Briefing Report:
Investigating Real Registered Nurse Staffing Levels in Ontario's Long-Term Care Homes

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Ontario Health Coalition
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Summary

The purpose of this research project is to investigate registered nurse (RN) staffing levels and the impact of inadequate RN staffing on care in Ontario's long-term care (LTC) homes. In November 2020, during the second wave of the COVID-19 pandemic, this research was conducted utilizing various methodologies including phone interviews and questionnaires. Our major finding was that one in three LTC homes that we could find information about in Ontario did not have even a single RN 24/7. We also found that this information is not transparent and is very hard to access. These issues have serious implications for resident safety, quality of care and care processes, and outcomes.

While acuity levels in Ontario's LTC homes have risen for decades, daily hands-on care levels have been generally static and even have declined over the last 14 years. Shortages of daily hands-on care staff, including RNs and PSWs were significant and problematic before the pandemic. They have become worse through the pandemic as thousands of staff became ill, could not work due to family and childcare requirements, or left. Emergency regulations that restricted staff from working in more than one LTC home, while important and necessary, also contributed to the shortages. The Ontario Health Coalition has documented the horrific inadequacy of care and resident suffering because of low staffing levels through the first two waves of the pandemic. Health care workers including RNs, RPNs, and PSWs are facing high levels of stress and ultimately burnout as a consequence of crushing workloads, inadequate supports, critical staffing shortages, lack of adequate safety and protection, and other issues that have contributed to unsupportive nursing environments in a significant number of LTC homes.

Section 8 of the Long-Term Care Homes Act (2007) Ontario states that all Ontario LTC homes must have at least one RN on duty at all times.[1] This legislative requirement applies to all homes, whether they have 40-beds or 400-beds and was inadequate prior to the pandemic. However, under the emergency orders in the pandemic, just as LTC residents needed more staff and more highly trained staff to care for the tens of thousands of ill residents[2] and improve infection control, this bare minimum nursing standard was deregulated and LTC homes were no longer required to even have one RN 24/7.[3] Adequate RN staffing levels play a significant role in providing safe, high-quality care and improving health outcomes for residents living in the homes; and as residents got sick by the thousands and required more intensive and complex care, more RN staffing, not less, was needed.

This research project aimed to find out how the deregulation of the nurse staffing standard in LTC was being used "on the ground" during the pandemic. We found that this information was very difficult to obtain. In other jurisdictions, staffing levels are openly reported, even posted in the homes. In Ontario, even with repeated requests for an answer to a very simple question – whether the homes have at least one RN on shift 24/7-- we could not get answers from the vast majority of homes. Only through surveys of family members of residents, essential caregivers and staff did we collect the information. What we did

[1] https://www.ontario.ca/laws/statute/07l08

[2] Almost 20,000 long-term care residents have contracted COVID-19 to date in the first and second waves https://www.ontariohealthcoalition.ca/index.php/report-tracking-the-spread-of-covid-19-large-outbreaks-in-health-care-settings-summary-report-over-two-thousand-dead-in-long-term-care-as-we-approach-end-of-wave-2-data-updated-to-march-3/

[3] https://www.ontario.ca/laws/regulation/200095

find was of deep concern. The existing body of research, and our own interviews with LTC RNs and advocates supports the need for RN staffing, particularly as acuity in Ontario's LTC homes is very high. Yet we found, of the LTC homes about which we were able to obtain any information at all, one in three homes does not have even a single RN 24/7. Our findings illustrate the urgency for the government of Ontario to at minimum comply with its own LTC legislation and increase staffing levels to meet the growing care needs of residents in LTC homes.

Methods

This is an informal research project in which we tried to gain a fair understanding of what RN staffing levels are "on the ground" during the second wave of the pandemic in Ontario. It is not an academic research study, and its purpose was to illuminate the issue and point the way for further research. In conducting this research, purposive sampling was utilized to collect data from a selection of all the LTC homes in Ontario. At the time of our research, there were a total of 626 Ontario LTC homes listed on the government of Ontario website.[4] It was not possible to call all 626 LTC homes due to limited time and human resources. Our sample was selected by grouping LTC homes by region to get a sample across multiple regions. The LTC homes selected to be included in the project were located in regions where there were significant COVID-19 outbreaks in October-early November as the second wave was gaining amplitude. We chose to select LTC homes in larger urban centres where shortages of available staff to hire, should the homes choose to do so, are likely not as severe as in small and rural communities. The LHINs selected were Mississauga Halton, Toronto Central, Central, and Champlain for a total sample size of 173 LTC homes. These LTC homes were called and a total of 31 responded fully to our queries. The remaining 142 LTC homes either did not answer the phone, did not respond to multiple follow ups by telephone and email, declined to answer, or the appropriate person to answer our questions was repeatedly unavailable. LTC homes that did not respond were phoned at least twice and followed up with by email.

In our second attempt to collect data, we surveyed the Ontario Health Coalition membership community of family members of loved ones living in LTC homes and staff working in LTC homes. The survey, delivered by email, targeted individuals with family members living in LTC homes, essential caregivers, and health care workers. A higher response rate was experienced, with 57 clear and usable responses received and recorded. As workers cannot speak publicly about conditions in their LTC homes and as families are often reticent to speak publicly for fear of reprisals against their loved ones, we committed to keeping identifying information about respondents and the LTC homes confidential.

