

# Long-Term Care Staffing Study

Long-Term Care Staffing Study Advisory Group  
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## Executive Summary

Staffing is essential to meet the needs of all long-term care residents across Ontario. The long-term care staffing study responds to Recommendation #85 of the report released by Justice Gillese of the [Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System](#). Recognizing the critical role of staffing in the system, the Ministry of Long-Term Care (the ministry) expanded the scope of the study to include all long-term care staff and to consider key factors in workforce recruitment and retention.

The ministry launched the staffing study in February 2020 to provide strategic advice on staffing in the long-term care sector across the province. To ensure that the needs and concerns of all impacted groups would be reflected, the ministry relied on the experience and expertise of an external Advisory Group comprised of operators, academics, and thought-leaders – as well as representation of residents and families. A range of long-term care partners, including labour unions and operator associations, were engaged during this process.

This study will help inform a comprehensive staffing strategy for long-term care and provides guidance on potential staffing levels, models and skill mix, sector culture, working conditions, and education and training. This guidance is intended to support better resident quality of life, respond to increased resident acuity and support the planned expansion of the long-term care system.

### System Overview

Long-term care homes employ over 100,000 people across Ontario. They serve an increasingly medically complex population of approximately 78,000 residents.

All long-term care homes across Ontario are required to have a staffing mix that provides an appropriate level of care and services. The requirements under the *Long-Term Care Homes Act, 2007* include various specified staffing roles, including administrators, personal support workers, registered nursing staff, and allied health professionals.

The staffing study provides an overview of average wages, education, tenure and turnover for employees working in long-term care. Some of the key long-term care sector statistics identified in this study are:

- 58 percent of employees are personal support workers (PSWs), followed by registered nurses (RNs) at 25 percent
- Approximately 40 percent of RNs and registered practical nurses (RPNs), and 63 percent of nurse practitioners work full-time
- Approximately 25 percent of PSWs who have two or more years of experience leave the sector annually

### Pressures of COVID-19

Many of the reoccurring issues facing both long-term care employees and the sector have been exacerbated by the COVID-19 pandemic. During the height of the pandemic, several long-term care

homes across the province reported critical staffing shortages – impacting the quality of resident care and employee safety.

## Challenges to the Sector & Barriers to Change

While the demand for long-term care and resident acuity have increased year over year, staffing levels and access to training have not kept a corresponding pace. Over time, the demand placed on long-term care staff often causes greater workload. This can increase the risk of worker injury, lead to less attention and time spent per resident and contribute to a stressful working environment. Issues such as working conditions and a negative public image have also contributed to staffing shortages in the sector.

While the province’s legislative and regulatory framework is designed to ensure that long-term care residents live in a safe environment and hold long-term care homes accountable, several operators and associations have reported that the framework can be a barrier for exploring potential solutions for staffing shortages and issues.

Across the sector, long-term care partners have identified the current culture of long-term care as one based heavily on compliance, which can create a punitive environment for staff. It was also heard that the current funding model for long-term care homes is too complex and requires high levels of documentation, which takes staff away from spending quality time with residents.

## Key Findings & Recommendations

The Long-Term Care Staffing Study Advisory Group’s findings highlight that staffing issues are complex and systemic in nature. The Advisory Group encourages the ministry to prioritize its plans to develop a comprehensive staffing strategy. Action must to be taken to:

- Urgently address the staffing crisis in long-term care;
- Make long-term care homes a better place to live and work; and
- Implement staffing approaches that reflect and respond to the complexity of the sector and diverse resident needs.

The Advisory Group provides recommendations within five priority areas to improve staffing across the sector:

### **1. The number of staff working in long-term care needs to increase and more funding will be required to achieve that goal**

- Staffing investment
- Minimum daily average of four hours of direct care per resident
- Guidelines for improving staffing ratios and skill mix for PSWs, nursing staff, and allied health professionals, with variance to address specific circumstances

### **2. The culture of long-term care needs to change – at both the system and individual home level**

- Regulatory modernization
- A quality improvement approach to sector oversight

- Renewed performance measurements
  - A strong coherent philosophy of care
  - Recognition of the critical role of PSWs
  - Respectful team environment
- 3. Workload and working conditions must get better, to retain staff and improve the conditions for care**
- Compensation
  - Full-time and part-time employment
  - Protection from physical, mental and emotional risk
  - Charting and documentation
  - Medication management
- 4. Excellence in long-term care requires effective leadership and access to specialized expertise**
- Clarifying the role and accountability of the Medical Director
  - Expanding the use of Nurse Practitioners
  - Ensuring access to strong Infection Prevention and Control (IPAC) expertise
  - Accessing specialists
- 5. Attract and prepare the right people for employment in long-term care, and provide opportunities for learning and growth**
- Attracting people with the right personal attributes through:
    - Improved public perception
    - Stronger relationships with secondary schools
    - Enhanced supports for new graduates
    - Expanding the labour pool
  - Aligning the number of graduates with needs across the health care sector
  - Addressing educational requirements for the long-term care sector by:
    - Increasing onsite experiences for students
    - Promoting preceptorships
  - Supporting staff to stay current, gain new skills and develop specialized expertise, including:
    - Continuing education
    - Micro-credentialing and job laddering

## Introduction

The long-term care system exists to support the advanced care needs of the people of Ontario. Long-term care homes are residents' homes, where they may live with dignity, in security, safety and comfort, and have their physical, psychological, social, spiritual and cultural needs adequately met.<sup>1</sup> At their best, Ontario's long-term care homes provide a sense of community and camaraderie for residents, as well as high job satisfaction for staff.

