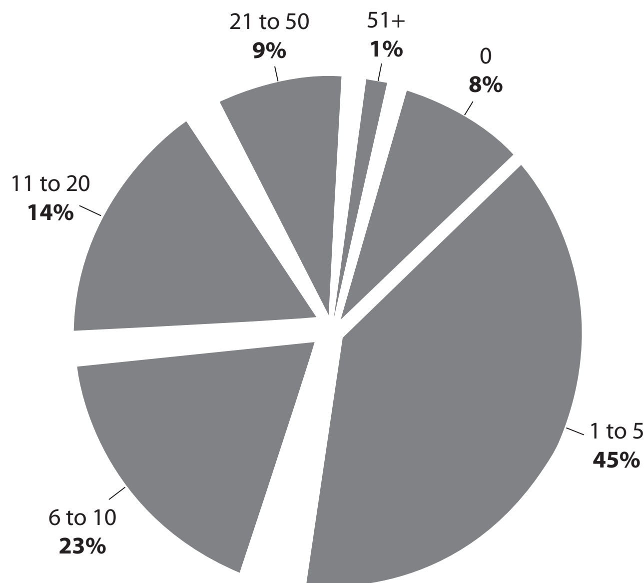
There is a general consensus that individuals entering homes are more in need of assistance than even five years ago. Figure 5 shows the number of residents workers cared for with particular ailments. The majority of workers care for between one and five residents who are completely confined to bed (44.1%), 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 "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)

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.[14]

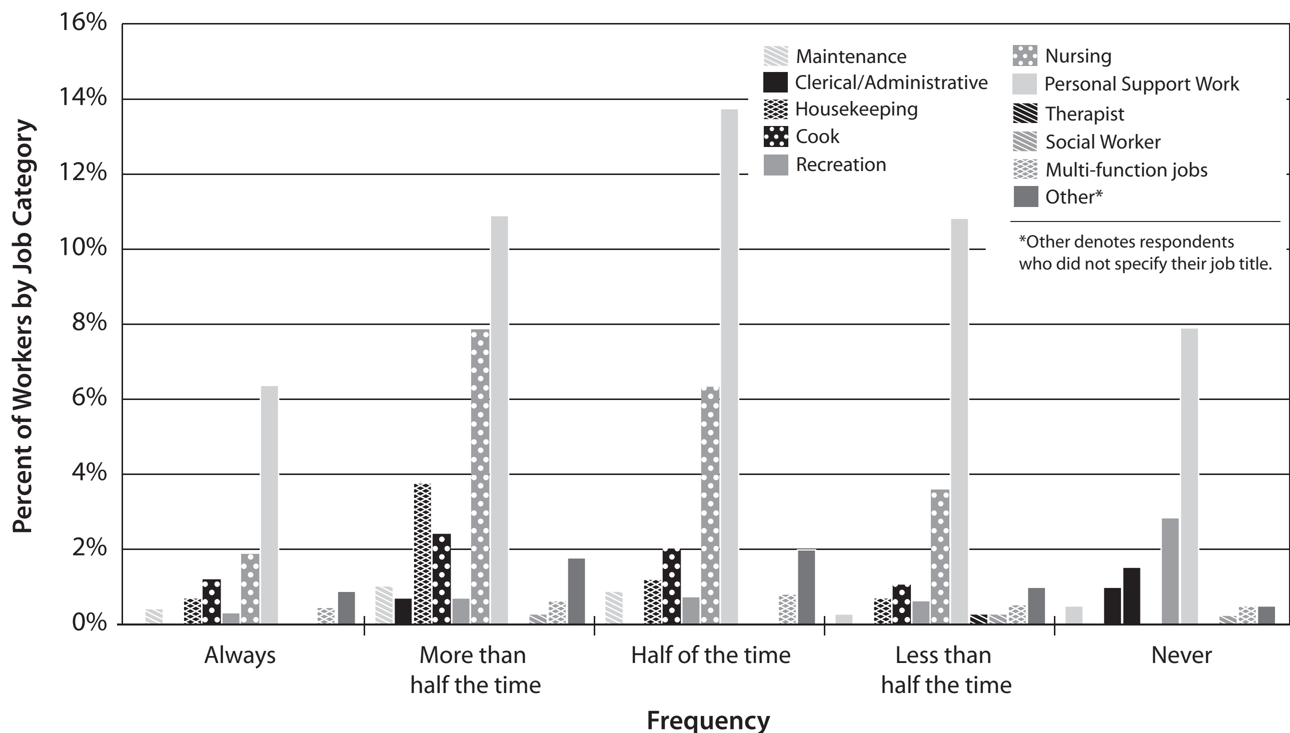
Quality of Life for Residents

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).