[4] https://covid-19.ontario.ca/data/long-term-care-homes

Key Findings

Minimum RN Staffing Levels Often Unmet

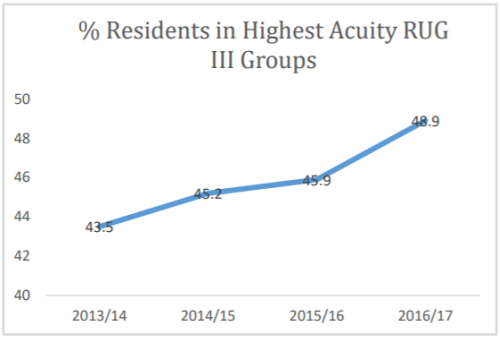
Out of the 173 LTC homes contacted, only 31 (18%) responded to our calls. Although voice mails were left and follow-up emails were sent upon request to homes unable to answer at the time of the call, 142 homes did not provide a response. All 31 respondents stated that at least one RN worked on shift in the home 24/7. In the email data request posed to the OHC membership community, a total of 57 responses were received. Of the email survey responses, 30% stated that there was no RN on duty at the LTC homes on a 24/7 basis. Of the email survey responses by family, essential caregivers and LTC staff, six respondents reported on homes that we had previously contacted but did not provide us with information. Among those, three respondents reported that the home did not have RN staff 24/7.

Without further access to information, it is impossible to know exactly what proportion of Ontario's long-term care homes do not have even a single RN on shift 24/7 but our preliminary findings show both that there are homes without RNs at all and that this information which should be transparent and easily accessible, is decidedly not. While some homes were undoubtedly in crisis due to COVID-19 outbreaks, the majority of the homes we contacted were not in outbreak. Given the results we found from our surveys of families and workers, a possible explanation is that LTC homes that were willing to disclose the requested information had a higher likelihood of meeting the legislative requirement for RNs. Another explanation is that the director of care and health care staff are afraid of the potential negative consequences on their job for disclosing this kind of information, particularly if the home did not have an RN 24/7. This would likely mean that homes without at least one RN 24/7 were less likely to answer our questions. On the other hand, it is also possible that family members and essential caregivers that had identified an RN working in the home 24/7 might not recognize the difference between an RN and RPN. Misidentifying an RPN for an RN has the potential to skew our findings in favour of over-reporting the number of homes that have at least one RN on shift 24/7. The number of LTC homes without at least one RN on duty at all times, could in reality, be a higher proportion than we found.

We were unable to come to a conclusive statement about the level of RN staffing that exists across LTC homes in Ontario due to the limitation of available data. When homes self-reported, 100% of the homes that gave any information said that they have at least one RN 24/7 but the overwhelming majority of homes would not answer the request for information. When staff, essential caregivers and family members of LTC residents were asked, they reported that at least 30% of LTC homes for which we were able to obtain information do not adhere to the provincial RN staffing requirement in the LTC Homes Act. RN staffing shortages in Ontario LTC homes were a significant concern before the pandemic and now, even more so with the increasing complexity of community living and care within the context of the pandemic. As acuity levels in LTC homes continue to rise, the need for RNs to provide specialized care, unique to their scope of practice, also grows.

Context and Significance of Findings

Level of Acuity: Increasing Acuity in LTC Homes



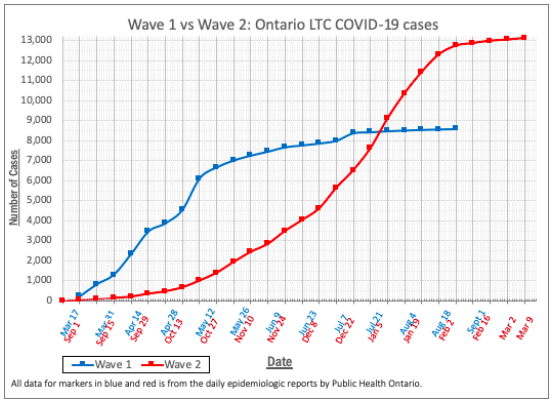
Acuity level -- the intensity of care required by a patient based on their physical and mental conditions-- has been increasing. The Ontario Health Coalition reported an increase in the percent of LTC residents in the highest acuity group from 43 percent to 49 percent between 2013 and 2017.[5] According to the Canadian Institute for Health Information (CIHI), the prevalence rate of endocrine, metabolic, pulmonary, heart, and/or circulatory diseases in LTC are similar to those that are seen in Ontario hospitals.[6] In 2019, roughly 78,000 residents were living in LTC homes across Ontario and more than half are 85 years and older.[7] Eighty-one percent of residents have some type of cognitive impairment and almost all residents are living with two or more chronic conditions.[8] [9] The Method for Assigning Priority Levels (MAPLe) is a scaling tool used to determine residents' priority based on their needs for care. The Government of Ontario reports an increase in the number of residents with very high MAPLe scores (requiring the highest level of care possible) from 82% to 87% between the year 2012 and 2019.[10] MAPLe scores measure acuity on admission. Similarly, the Ontario Health Coalition reported an increase in the percent of residents who are totally dependent on assistance when performing the activities of daily living such as bathing, feeding and grooming.[11] As residents age and the complexity of their care needs change, the increased measure of acuity indicates a need for more specialized training and staffing to provide adequate and safe care for residents living in LTC homes.