Concerns have been heard from a wide range of organizations regarding staffing challenges within the long-term care sector. Addressing these concerns is fundamental to developing a modernized system that delivers safe, quality and resident-centered care, and can meet the growing demands of an aging population.

In 2019, Justice Eileen E. Gillese released the report of the [Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System](#) (The Gillese Inquiry). The Gillese Inquiry was established to examine the offences of a registered nurse in long-term care. The Gillese Inquiry's mandate was to understand the events which led to the offences, as well as the circumstances and contributing factors. Eighteen of the resulting 91 recommendations related directly to staffing within the long-term care sector.

These recommendations include potential improvements around staff training (e.g., registered nursing staff, medical directors, contract and full-time staff, and management), human resource management, funding changes within the system, and overall changes to culture. Recommendation #85 directed the ministry to complete a staffing study to determine adequate levels of registered staff in long-term care homes.

**Recommendation 85:** The Ministry of Health and Long-Term Care should conduct a study to determine adequate levels of registered staff in long-term care homes on each of the day, evening, and night shifts. The Minister of Health and Long-Term Care should table the study in the legislature by July 31, 2020. If the study shows that additional staffing is required for resident safety, long-term care homes should receive a higher level of funding overall, with the additional funds to be placed in the nursing and personal care envelope.

To address this recommendation, the Ministry of Long-Term Care launched a long-term care staffing study in early 2020, with support from an external [Advisory Group](#). This group was instructed to directly respond to Recommendation #85, as well as to seek broader input on a wider range of long-term care staffing issues. The study was launched to provide advice to the Deputy Minister on potential long-term care staffing models to support resident safety, quality of care, and critical factors associated with improved long-term care workforce recruitment and retention. The Advisory Group engaged with a variety of long-term care sector partners (e.g., associations, operators, unions) to better understand the range of perspectives on staffing issues facing the sector.

During the course of the staffing study, the province declared a state of emergency due to the COVID-19 pandemic. Long-term care residents, who are older and frailer than the general population with more complex medical needs, were impacted by COVID-19. A high concentration of outbreaks (defined as a single, laboratory confirmed case of COVID-19 in a resident or staff member<sup>2</sup>) and mortality occurred within Ontario's long-term care homes.<sup>3</sup> As of July 2020, 21.5 percent of confirmed cases of COVID-19 in

<sup>1</sup> As outlined in the *Long-Term Care Homes Act, 2007*

<sup>2</sup> As defined by the Chief Medical Officer of Health's Directive #3 issued to long-term care homes

<sup>3</sup> An outbreak is defined as a single laboratory confirmed case of COVID-19 in a resident or staff member, as defined by the Office of the Chief Medical Officer of Health.

Ontario were reported to be long-term care residents and staff, and 63.7 percent of deaths with COVID-19 were long-term care residents and staff.<sup>4</sup>

The impact of COVID-19 among Ontario's long-term care homes has varied substantially across the province. As of July 2020, 52 percent of long-term care homes experienced one or more cases of COVID-19 within their resident or staff population. While all staff, residents, and families were directly impacted by the pandemic, most homes, while challenged, have managed well through the pandemic by limiting significant disease spread within the home or by avoiding any cases within the home altogether. Regrettably, it is clear that other homes struggled to contain the spread of the disease, resulting in a greater number of cases and the loss of life of both residents and staff.

Staffing challenges have clearly been exacerbated throughout the province since COVID-19 first took hold in March 2020. Where relevant to the focus of this study, this report includes some initial observations about the impact of the pandemic on long-term care staffing. The government has announced an Independent Commission into long-term care to gain a better understanding of the impacts and responses to COVID-19.

In addition to the Advisory Group's key findings and recommendations, this staffing study documents the current state of staffing in Ontario's long-term care system, including the perspectives of long-term care organizations. This study is intended to inform a comprehensive staffing strategy for the long-term care sector.

Overall, this study will assist the Ministry of Long-Term Care to address staffing challenges, modernize the sector, and transform long-term care into a resident-centered home for some of Ontarians most vulnerable.

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<sup>4</sup> Ontario COVID-19 epidemiology summary. Accessed via: <https://files.ontario.ca/moh-covid-19-report-en-2020-07-14.pdf>

## Long-Term Care System Overview

Under the *Long-Term Care Homes Act, 2007* (LTCHA) and Regulation 79/10 (the regulation), all long-term care homes in Ontario are required to provide residents with care and services that meet the assessed needs of residents. This includes meeting specific staffing requirements, such as:

- *Administrator*: Each home must have an Administrator who is in charge of the home and is responsible for its overall management
- *Director of Nursing and Personal Care (DONPC)*: Each home must have a DONPC, who must be a registered nurse. They supervise and direct the nursing staff and personal care staff of the home as well as provide care.
- *Medical Director*: Each home must have a Medical Director to evaluate and address medical practices, clinical procedures and resident care. This position must be filled by a physician, and may not be the licensee, a person having a controlling interest in the license or a member of the board of a corporate licensee.
- *Attending Physician or Registered Nurse in the extended class (RNEC)*: Each home must ensure that either a physician or RNEC conducts a physical examination of each resident upon admission and annually thereafter. The RNEC shall supply a written report of their findings.
- *Registered Nurse*: Each home must have at least one registered nurse on duty and present in the home at all times, except as provided for in the regulation. The registered nurse must be both an employee of the licensee and a member of the regular nursing staff of the home.