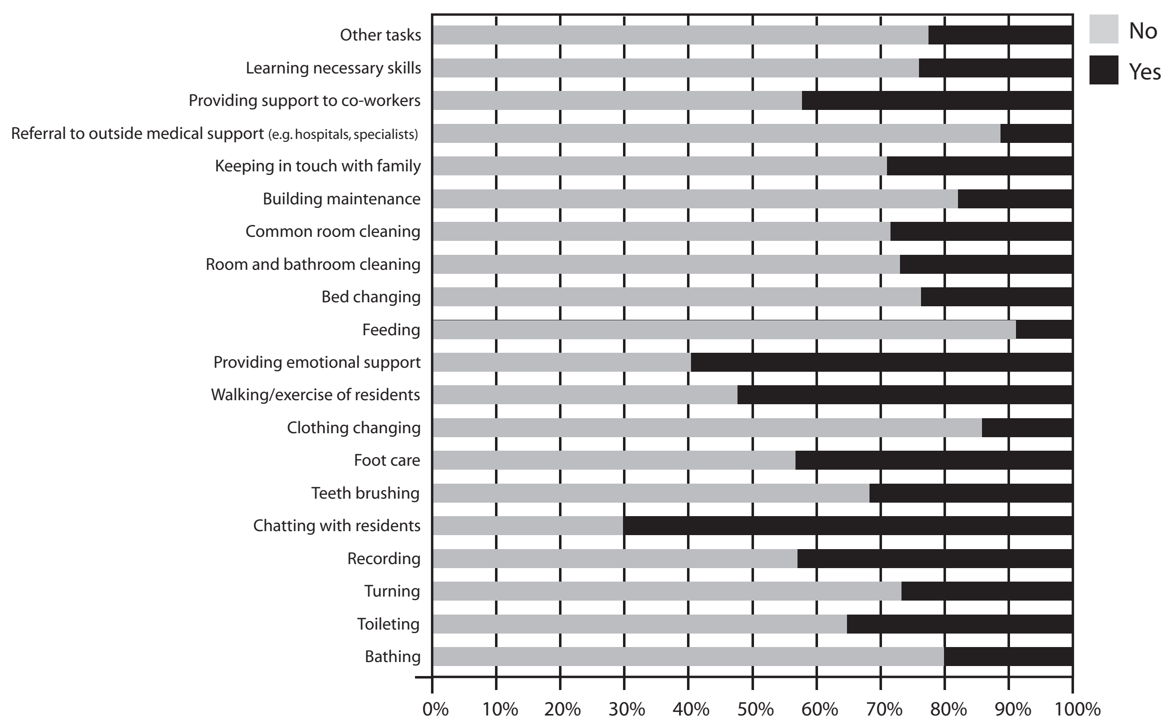
Figure 7: **Time to Complete Tasks to Standards**



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 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%), 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!