[5] http://www.ontariohealthcoalition.ca/wp-content/uploads/FINAL-LTC-REPORT.pdf
[6] https://www.oltca.com/oltca/Documents/Reports/PreBudgetSubmission2015-2016.pdf
[7] https://www.ona.org/wp-content/uploads/ona_ltcreport_2019.pdf
[8] https://www.ontario.ca/page/long-term-care-staffing-study
[9] https://www.ona.org/wp-content/uploads/ona_ltcreport_2019.pdf
[10] https://www.ontario.ca/page/long-term-care-staffing-study
[11] http://www.ontariohealthcoalition.ca/wp-content/uploads/FINAL-LTC-REPORT.pdf

COVID-19 in LTC Homes

Devastating Outbreaks

LTC homes have suffered many large outbreaks and significant staffing shortages as a direct result of COVID-19. The Ontario Health Coalition tracked the number of residents and staff who contracted COVID-19 in Ontario's long-term care homes throughout the pandemic to date. We found more than 8,000 cases in residents and staff from March 24 to August 18 2020 during the first wave. The second wave, from September 1, 2020 to February 9, 2021, saw more than 13,000 cases of COVID-19 in residents and staff in long term care alone.[12]



Prior to the pandemic, 30% of registered staff worked in multiple LTC homes.[13] Under a Public Health Directive which took effect on April 22, 2020, long-term care staff were prohibited from working in multiple homes therefore limiting the number of staff available for work in some of the homes.[14] Additionally, some staff quit or went on leave due to fear, family caregiving and childcare obligations, injury, stress and others who actually contracted COVID-19 were placed on mandatory 14 day isolation.. These factors reduced the workforce available to LTC homes and residents. Thousands of long-term care staff also became ill with COVID-19 and were off work as they recovered. Staff then began to report higher levels of burnout and emotional trauma, and families began to describe care, which was always inadequate, that had dropped to perilously low levels.

In a survey conducted by the Ontario Health Coalition after the first wave of COVID-19, 53% of the LTC staff reported experiencing staffing shortages every day and 63% of the LTC staff reported that staffing levels had become significantly worse in the pandemic.[15] LTC staff who had worked through the first wave reported frequently working overtime in multiple shifts and were denied vacations, holidays and weekends.[16] Many found themselves having little to no time to attend residents' vital basic needs such as feeding and toileting.[17] They reported more falls during the pandemic due to a lack of time and supervision.[18] Basic needs for adequate time to feed and to cue residents to eat, and time to hydrate

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[12] https://www.ontariohealthcoalition.ca/index.php/report-tracking-the-spread-of-covid-19-large-outbreaks-in-health-care-settings-summary-report-over-two-thousand-dead-in-long-term-care-as-we-approach-end-of-wave-2-data-updated-to-march-3/

[13] https://www.ontario.ca/page/long-term-care-staffing-study?_ga=2.209897943.372997613.1595963126-1510495429.1593092801

[14] This directive did not apply to agency (temporary) staff, only employees of LTC homes. https://www.ontario.ca/laws/regulation/200146

[15] https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-Report.pdf

[16] https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-Report.pdf

[17] https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-Report.pdf

[18] https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-Report.pdf

residents were not met. Residents' dignity deteriorated as they remained ungroomed, soiled and uncomfortable for extended periods of time. The inadequacy of care has placed residents at risk for higher mortality as falls and unattended pressure ulcers have dire outcomes. In this context, the government continued with the deregulation of the minimum legislative requirement for one RN 24/7, and while a few LTC homes in outbreak were assigned emergency staffing teams from hospitals temporarily, the vast majority were not. The Ontario government never lifted the deregulation emergency order, and never acted to urgently increase RN staffing levels (and all staffing levels) in long-term care homes throughout the pandemic to date.

Final Submission to Ontario's Long-Term Care COVID-19 Commission the Ontario Nurses Association (ONA)

In their Final Submission to Ontario's Long-Term Care COVID-19 Commission the Ontario Nurses Association (ONA) reported on many challenges that were plaguing the employees at Ontario's Long Term Care Homes.[19] The RNs role was described as challenging because of the lack of support and inability for RNs to consult as they was often only one RN on the premises at a time. Added to this was the staffing shortage at the start of the pandemic. Many homes were faced with labour shortages that they tried to fill with agency staffing and this was inadequate. ONA reported that many staff members chose not to return to work out of fear of contracting the virus, and because of the lack of personal protective equipment that was available for their use. Many RNs urged their facilities and government to begin regular testing, unfortunately those warnings were unheeded and by the time residents and staff were tested, many staff were working with COVID-19 positive patients without appropriate personal protective equipment.

Another area that RNs play an important role is in infection prevention and control measures. RNs reported attempting to implement infection control measures, however these measures were routinely rejected by the management of the homes even when they aligned with the Public Health's recommendations. Further, RNs feared repercussions, such as losing their job, if they shared their challenges with Public Health officials.

Canadian Armed Forces Report

Early on in the pandemic, it was reported that LTC homes were being hit particularly hard by COVID-19, but with visitor access restricted and the lack of transparency, very little was known about just how dire the situation inside the homes was. The Ontario Health Coalition conducted its first survey of staff in July which found that the majority of LTC homes had chronic staffing shortages that had become worse through the first wave, and that these shortages meant that vital care functions were not being provided.[20] Our findings were supported by the Canadian Armed Forces report.