The LTCHA requires that all staff, including administrators, personal support workers, registered nursing staff, and allied health professionals, must have the proper skills and qualifications to perform their duties and possess the qualifications outlined in the LTCHA and regulation. The legislation and regulation do not contain requirements around the proportion of staff, or the number of hours of direct care provided to residents. This is determined by yearly staffing plans developed by the homes based on the residents' care needs.

Long-term care homes employ over 100,000 staff across the province, not including staff service providers who come into the home to provide special services such as x-ray technicians and optometrists.<sup>5</sup> As of 2018, homes reported over 56,000 full time equivalent (FTE) positions that provide direct care to residents across the sector, compared to 43,023 reported FTEs in 2009.<sup>6</sup> The number of beds increased by 2,799 in the same time, which is approximately a four percent increase in beds.

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<sup>5</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care. The long-term care staffing report (2018), determined a headcount based on 602 of the 626 homes that responded. This is approximately 83,000 staff, and does not include some staff, including cleaners and cooks. If included, these numbers would result in a headcount of over 100,000.

<sup>6</sup> Statistic provided by the Long-Term Care Operations Division, Ministry of Long-Term Care. The 2009 long-term care staffing report is based on responses from 550 homes, and the 2018 report is based on responses from 602 out of 626 homes.



Onsite staff include clinical, caregiving, administration, housekeeping, food preparation, facilities, maintenance, and recreation staff. Long-term care staff in both clinical and non-clinical positions provide direct care to residents.

The largest proportion of employees in long-term care are:

1. Personal support workers (58 percent);
2. Registered nursing staff (including registered practical nurses, registered nurses, and nurse practitioners) (25 percent); and
3. Allied health professionals and programming support (such as activity assistants, dietitians, occupational and physical therapists, and social workers) (12 percent).

**Personal support workers** (PSWs) are the largest population of employees in the long-term care sector. Each year, long-term care homes across Ontario submit reports about staffing to the ministry. This information is used to generate the long-term care staffing report.<sup>7</sup> According to the latest available report (2018), 41 percent of PSWs work full-time, 48 percent work part-time, and 10.7 percent are casual.<sup>8,9</sup> Approximately half of these employees would prefer to work more hours, and 7 percent would prefer to work less; while 43 percent are satisfied with the number of hours they work.<sup>10</sup>

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<sup>7</sup> The long-term care staffing report is generated via voluntary submission of a staffing survey. In the last complete dataset, 2018, 602 of 626 long-term care homes submitted data.

<sup>8</sup> Full-time is defined as an employee who is regularly scheduled for work 75 hours or more on a biweekly basis for the purposes of the long-term care staffing report.

<sup>9</sup> The long-term care staffing report does not measure purchased services, such as agency staff.

<sup>10</sup> Zeytinoglu, I.U., Denton, M., Brookman, C. et al. (2017). Health and safety matters! Associations between organizational practices and personal support workers' life and work stress in Ontario, Canada. *BMC Health Serv Res* 17, 427. <https://doi.org/10.1186/s12913-017-2355-4>

## Personal Support Workers (PSWs) in the Health Care Sector

As of 2018, there were 100,000 PSWs employed in Ontario in all healthcare sectors.<sup>11</sup>

50,000 of these employees work in long-term care, where they share the equivalent of 32,700 FTEs.



90% of the PSW workforce in the health care sector is female.

50% of the PSW workforce in the health care sector are between 35 and 54 years old.

**35-54**  
years old

25% of the remaining PSWs are 55 years or older.

**41%**

41% of the PSW workforce in the health care sector are visible minorities

MLTC understands that the number of training positions has not declined, but instead there has been a reduced interest of students to enter the PSW training programs.<sup>12</sup>



2015/16

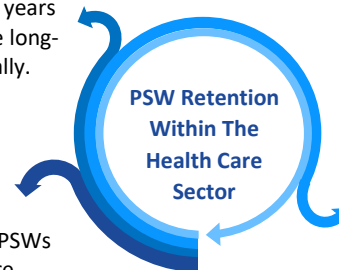
Over 8,000 students enrolled in PSW training programs (e.g., public programs, private programs and boards of education).



2018/19

Approximately 6,500 students enrolled in PSW training programs.

Approximately 25% of PSWs who have two or more years of experience leave the long-term care sector annually.



According to Health Force Ontario, 50% of PSWs are retained in the health care sector for fewer than 5 years, and 43% left the sector due to burnout of working short staffed.<sup>13</sup>

Approximately 40% of PSWs have left the health care sector after graduating or within a year of training.