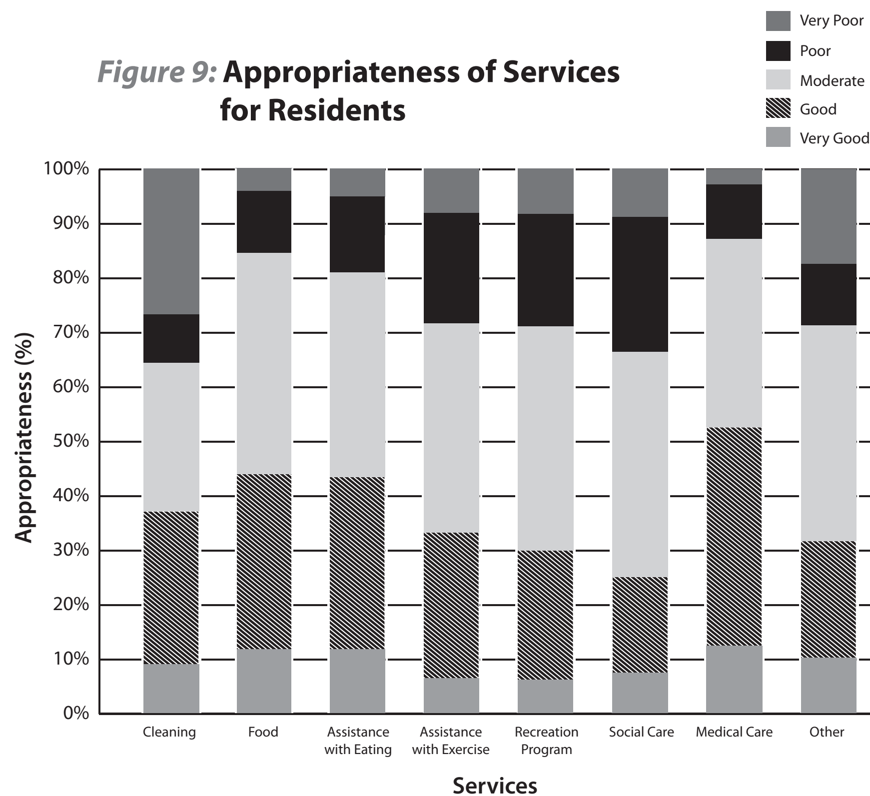
Figure 8: **Tasks Left Undone in Past Seven Days**



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 per cent considered it is very good. One-third indicated that "other services" are poor or very poor.

Figure 9: **Appropriateness of Services for Residents**



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

Worker Autonomy

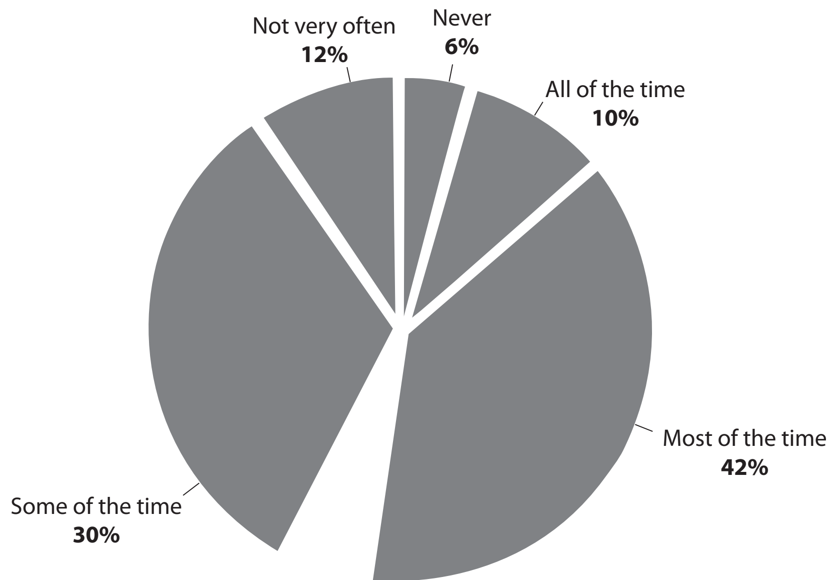
Karasek and Theorell[15] , among others, have demonstrated that autonomy is critical to workers' health. Workers need to have some control over their own work, not only for the sake of their own health but also so they can adapt their work to the individual needs of residents.