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[19] https://www.ona.org/commission/

[20] https://www.ontariohealthcoalition.ca/index.php/release-report-95-of-ontario-long-term-care-staff-report-staffing-shortages-leaving-basic-care-needs-unmet-health-coalition-releases-staffing-survey-calling-for-ford-government-to-take-action/

A small number of LTC homes had been identified as most at risk by the Ministry of LTC and the Canadian Armed Forces (CAF) were called in to provide humanitarian relief and medical support to five LTC homes (and later a sixth). Ultimately, 1,675 troops were called in and deployed across the five LTC homes in Ontario and 25 in Quebec.[21] The CAF provided a briefing to the government on the horrific conditions they found in the homes. In Ontario, the LTC homes reported on were:

- Eatonville Care Centre in Etobicoke;
- Hawthorne Place Care Centre in North York;
- Orchard Villa in Pickering;
- Altamont Care Community in Scarborough and;
- Holland Christian- Grace Manor in Brampton.

The categories of issues observed most relevant to RN staffing levels included: infection control, standard of practice and quality of care concerns, medications, supplies, ambiguity on local practices and communication. For clarity, we have focused on issues identified by the CAF that are directly linked to the scope of practice and responsibility of RNs in LTC homes. Overall, the CAF report indicates a severe lack of staffing including RN staffing and the use of untrained agency staff or agency staff that had received no or little orientation to the facility. The summary below is not meant to lay blame on individual staff. What is clear from the report is that staffing was dangerously low and precarious.

Securing safe, efficacious and ethical infection prevention, mitigation and control practices is a significant aspect of registered nursing care.[22] All of the five Ontario LTC homes in the CAF report, had troubling evidence of a lack of adequate infection prevention and control practices. Some of the infection prevention and control infractions that indicate a deficiency in RN direction and support include improper usage of PPE and high-risk contamination behaviours by staff and residents. Staff in the homes were observed to:

- Wear surgical masks or scarves under N95 respirator type masks;
- Wear double gowns, and continue to wear gowns worn in COVID-19 positive spaces in COVID-19 negative spaces;
- Reuse gloves;
- Fail to perform hand washing or sanitizer use from areas of high levels of contamination to lower levels with an individual resident, or even between providing care to residents;
- Fail to sanitize assessment tools between residents (blood pressure cuffs, oxygen saturation sensors, thermometers, stethoscopes) and;
- Allow residents to wander into/out of COVID-19 positive/negative spaces.[23]

Standard of practice and quality of care concerns raised by the CAF report were significant and especially disturbing, as many observances, at best, could reduce quality of life and at worst, could be the critical event that cascades toward untimely death. Standards of practice can be described as the professional standards that the public expects to receive from RNs entrusted in their care.[24] Standards of practice guide RNs in maintaining the knowledge, skill, judgment and attitudes that are required to practice in a

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[21] www.cbc.ca/news/canada/toronto/covid-19-coronavirus-ontario-update-may-26-1.5584665
[22] www.cno.org/en/learn-about-standards-guidelines/educational-tools/infection-prevention-and-control/
[23] www.tvo.org/article/covid-19-read-the-canadian-forces-report-on-long-article-care
[24] https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf

way that is consistent with safety and ethical behaviours.[25] The most common areas where standards of practice and quality of care were not attended to pertain to: medication stocking and administration, assessments of residents, wound care, pressure injury prevention and medical device maintenance and management. The CAF observed:

- Presence of medications to be administered that were significantly out of date;
- Medication errors in dosing concentrations, schedule and route of administration;
- Vital assessments not completed on schedule or at all, even prior to medication administration;
- Inadequate pain management in general population and residents receiving palliative care;
- Sterile technique not utilized when required (catheterization, wound dressing, hypodermoclysis) including using equipment that had fallen or been found on the floor;
- Catheterization care incomplete or expired by weeks, leading to bleeding fungal infections and;
- Improper feeding positions increase risk of aspiration or leaving residents to sleep with food in their mouths.[26]

Issues related to vertical and horizontal communication between staff members in the homes was also observed to be barely functioning or broken, contributing to a culture of limited accountability, infighting and collective negligence in caring for residents. A lack of consistent standards, training, expectations and across all staff members lead to the problems in transfer of accountability, shift reporting, resident care distribution and supply needs. The CAF reported:

- Resident care assignment not communicated, leading to some residents being missed completely;
- End of shift report not completed/given to oncoming staff;
- Incomplete or absent documentation;
- Limited or no communication on functional abilities of residents
- DNR status not communicated;
- Essential equipment not accessible, under lock and key with keyholder (RN) often unavailable and;
- Safety equipment not available, unassessed or not maintained (Suctioning not working, only working machine locked in basement, battery checks not completed since 2014).[27]

[25] https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf
[26] www.tvo.org/article/covid-19-read-the-canadian-forces-report-on-long-article-care
[27] www.tvo.org/article/covid-19-read-the-canadian-forces-report-on-long-article-care

Relevant Health Legislation

Minimum RN Staffing in LTC Homes

- Under Section 8 of the Long-Term Care Homes Act (2007) Ontario [28]
    - Licensees must ensure that at least 1 registered nurse is always on duty at the long-term care home; and
    - that RN must be an employee of the home and be a regular staff member.