The average overall job tenure of a PSW (in all sectors) has dropped 10 months to 85-90 months between 2015 and 2017.

Turnover is highest for part-time and casual positions predominantly held by entry-level PSWs.

In addition to long-term care, PSWs are employed in the hospital sector, and in the home and community care sector. Compensation differs by sector, and by home type within the long-term care sector, itself.<sup>14, 15, 16</sup>

<sup>11</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care

<sup>12</sup> Ibid.

<sup>13</sup> Lakusta, W. (2018). Employer Perspectives on Personal Support Worker Recruitment and Retention. Health Force Ontario.

<sup>14</sup> Hourly Range and Average wage data: hospital data sourced from Ontario Hospitals Association, home and community care compensation sourced from Ontario Collective Agreements Database in 2019, and long-term care (avg) sourced from the long-term care staffing report, 2018.

<sup>15</sup> Hourly Range and Average wage information for for-profit, not for profit and municipal long-term care homes is sourced from the long-term care staffing report and is based on 10<sup>th</sup>-90<sup>th</sup> percentile of home level hourly salary.

<sup>16</sup> Hourly Range and Average wage information for for-profit, not for profit and municipal long-term care homes (in blue) sourced from the Ministry of Labour collective agreement database as of August 2, 2019. The wage 'Average' is the average of the minimum and maximum hourly wage provided in the "Hourly Range" and does not represent the actual average wage of staff in each sector.

### Average Wage of PSWs Across Sectors

Sector	Hourly Range	Average
Hospital	n/a	\$23.78
	\$22.51 - \$23.31	\$22.91
Home and Community Care	\$16.78 - \$17.82	\$17.30
Long-Term Care (avg)	\$20.43 - \$27.23	\$22.69
	\$20.64 - \$22.25	\$21.41
Long-Term Care – For Profit	\$20.43 - \$26.48	\$22.27
	\$19.52 - \$21.15	\$20.33
Long-Term Care – Not For Profit	\$20.43 - \$27.23	\$22.75
	\$19.86 - \$21.69	\$20.78
Long-Term Care - Municipal <sup>17</sup>	\$21.90 - \$27.22	\$25.01
	\$23.58 - \$24.99	\$24.28

**Note:** The variability in the average wages above is due to the different sources of data. See footnotes for more details.

- Hospital sector data - Ontario Hospitals Association (white), and collective agreements held within the Ministry of Labour (MOL) Collective Agreement Database (blue).
- Long-term care sector data - voluntary data provided by long-term care homes as part of the annual long-term care staffing report (white), and collective agreements held within the MOL database (blue).

**Registered Nursing Staff** are the second largest population of long-term care employees:

- 63 percent of nurse practitioners (NPs), 40 percent of registered nurses (RNs), and 39 percent of registered practical nurses (RPNs) work full time;
- 35 percent of NPs, 41 percent of RNs, and 45 percent of RPNs work part time;

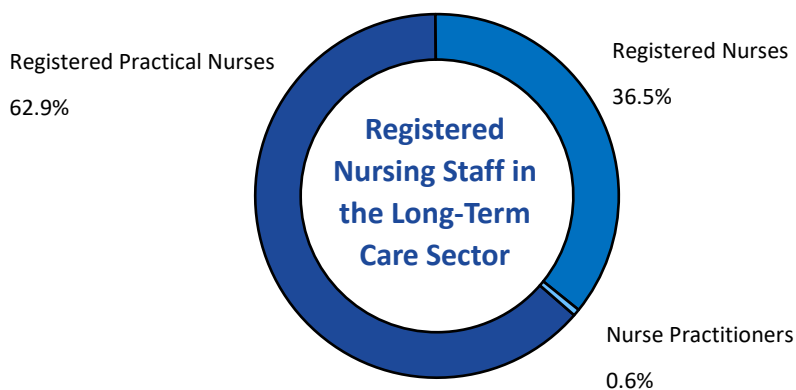
<sup>17</sup> Municipally-operated long-term care homes have similar wage agreements as other municipal staff, so staff in municipal homes tend to have higher rates of compensation compared to other homes. Municipally-operated homes also receive additional funding from the municipality.

- 2 percent of NPs, 19 percent of RNs, and 16 percent of RPNs work ‘casual’.<sup>18</sup>

Approximately 30 percent of RNs and RPNs working in long-term care hold two or more jobs.<sup>19</sup>

### Registered Nursing Staff in the Long-Term Care Sector

In 2018, 23,701 RPNs, RNs and NPs were employed in the long-term care sector.<sup>20</sup>



The number of registered nursing staff in the long-term care sector has increased by 9.6% since 2013.

**9.6%**

However, the proportion of RNs in the long-term care sector has decreased over the same time period, while the proportion of RPN and PSWs has increased.

The average age of registered nursing staff within long-term care is 42.4 years old

**42.4**  
years old

Between 2013 and 2018, RN employment levels across all sectors remained the same, while registered practical nurse levels rose by 15.1% and nurse practitioner levels rose by 130.6%. The number of registered nursing staff of all nursing classes rose by 9.5%.<sup>21</sup>

**76.1%**

76.1% of LTC registered professionals reported they prefer fulltime work.