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**

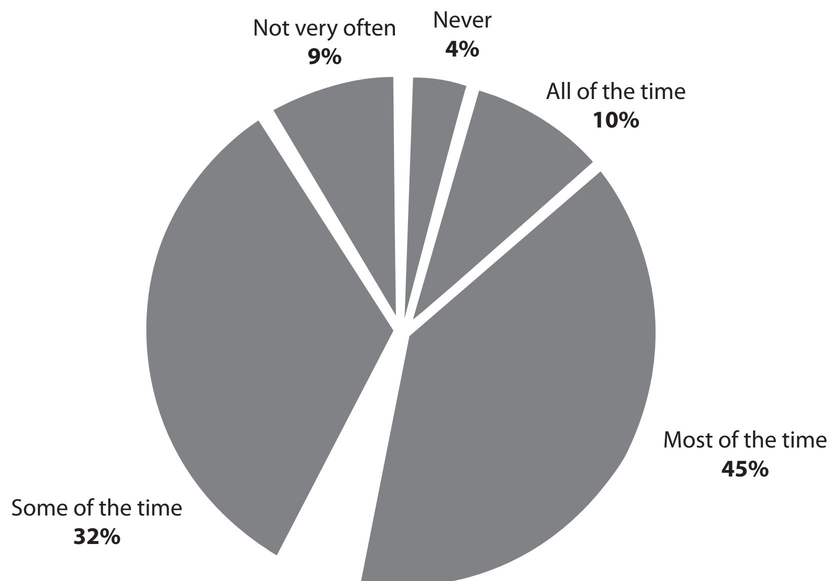
over *what* they do during the day. Just over half reported mostly controlling (41.8%) or always controlling (9.9%) what they do. (Figure 10)

Figure 10: Worker Control over Tasks



When asked if they retain control over *how* they do things, 55.2 per cent 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



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 per cent 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.[16] *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.[17]

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.

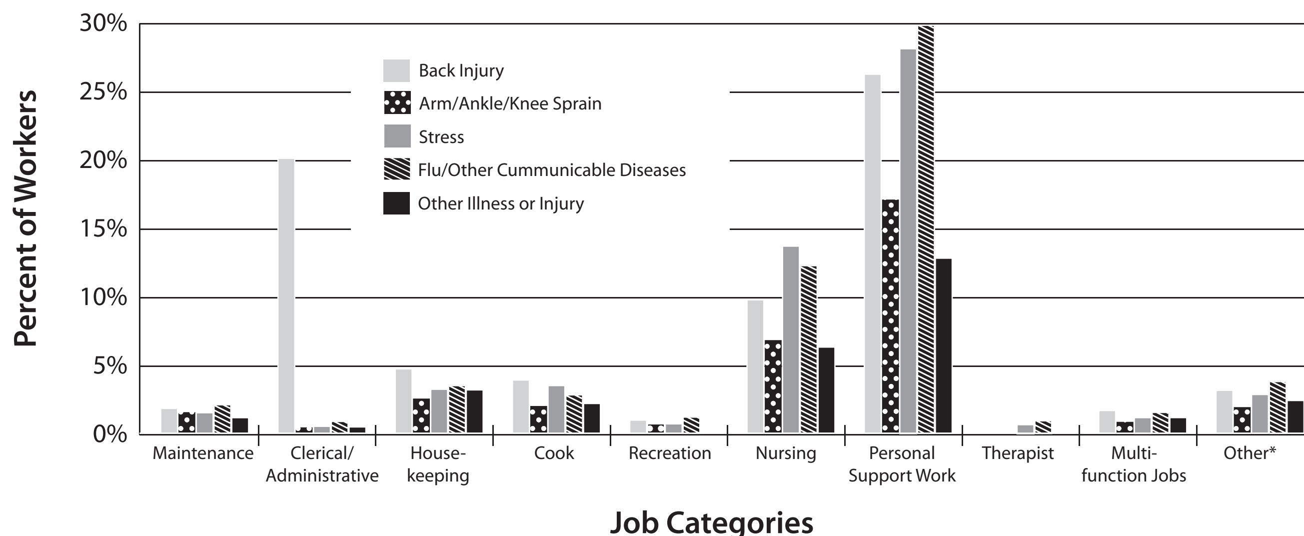
The rising injury and illness rates are no mystery. As one respondent put it, "Staff now are wearing themselves out with stress, shoulder injuries and back injuries." They work harder, faster and often alone because there are fewer people to help. Moreover, "Vacation or sick time are often denied due 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



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 per cent 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 per cent calling them good or very good and 28.9 per cent 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 per cent 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 undermining workers' health and their capacity to care. For residents to enjoy quality of life, workers must too.

[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.

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