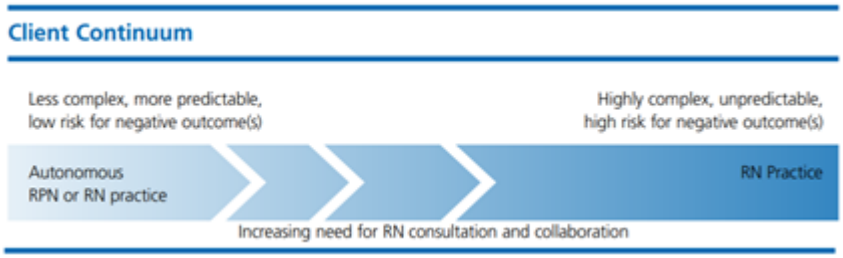
- Under Emergency Order (O. Reg. 95/20) [29]
    - Owners of LTC homes are not required to meet the minimum hours of staffing that is outlined in the LTCHA if the care requirements are met. (The only minimum hours of staffing required in the LTCHA is the requirement to have one RN 24/7. Thus, this directive specifically relates to that legislative requirement. Despite the lip service paid to meeting the care needs of residents, the failure of the homes to comply with this, as reported above, is well-documented; the operative effect of this directive was to remove the requirement that each LTC home have at least one RN 24/7).
    - Owners of LTC homes can fill positions with people without qualifications if they deem the person to have adequate skills and knowledge to perform the role.

[28] https://www.ontario.ca/laws/statute/07l08
[29] https://www.ontario.ca/laws/regulation/200095

The Role and Importance of Registered Nurses (RNs) in LTC homes

According to the College of Nurses of Ontario (CNO) and the Registered Nurses of Ontario (RNAO), the choice to utilize the expertise of an RN should be made by considering: the resident, the nurse, or other support persons in long term care, and the environment.[30] [31] The resident's complexity, predictability and risk of negative outcomes must all be considered.[32] In LTC homes, registered nurses (RNs) are responsible for residents who are less predictable with a higher acuity level and higher risk of poor outcomes, while personal support workers (PSWs) and/or registered practical nurses (RPNs) are responsible for those whose care needs are more predictable with lower acuity and risk level.[33] The RN's role is unique and cannot be filled with other professions. RNs bring a level of knowledge, expertise and critical thinking skills that, when absent, result in outcomes that are not in the best interests of the residents.[34]

RPNs and RNs share the same body of nursing knowledge, but RNs study for a longer period that allows them to acquire greater foundational knowledge in clinical practice to care for less predictable and less stable residents.[35] As complexity of the condition raises, the need for consultation from RNs increases as shown in the graphic below.[36]



RNs are given the authority under the *Regulated Health Professional Acts, 1991,* to perform specific controlled acts based on three factors: client, nurse, environment[37] that otherwise cannot be done by a PSW without delegation.[38] Although PSWs are allowed to perform certain controlled acts with a delegation from RNs, this only extends to the degree where the procedure is considered a routine activity of living and outcomes of the procedure are predictable.[39] Furthermore, an RN is needed to determine if the procedure is appropriate for a PSW to perform and to provide the proper supervision and

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[30] https://rnao.ca/sites/rnao-ca/files/Transforming_long-term_care_backgrounder.pdf
[31] https://www.cno.org/globalassets/docs/prac/41062.pdf
[32] https://www.cno.org/globalassets/docs/prac/41062.pdf
[33] https://rnao.ca/sites/rnao-ca/files/Transforming_long-term_care_backgrounder.pdf
[34] https://rnao.ca/sites/rnao-ca/files/Transforming_long-term_care_backgrounder.pdf
[35] https://www.cno.org/globalassets/docs/prac/41062.pdf
[36] https://www.cno.org/globalassets/docs/prac/41062.pdf
[37]https://rnao.ca/sites/default/files/2020-06/Nursing%20Home%20Basic%20Care%20Guarantee%20-%20RNAO%20submission%20to%20LTC%20staffing%20study%20advisory%20group%20-%20Final%20-%20June%2009%2C%202020.pdf
[38] https://www.cno.org/globalassets/docs/policy/41052_rhpascope.pdf
[39]https://www.cno.org/fr/exercice-de-la-profession/educational-tools/ask-practice/ask-practice-teaching-a-personal-support-

instructions.[40] Even if the procedure is appropriately delegated and teaching is provided to the PSW, it is the role of the RN to conduct an ongoing assessment of the PSW's competency and monitor any changes in the resident's condition that are necessary to ensure safety of all residents.[41]

While the entire team, including RPNs and PSWs, play a vital role in caring for residents, RNs provide skills that are particularly essential to the trend of increasing complexity and acuity level in LTC homes. RNs are essential to meet the increasing care needs of residents that are beyond the scope of RPNs and PSWs. With an inadequate RN staffing level in LTC homes, RNs are unable to attend to each resident's needs.[42] Overwork and high-stress levels can also lead to more mistakes being made, putting the residents' health at a greater risk.[43]

The Responsibilities and Duties Specific to the RNs

The College of Nurses of Ontario (CNO) is the regulating body for nurses in Ontario. The CNO works with the Government of Ontario by ensuring that nurses in the province practice competently, safely and ethically in accordance with legislation that is intended to protect the public and define the role of nurses (Nursing Act, 1991 and Regulated Health Professions Act, 1991).[44] Typically, RNs are the professionals with the highest level of medical skill and knowledge in a LTC home at any given time, and are therefore the only professionals with the education and expertise to holistically care for residents in this complex setting. This means that tasks critical to the wellbeing of residents like in-depth assessments, care planning, complex clinical interventions, delegation, supervision of tasks and on-going evaluation are the responsibility of the RN on duty for all residents in their care.