As is the case for PSWs, nurses’ salaries vary across sectors. The average hourly wage across the sectors and nursing categories is below.<sup>22</sup>

<sup>18</sup> Statistic provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care. This data is based on staff headcount and does not capture purchased services (e.g., agency staff)

<sup>19</sup> Ibid.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> Wage information sourced from Long-Term Care Staffing Report, Hospital data sourced from Ontario Hospitals Association, Home and community care compensation sourced from Ontario Collective Agreements Database.

### Average Wage of Nurses across Sectors<sup>23,24</sup>

Sector	Nurse Practitioners		Registered Nurses		Registered Practical Nurses	
	Hourly Range	Average	Hourly Range	Average	Hourly Range	Average
Hospital	n/a	\$56.47	n/a	\$46.75	n/a	\$30.67
	\$51.88 - \$60.12	\$56.00	\$33.48 - \$47.46	\$40.47	\$29.08 - \$30.91	\$29.99
Home and Community Care	\$47.04 - \$54.54	\$50.79	\$34.90 - \$39.05	\$36.98	\$23-76 - \$26.51	\$25.14
Long-Term Care (avg)	\$44.41 - \$70.02	\$57.36	\$38.52 - \$49.75	\$44.14	\$25.49 - \$34.25	\$29.40
	\$53.47 - \$63.65	\$58.56	\$30.64 - \$45.45	\$38.05	\$26.04 - \$28.36	\$27.02
LTC – For Profit	\$47.42 - \$67.78	\$57.17	\$38.53 - \$49.75	\$43.71	\$25.50 - \$33.67	\$27.60
	n/a	n/a	\$30.02 - \$45.14	\$37.58	\$23.48 - \$26.29	\$24.88
LTC – Not For Profit	\$46.07 - \$70.02	\$58.05	\$38.52 - \$49.74	\$43.91	\$25.49 - \$34.25	\$28.46
	n/a	n/a	\$31.12 - \$45.15	\$38.13	\$25.13 - \$27.26	\$26.19
LTC - Municipal	\$44.41 - \$67.08	\$56.56	\$38.70 - \$49.49	\$45.38	\$27.00 - \$34.17	\$30.56
	\$53.47 - \$63.65	\$58.56	\$33.13 - \$47.40	\$40.27	\$28.91 - \$30.81	\$29.86

**Note:** The variability in the average wages above is due to different sources of data. See footnotes for more details.

- Hospital sector data - Ontario Hospitals Association (white), and collective agreements held within the MOL Collective Agreement Database (blue).
- Long-term care sector data - voluntary data provided by long-term care homes as part of the annual long-term care staffing report (white), and collective agreements held within the MOL Database (blue).

<sup>23</sup> Hourly Range and Average wage information for for-profit, not-for-profit and municipal long-term care homes (in white) sourced from long-term care staffing report and based on 10th-90th percentile of home level hourly salary.

<sup>24</sup> Hourly Range and Average wage information for for-profit, not for profit and municipal long-term care homes (in blue) provided by Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care, values sourced from the Ministry of Labour collective agreement database as of August 2, 2019.

The wage 'Average' is the average of the minimum and maximum hourly wage provided in the "Hourly Range" and does not represent the actual average wage of staff in each sector.

### Allied Health Professionals and Programming Support

In 2018, 9,700 allied health professionals and programming support staff worked in the long-term care sector.<sup>25</sup> This group of staff includes, but is not limited to:



- Occupational Therapist
- RAI Coordinator
- Physiotherapist
- Clinical Manager
- Infection Control Practitioner
- Volunteer Coordinator
- Dietician
- Social Worker/Social Service Worker
- Activity Director
- Respirative Aide (Rehab/Therapy Aide)
- Secretary/Ward Clerk
- Health Care Attendant/Aide
- Activity Assistant
- Other (Resident Services Coordinator, Staff Educator, Palliative Care, Nursing Administrative Support)



The proportion of each staff group varies across long-term care homes due to a range of factors such as resident need, staff availability, recruitment and retention, the size and structure of the home and local management discretion.

Above is a graph of the top 10 employment types in long-term care, and their average proportion across the province.<sup>26</sup>

The mix of these groups can differ slightly depending on the type of home. For the top 10 job classifications, homes have largely the same staffing mix. However, slight variations exist; for example,

