Ontario Health Coalition
Issues in Long-term Care Facilities
Briefing Note

January 2007

Why Is A Minimum Care Standard So Important?

What is a Minimum Care Standard?
This is a defined number of hours of care that is attached to a particular level of assessed need. We are proposing that Ontario adopt a 3.5 hour minimum care standard of hands-on care. This means that a facility with the average case mix (or an average level of need) would receive resources for nursing and personal care specifically to provide 3.5 hours of care per resident. Those facilities with lower acuity levels (less needy residents) would receive less. Those with higher acuity would receive more.

Ontario Used to Have a Minimum Standard
In 1996 the Conservative government withdrew the regulation that provided for a minimum standard of 2.25 hours of care. Since then, Ontario has had no care standard. We are insisting that the government re-instate a care standard to improve quality of life in long-term care homes. Since the level of acuity has increased with the downloading of heavier care patients from hospitals and mental health facilities and with the aging of residents, the standard must be modernized to meet today's care needs. Based on our research of standards in other jurisdictions across Canada and the US, we believe that 3.5 hours of care would be the minimum required to reach the goal of prevention of risk. It is not an optimum.

How does it work?
The government uses an assessment tool to figure out how much care residents need. The current tool is recognized as flawed, and the government is piloting a new assessment tool in 70 long-term care homes. The tool allows facilities and the government to determine the "case mix". The average case mix across the province is then calculated. Those with lighter care needs than the average are deemed to have lower acuity, those with heavier care needs are deemed to have higher acuity. The funding the home receives for nursing and personal support care (feeding, bathing, nursing etc.) is based on the level of acuity in the home.

However, there is no expected amount of care that is attached to the average level of acuity. An array of reports and media exposes, and testimony of families and care staff, have shown that there are serious inadequacies in care provision. There are not enough staff to provide the needed care. Staff are unable to get their care work done to expected standards within the time they have on their shifts. Bathing, repositioning, referrals to medical care, even feeding, are left undone because there is not enough care time. This shortfall has serious health and quality of life implications for residents and staff.

A minimum care standard would set a minimum expected level of care, weighted by the assessed acuity of the resident. This would provide one of the most important tools in assessment of appropriate funding and provide greatly improved opportunities for accountability.

What Is the Situation in Ontario?
The Findings of
the Provincial Auditor

The provincial auditor in 1995 and 2002 noted that inaction on issues such as the staffing mix and appropriate levels of funding meant that there was no basis to assess whether funding in the sector is appropriate to meet the assessed needs of residents. In addition, the auditor criticized the government for inadequate financial reporting, inadequate inspections, the lack of action to address the findings of the 2001 PriceWaterhouse Coopers Report, and inadequate tracking of contagious disease outbreaks.

As of the 2004 auditor's report, some improvements to the inspection regime and reporting requirements had been made. However, the collected staffing data is not available publicly, the appropriateness of the funding is not assessed - or if it is, the information is not available to the public - and no staffing standards have been created, despite the auditors' repeated recommendations.

Further, the Ministry has never updated nor has it addressed the findings of the 2001 PriceWaterhouse Coopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies while having significantly older residents with complex care needs including depression, cognitive impairment and behavioural problems.

A review of the research...next page>

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What Does the Research Show About Minimum Care Standards?

- The Province of Alberta has set a policy direction to bring care to 3.6 hours. As of the latest budget, Public Interest Alberta and the Capital Health Authority report that funding is at 3.6 hours.
- The Liberal Party of New Brunswick recently won an election with a pledge to phase in a minimum standard of 3.5 hours by 2008.
- Nova Scotia is increasing their previous 2.25 hour guideline to 3.25 hours.
- PriceWaterhouse Coopers found that Saskatchewan was at 3.1 hours in 2001.
- 37 U.S. States have established minimum staffing standards either in statute or in regulation. While Ontario axed its care standard, 13 U.S. states increased their staffing standards (between 1999 and 2001).(Harrington, 2001).
- The US Health Care Financing Administration conducted major research to deliver two phases in its "Report to Congress: Appropriateness of Minimum Nursing Staff Ratios in Nursing Homes". They used multivariate analysis and time motion studies to assess the impact of levels of care. Their findings yielded a strong link between staffing and quality. They found that preferred minimum levels existed above which quality was improved across the board. The total preferred minimum level was 3.45 hours of care, with a staffing mix of aides, RPNs (or equivalent) and RNs. They also found that residents in understaffed homes are at a greater risk of preventable health conditions including pneumonia, urinary tract infection, sepsis, congestive heart failure and dehydration.
- The Institute of Medicine (IOM) report Improving the Quality of Long-term Care (2001) recommended the development of minimum care levels integrated with case mix adjusted standards. It found increasing acuity of nursing home residents and recommended "[F]ederal staffing levels must be made more specific and that the minimum level of staffing has to be raised and adjusted in accord with the case-mix of residents. The objective should be to bring those facilities with low staffing levels up to an acceptable level and to have all facilities adjust staffing levels appropriately to meet the needs of their residents, by taking case-mix into account."
- The Coroner's Jury in the Casa Verde inquest recommended increased staffing and regulation, including a minimum staffing standard.

In the last 5 years, violence in the homes has shown a precipitous increase.

- In 2004 violent residents attacked other residents 864 times and attacked staff 264 times, a ten-fold increase in five years.(CBC News. April 19, 2005)
- There have been 11 homicides in Ontario nursing homes since 1999 and 3,000 reported attacks.(Ontario Nurses' Association Submission to Coroner's Inquest into deaths of Ezz-El-Dine El-Roubi and Pedro Lopez at Casa Verde Health Centre.)
- Neil Boyd, a criminology professor at Simon Fraser University who is studying physical abuse in the health care sector, says the main reason for increasing violence is the aging population. He says abuse of workers occurs most frequently in long-term-care facilities, where residents have disabilities such as brain injuries, age-related dementia and chronic progressive diseases.(CMAJ 1998; 159:983-5).
- 60 - 80% of residents have some form of cognitive impairment.
- In 2005 - 140,000 Ontarians had Alzheimer Disease or related dementia. This number is expected to double to 307,000 in the next 25 years.(Alzheimer Society Ontario. Position Paper on Casa Verde Recommendations, September 2005).

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