The nine roles that a RN must practice to fulfill their duty as a nurse are as follows: clinician, professional, communicator, collaborator, coordinator, leader, advocate, educator and scholar. Each of these sub-roles are represented in the responsibilities that comprise a typical day for a RN working in the LTC setting. These competencies are the foundation for all nursing practice and also guide the ongoing appraisal of a RN's competency to practice in the province of Ontario.[45]

As Clinicians, RNs provide competent, safe, ethical, compassionate and evidence informed care in response to individual resident needs while integrating knowledge, skills, professional judgment and values in their practice.[46] This means that the nurse uses their experience, in-depth education and training related to pharmacology, the progression of disease and psycho-social skills to inform the clinical decisions that they make when caring for high acuity residents in LTC homes. This might mean

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[40]https://www.cno.org/fr/exercice-de-la-profession/educational-tools/ask-practice/ask-practice-teaching-a-personal-support-worker/#:~:text=The%20Regulated%20Health%20Professions%20Act,a%20routine%20activity%20of%20living.
[41]https://www.cno.org/fr/exercice-de-la-profession/educational-tools/ask-practice/ask-practice-teaching-a-personal-support-worker/#:~:text=The%20Regulated%20Health%20Professions%20Act,a%20routine%20activity%20of%20living.
[42] https://nurse.org/articles/nurse-staffing-unsafe-long-care-facilities/
[43] https://nurse.org/articles/nurse-staffing-unsafe-long-care-facilities/
[44] https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
[45] https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
[46] https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf

recognizing subtle changes in the resident's health status, responding to deterioration and implementing evidence informed practices to prevent the progression of illness/disease, increase comfort, manage pain and incorporation of the resident's cultural values as they relate to health into the plan for recovery.[47]

As Professionals, RNs are committed to the health and wellbeing of residents above all things by upholding profession's standards of practice and ethics and being accountable to the public and colleagues.[48] RNs live this role by demonstrating that they are worthy of the trust that residents, their families and the public bestow upon RNs. This is most relevant to LTC settings in that RNs continually engage in a process of self-reflection and regulation of the RN's individual behaviours required of them through legislation (Nursing Act, 1991 and Regulated Health Professionals Act, 1991).[49] This continued reflection means that RNs are assessing their practice, seeking new knowledge, increasing their competence and evaluating plans for their own improvement in the setting to enhance practice. [50] This drives continuing competence and innovative solutions to problems experienced by residents or staff in the LTC home.

As Communicators, RNs engage in strategies and use relevant technology to create and maintain relationships with the health care team, residents and their families.[51] This means producing clear and concise reporting on resident health or care, using evidence based communication skills to build therapeutic relationships and using conflict resolution skills to create a productive environment for all working or living in LTC.[52] Strong communication skills are the backbone of the provision of satisfying, effective and dignified care for residents in LTC.

As Collaborators and Coordinators, RNs bridge the gap between all members of the health care team through the creation and support of partnerships between RPNs, PSWs and other allied health professionals involved in resident care.[53] When a resident is transferred to hospital for a procedure or to solve a problem outside of the capability of the LTC home, it is the RN that initiates this type of extra and necessary support while ensuring that a smooth transfer of care and responsibility is achieved. Additionally, the RN has the expertise to understand and know the implications of care for the resident based on the procedure performed, and must alter the care plan accordingly. This type of collaboration is critical to a high acuity population that may undergo complex medical procedures. The collaboration between RN and allied health professionals is key to effective and quality care.

As Leaders, RNs use their influence to create a culture of inspiring other health team members to achieve optimal health outcomes for residents.[54] RNs recognize the impact that a healthy work environment, for staff make, on the quality of care that is provided for residents in LTC[55], and with this, understand that it

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47 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
48 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
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55 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf

is their responsibility to do their part to support other staff and act in a way that is conducive to this end. Providing and receiving constructive feedback on resident care, resolving conflict and fostering an environment of valuing the contribution of team members while providing the highest possible quality of care, is key to leading as an RN.[56] Leadership in nursing as an RN is the management of resources available to support resident care in their homes in a way that is equitable and fair. Without RN leadership, the management of resources, human or material, may not be distributed appropriately, resulting in poorer outcomes for residents.

As Advocates, it is the job of a RN to support residents in voicing their health care needs and to amplify the voices of residents unable to advocate for themselves.[57] RNs in LTC assess, recognize and address real or potential safety issues in the interest of protecting the wellness of residents. Advocacy is critical when working with populations that are more vulnerable due to health status. In LTC homes, this is particularly relevant, as many residents are living with physical or cognitive deficits that impact their ability to advocate for their needs.[58] A RN's competence in the areas of assessing for informed consent, and ethical and evidence-based practice, are critical to advocating for residents living with challenging conditions.