<sup>25</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care

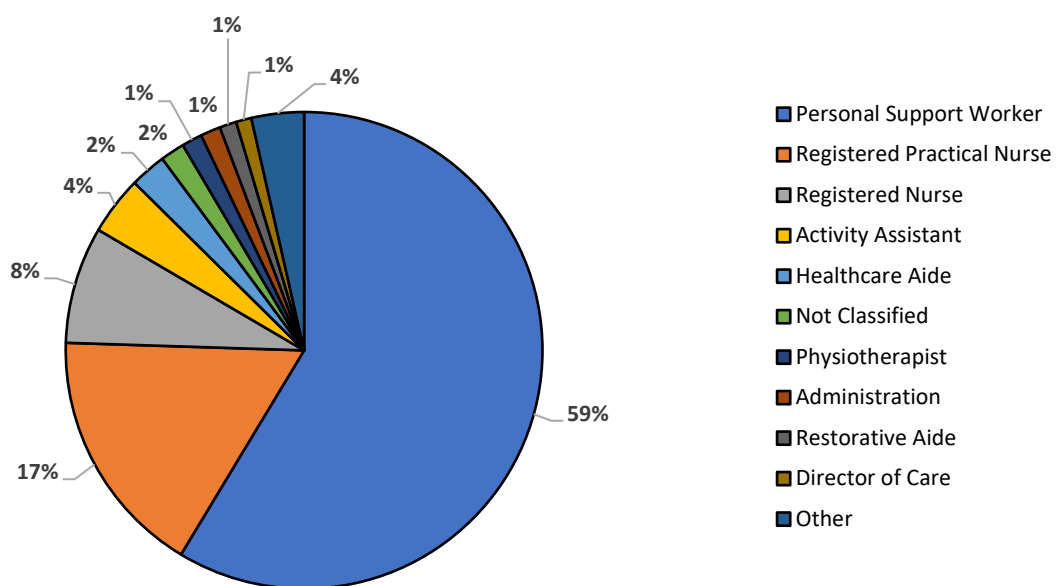
<sup>26</sup> The category “other” is included to denote job classifications which were not in the top 10 categories, and “not classified” refers to jobs which do not have their own classification in the long-term care staffing report.

homes of under 64 beds tend to have fewer PSWs and more RNs and healthcare aides per resident, than larger homes.

Most Ministry of Long-Term Care funding is targeted at care and accommodation. This is organized through four Level-of-Care (LOC) envelopes: Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF) and Other Accommodation (OA). The funding provided through the NPC and PSS envelopes may only be used to fund salaries, benefits, equipment and supplies specific to the types of staff performing roles as defined for those envelopes (i.e. nursing and program staff). The provincial government provides 60 to 70 percent of home funding, and the remainder comes from sources such as resident co-payments, fundraising, and municipal governments.<sup>27</sup> How homes can spend this funding is prescribed by eligibility criteria, yet it can still vary to a degree.

For instance, total spending on compensation accounts for approximately 71.3 percent of total expenses in for-profit homes, 73.3 percent in not-for profit homes, and 81 percent in homes operated by municipalities.<sup>28</sup> This variation may be due to different funding sources such as municipal government funding and fundraising, and how these funds are allocated within each home.

**Average Proportion of Staff Employed in Homes, as of 2018<sup>29</sup>**



<sup>27</sup> Resident co-payments comprise a significant portion of non-provincial government funding for all homes (estimated at \$1.6 billion from resident co-payments in 2019-2020). Fundraising is predominantly used by not for profit homes, and municipal funding is provided for homes which are operated by the municipality.

<sup>28</sup> Statistics provided by the Long-Term Care Operations Division, Ministry of Long-Term Care.

<sup>29</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care. This is a headcount based on 602 of the 626 homes that responded to the 2018 long term-care staffing report.

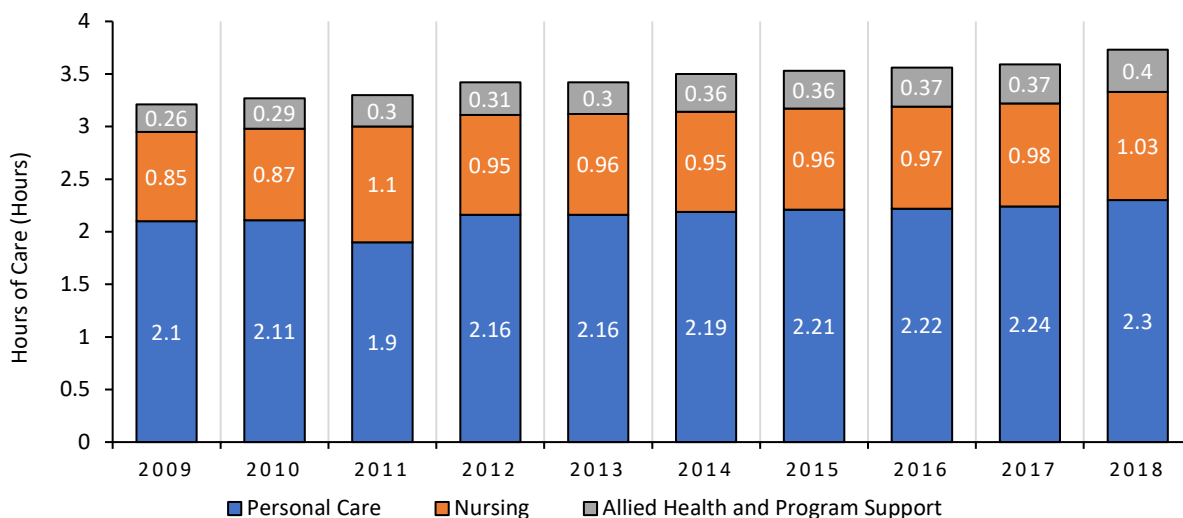
As of 2018, homes report an average of 3.73 direct hours of care per resident, per day based on paid hours. This breaks down to an average of two hours and 18 minutes from PSWs, one hour and 2 minutes from RNs or RPNs, and 24 minutes from allied health professionals and programming support. The chart below depicts how paid care hours for caregiving staff per resident has increased by 15 percent between 2009 and 2018.<sup>30</sup>

**Worked Hours** are the hours that are spent by staff carrying out the mandate of the service, i.e. staff are present and available for work. Worked hours include regular worked hours, worked statutory holidays, relief/replacement hours for vacation and sick days, overtime and callback hours paid and banked and attendance at committee meetings and informal education.