As Educators, RNs identify the learning needs of residents and their families to assist in applying strategies designed to meet the individual health needs of residents.[59] In LTC homes, the RN can address client and family learning needs by assessing health literacy and cultural needs to inform the care plan and foster active participation in care by the resident and family.[60] This participation paired with the utilization of teaching skills and evaluation of client understanding ensures that the RN is meeting the learning needs of the family as a unit. In this way, education and participation in the LTC home is a tool of maintaining a sense of purpose, self-determination and dignity for residents, in addition to the practical aspects of knowledge acquisition.

As Scholars, RNs are committed to excellence in their practice through lifelong learning, critical inquiry, engagement in research and the application of evidence in daily practice.[61] This means that RNs are always seeking out the most current information to change the approach in solving problems, support high quality care and improve the quality of life of residents in LTC.[62] As professionals that are constantly exposed to complex, clinical problems in a high acuity setting like LTC, RNs are well positioned to engage in research that contributes to the body of knowledge that informs how best to care for residents with specific health problems or needs.

Supporting RNs to engage in the full breadth of their scope of practice and each of their sub-roles through appropriate staffing levels in LTC settings is crucial to maximizing the benefit of RN skills through advancing quality of care and the quality of life experienced by residents in care.

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56 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
57 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
58 https://www.ontario.ca/page/long-term-care-staffing-study
59 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
60 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
61 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf
62 https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf

Registered Nurses Association of Ontario's Submission to the Long-Term Care Staffing Study Advisory Group

The Registered Nurses of Ontario's submission to the Long-Term Care Staffing Study Advisory Group, outlines how RNs are valuable members of the care team.[63] In addition to caring for complex residents, they complete thorough assessments, monitor infection and changes in health status, and identify cases that require follow up with a Nurse Practitioner or another appropriate health professional, or transfer to a hospital. RNs also facilitate a smooth admission process that includes thorough assessments, development and continuity of a person-centered care plan by incorporating the desires of the resident and their family, as supported by complete documentation.[64] Another role that should be undertaken by the RN is that of the infection prevention and control nurse. In this role, the RN develops infection prevention and management protocols, educates staff, monitors and evaluates the effectiveness of the plan, and makes adjustments as needed.[65] This role would ensure that LTC homes will not be devastated in future outbreaks.[66]

The research shows that care by RNs decreases mortality risks and improves positive outcomes for residents.[67] The presence of an adequate number of RN hours improves conditions for residents by creating a favourable work environment that is attractive to a sustainable number of staff. Improving the amount of RN staffing would support the best care possible to the residents in long-term care.[68]

[63]https://rnao.ca/sites/default/files/2020-06/Nursing%20Home%20Basic%20Care%20Guarantee%20-%20RNAO%20submission%20to%20LTC%20staffing%20study%20advisory%20group%20-%20Final%20-%20June%2009%2C%202020.pdf
[64]https://rnao.ca/sites/default/files/2020-06/Nursing%20Home%20Basic%20Care%20Guarantee%20-%20RNAO%20submission%20to%20LTC%20staffing%20study%20advisory%20group%20-%20Final%20-%20June%2009%2C%202020.pdf
[65]https://rnao.ca/sites/default/files/2020-06/Nursing%20Home%20Basic%20Care%20Guarantee%20-%20RNAO%20submission%20to%20LTC%20staffing%20study%20advisory%20group%20-%20Final%20-%20June%2009%2C%202020.pdf
[66]https://rnao.ca/sites/default/files/2020-06/Nursing%20Home%20Basic%20Care%20Guarantee%20-%20RNAO%20submission%20to%20LTC%20staffing%20study%20advisory%20group%20-%20Final%20-%20June%2009%2C%202020.pdf
[67]https://rnao.ca/sites/default/files/2020-06/Nursing%20Home%20Basic%20Care%20Guarantee%20-%20RNAO%20submission%20to%20LTC%20staffing%20study%20advisory%20group%20-%20Final%20-%20June%2009%2C%202020.pdf
[68]https://rnao.ca/sites/default/files/2020-06/Nursing%20Home%20Basic%20Care%20Guarantee%20-%20RNAO%20submission%20to%20LTC%20staffing%20study%20advisory%20group%20-%20Final%20-%20June%2009%2C%202020.pdf

The Consequences of Inadequate RN Staffing

Several studies have proven that the presence of RNs is vital in the context of increasing acuity and needs in LTC homes. Increased risk of falls, malnutrition, pressure injuries, urinary tract infections, and infections are results of inadequate nursing care.[69] [70] In a study on the relation between RN staffing levels and clinical outcomes in LTC homes, researchers find more than one-quarter of their targeted residents developed a pressure ulcer or experienced weight loss as a consequence of inadequate RN staffing.[71] The Ontario Health Coalition receives frequent complaints from family members of loved ones in LTC homes who suffer or die as a result of urinary tract infections that are not diagnosed until too late. This, along with devastating falls that are also not properly assessed by an RN or physician, is one of the most frequent complaints, pre-COVID that the Coalition received regarding LTC. Negative health outcomes lead to burdens on the healthcare system due to increased hospital admissions, treatment costs, and mortality.[72]

When working as the only RN on shift, the focus is to complete the most prioritized activities that require clinical decision-making. As a result, the psychosocial and emotional needs of the clients are not met, and there is less time to communicate with other care workers.[73] With fewer RNs on staff, most RNs find themselves working in isolation. This creates a challenge in practical settings when RNs are unable to gain support from other staff members who carry a similar level of expertise. The lack of work collaboration between RNs also creates a barrier to opportunities for innovative changes and strategies to address challenges in the homes. Other health care workers such as PSWs and RPNs also suffer from inadequate RN staffing in the homes. Staff members experience stress and burnout when they are incapable of meeting the needs of assigned tasks beyond their scope of practice.[74] [75]

[69] https://rnao.ca/sites/rnao-ca/files/Transforming_long-term_care_backgrounder.pdf
[70] https://nurse.org/articles/nurse-staffing-unsafe-long-care-facilities/
[71] https://journals.lww.com/ajnonline/Fulltext/2005/11000/RN_Staffing_Time_and_Outcomes_of_Long_Stay_Nursing.28.aspx
[72] https://nurse.org/articles/nurse-staffing-unsafe-long-care-facilities/
[73] https://rnao.ca/sites/default/files/2020-06/Nursing%20Home%20Basic%20Care%20Guarantee%20-%20RNAO%20submission%20to%20LTC%20staffing%20study%20advisory%20group%20-%20Final%20-%20June%2009%2C%202020.pdf
[74] https://www.ona.org/wp-content/uploads/ona_ltcreport_2019.pdf
[75] https://nurse.org/articles/nurse-staffing-unsafe-long-care-facilities/

Nursing Environment in LTC Homes

It is important to note that LTC homes staffing consists largely of racialized women who are working in unsupportive environments.[76] There is a pervasive environment of fear where people are afraid to complain or speak out, or advocate for systemic reform. We believe that this is one of the factors that result in the poor response rate in our research.

"Why would a RN want to work in a setting
that is chronically understaffed, unsafe and a complicated work environment for less money?"
- A lawyer who has been working to advocate for the aging population.

Another challenge created by the staffing shortages of RNs is that many homes rely on temporary hiring agencies to fill roles. When this happens, the RNs are unofficially considered 'guests' or outsiders by regular staff. Due to the nature of social groups and othering, agency RNs often do not have much power to advocate for their patients and effect change in their workplace. This is especially true if there is a disagreement between the agency hired RNs and other professionals hired by the LTC home.

"The agency hired RN may feel less confident advocating for patient safety and may even be bullied by the other staff for attempting to pursue different care options for clients."
- Anonymous, RN working at a LTC home.

A part of the pride and joy that LTC nurses experience is the deep connection that they develop with residents and the families. Unlike in hospitals where patients come and go, LTC nurses get to know and bond with each and every one of the residents in the building. It is the camaraderie that keeps nurses in the sector.[77] However, it is hard to see that kind of joy happening during the pandemic. Grief, trauma, and stress have pushed burnout to a critical point. In the stories shared by LTC nurses through ONA, it is clear that nurses in LTC love and care for the residents like they belong to their own families. It becomes very difficult for both the nurses and family members when the resident passes away.[78] Nurses further suffer when vacations and breaks are denied to allow time for grieving.[79]

"To us, they [the residents] were each a person, they were our family and they were loved. You become attached to them and it's very, very difficult when they do pass. It's about personalities; we have quite the characters. I realize it's very hard on the family, but it's not any easier for us."
-Shelley, RN working in LTC for over 14 years[80]

[76] https://www.cmaj.ca/content/192/23/E632
[77] https://www.ona.org/carenow/#1562958318821-b57fcee3-156c
[78] https://www.ona.org/carenow/#1562958318705-51b605e9-4951
[79] https://www.ona.org/carenow/#1562958319130-0ea626e3-94d3
[80] https://www.ona.org/carenow/#1562958318705-51b605e9-4951

Recommendations

We recognize the limitations in our study, further research is needed to confirm the RN staffing levels in LTC homes across Ontario and we hope that our findings help illuminate the need for reporting on actual RN staffing levels in LTC. Based on our research, the following are our recommendations to help improve quality of life and quality of care for residents in Ontario's LTC homes:

- Transparent and easily-accessible reporting of actual hands-on staffing levels in all long-term care homes should be required.
- The emergency order that deregulates the only existing staffing standard for RNs, contained in Section 8 of the LTC Homes Act, Ontario (2007) should be removed and the minimum staffing standard in the Act should be immediately reinstated.
- The minimum RN standard of one RN 24/7 no matter the size of the LTC home is inadequate. It should be amended to reflect the real intensity of RN staffing required to meet the increased acuity of LTC home residents.
- A minimum care standard for daily hands-on care (RN, RPN, PSW) of 4-hours per day should be implemented as quickly as possible.
- LTC home licensees must be held accountable in meaningful ways to uphold the fundamental principle in the LTC Homes Act "...that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."
- LTC home inspections programs should be amended to ensure that staffing, including RN staffing, is adequate.
- LTC home licensees must be held accountable in meaningful ways to meet the required staffing levels, including RN staffing.
- Stronger, more effective whistleblower protection must be provided for nurses to fulfil their role as advocates on behalf of their residents and to report inadequacies in care and conditions.
- At least one dedicated RN Infection Prevention and Control specialist with adequate coursework, training and certification through the Canadian Nurses Association's Certificate of Infection Control should be in every LTC home.
- Geriatric nursing care should be integrated into the nursing curriculum as it reflects the challenges and expertise of nurses working in LTC homes.
- Measures to improve working conditions should be implemented in LTC homes.