**Paid Hours** includes all worked hours, with the addition of vacations, statutory holidays, and benefits.

It is difficult to accurately compare Ontario with other Canadian jurisdictions given differences in measurement. In terms of paid care hours per resident, Alberta reports providing 3.6 hours of nursing and personal support with an additional 0.4 hours from allied healthcare providers.<sup>31</sup> British Columbia provides 3.6 *worked* hours, with additional direct care from allied health care providers.<sup>32</sup>

**Paid Direct Hours of Care Per Resident Per Day in Ontario<sup>33</sup>**



In some homes, families hire additional care staff to provide for their loved ones. Outside of paid employees, care is also provided by family and volunteers. In 2018, approximately 3.6 million Canadians reported providing care for their parents or parents-in-law, and another 1 million, usually older

<sup>30</sup> Statistics provided by the Long-Term Care Operations Division, Ministry of Long-Term Care.

<sup>31</sup> Report of the Auditor General of Alberta. (2014). Health and Alberta Health Services – Seniors Care in Long-term Care Facilities Follow-up.

<sup>32</sup> Government of British Columbia: Ministry of Health. (2017). Residential Care Staffing Review.

<sup>33</sup> Long-term care staffing report, 2018.



Canadians, supported a spouse or partner.<sup>34</sup> It is estimated that these family caregivers contribute the equivalent of between \$26 and \$72 billion to our society every year.<sup>35</sup> Thirteen percent of these caregivers provided care to a loved one in an institution or facility, such as long-term care homes.<sup>36</sup>

These family caregivers spend significant amounts of time in the long-term care home and remain intensively involved in care. It has been found that just over 20 percent of the family caregivers assisting someone in a care facility gave over 10 hours of care per week, with more hours provided when a resident was older and had more severe health conditions such as dementia.<sup>37</sup> The care they provide includes feeding, grooming and washing, toileting, exercise, social and emotional support, memory support, and mobilization.<sup>38</sup> Operators, resident and family voices alike consider family caregivers to be important members of the care team.

### Pressures of COVID-19

Critical shortage determination based on:

- Whether the home had exhausted all available staffing options
- Size of home (and therefore infection prevention and control (IPAC) risk)
- Number of staff off and vacant shifts, particularly in key roles such as director of care, RNs, and PSWs
- Impact to resident care
- Immediacy of staffing decline

The issues facing long-term care employees, and the sector at large, have been exacerbated by the COVID-19 pandemic. This is particularly true of homes which have experienced outbreaks (defined as a single, laboratory confirmed, case of COVID-19 in a resident or staff member).<sup>39</sup> As of July 2020, 52 percent of long-term care homes in Ontario have not had any cases of COVID-19, while outbreaks were declared in the other 48 percent of long-term care homes.

Due to these outbreaks and other COVID-19 related issues, the sector peaked at 38 homes reporting critical staffing shortages. The largest proportion of missing shifts were among PSWs, with

one home reporting as many as 60 vacant PSW shifts experienced daily. Shortages existed in other staffing categories, as well. For instance, one 128 bed home reported 10 registered nurses missing per day.<sup>40</sup> The larger organizations operating multiple homes and a number of other homes experiencing staffing challenges were asked to complete “Return to Work” plans to outline how operators were managing these shortages. In no particular order, the following reasons were among the most commonly cited by employers for staff absenteeism, regardless of outbreak status:<sup>41</sup>

- Contracted COVID-19 themselves, or failed screening measures without a positive lab test
- Fear and anxiety about contracting COVID-19 at the long-term care home
- Requirement for staff to work at a single health care site as of April 22, 2020

<sup>34</sup> StatsCan. Accessed via: <https://www150.statcan.gc.ca/n1/daily-quotidien/200108/dq200108a-eng.htm>

<sup>35</sup> The Change Foundation calculated by using Ontario’s current minimum wage (\$14/hour) and multiplying the average hours per week of caregiving (11-30) by the number of caregivers in Ontario

<sup>36</sup> The Change Foundation. 2019. Spotlight on Ontario’s Caregivers.

<sup>37</sup> Turcotte, M., & Sawaya, C. (2015). Senior care: Differences by type of housing (Catalogue No. 75-006-X). Ottawa: Statistics Canada.

<sup>38</sup> RGP of Ontario, Provincial Geriatrics Leadership Office, & Canadian Geriatrics Society. 2020. Family Presence in Older Adult Care: A Statement Regarding Family Caregivers and the Provision of Essential Care

<sup>39</sup> As defined by the Chief Medical Officer of Health’s Directive #3 issues to long-term care homes.

<sup>40</sup> Statistic provided by the Operations Division, Ministry of Long-Term Care.

<sup>41</sup> As reported by operators.

- Misinformation about how COVID-19 spreads
- Concerns about accessing adequate personal protective equipment (PPE) demands/supply
- Timeliness and availability of testing
- Personal factors such as infection status of staff, family member vulnerability, access to childcare, Canada Emergency Response Benefit, burnout
- Early retirement (potentially to avoid contracting COVID-19)
- Agency unwilling to staff certain homes, or agency staff not returning to work

In response to the severe impact of COVID-19, the government enacted several temporary staffing measures, such as emergency orders and regulatory amendments, connecting long-term-care organizations with acute care facilities and using the Canadian Armed Forces to assist the most at-risk homes. Additional staffing measures include:

- Increased flexibility for human resources through emergency orders and temporary regulatory amendments:
  - This **staffing flexibility** enabled operators to more readily address overnight RN coverage issues, opened the door to recruiting students and volunteers, and utilize new staff cohort models, while ensuring safety was maintained.
- An emergency order to limit work locations:
  - Limiting long-term care employees to **work in one location** (either long-term care home or other healthcare setting) impacted long-term care staffing levels in some cases.
- Launch of the **Ontario Matching Portal**:
  - The [Ontario Matching Portal](#) was launched on April 7, 2020 to match volunteer health care providers with Health Human Resources (HHR) deficits across the health system. Of the **1,427** requests for staff, **49.4 percent** of requests were made by long-term care homes (705 requests), and **84.6 percent** of these requests have approved matches (as of July 6, 2020).
- An emergency order to provide pandemic **pay** for front-line workers, including long-term care clinical and support staff:
  - Increased funding of \$4 per hour is intended to provide additional support and relief to frontline staff, encourage staff to continue to work during the COVID-19 pandemic and to attract prospective new employees in order to maintain safe staffing levels and operations in long-term care homes. Pandemic pay is available for 16 weeks from April 24 to August 13, 2020.

## What Was Heard

From the outset, resident quality of life was identified as a paramount goal and guiding principle of the staffing study. This was a key component of discussions among the Advisory Group and during engagement with virtually all long-term care organizations consulted (e.g. operators, professional associations, labour unions, resident and family voices, and sector associations, such as AdvantAge Ontario and the Ontario Long-Term Care Association).

Through these conversations, it was evident that staff are committed to their work and want to provide high quality, resident-centered care; however, the current circumstances (e.g., staff shortages, education and training gaps, and rising resident acuity) can impede their ability to do so.

This section captures the feedback of the above-mentioned organizations and Advisory Group around staffing issues in the long-term care sector, including obstacles to progress. It is important to note that not all homes face the same obstacles, and staffing challenges are not uniformly reported across the sector. The following is a summary of the primary concerns brought forward.

### Sector Challenges

#### Responding to Rising Resident Acuity

The long-term care sector exists to support Ontarians with round-the-clock care needs, who require frequent assistance with activities of daily living, and on-site care and medical supervision that can no longer be provided in their homes. On average, residents in long-term care homes are 84 years old.<sup>42</sup> Eighty one percent of residents have some type of cognitive impairment, and often residents have advanced and ongoing medical conditions and rely on multiple drug therapies to manage them.<sup>43</sup> The demand for such services is high. As Ontario's elderly population continues to grow, the need for long-term care services, and the needs of residents within long-term care, will continue to rise.

The current long-term care waitlist is over 38,000 individuals. In general, priority on the waitlist is provided to those with the highest care needs.<sup>44</sup> The average wait time is currently 152 days, and in that time, resident needs may continue to increase. As such, long-term care becomes the home of increasingly ill people, often in the end stage of their life, with higher acuity and care needs than other care settings.

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<sup>42</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care

<sup>43</sup> Long-term care home staffing report (2018)

<sup>44</sup> An individual's prioritization on a waitlist may change as a result of additional new individuals to a waiting list who have greater care needs and as a result receive higher prioritization. In addition, an individual's own care needs may change, which could result in the individual's reprioritization on the wait list.

This increase in resident acuity can be measured in two ways:

- Case Mix Index: (CMI) is a measure of average resource need to address resident needs in the province, and/or home. From 2004-2009 the provincial CMI score increased by 12.2 percent, and by another 7.6 percent from 2009 – 2018.<sup>45, 46</sup>
- The Method for Assigning Priority Level: (MAPLe) is a score used by care coordinators to classify long-term care applicants as potential low, moderate, high, or very high-need residents, based on their medical status, cognition, behaviour, physical functioning before they are admitted to long-term care homes. The number of applicants with high or very high MAPLe scores was 82 percent in 2012, and increased to 85 percent in 2018, and 87 percent in 2019.<sup>47</sup>

**Case Mix Measurement** and methodologies are used to determine the level of resources required to care for a population. **Case Mix Index** is calculated by summing a variety of factors, including the severity of medical diagnoses, per resident, and dividing by the total number of residents. This is then weighted across the province.

The **MAPLe** methodology divides residents based on risk of adverse outcomes. The scale is out of five, beginning at self-reliance and ending at the presence of Activities of Daily Living (ADL) impairment, cognitive impairment, wandering, and/or behaviour problems. Research has demonstrated that individuals in the highest priority level are nearly nine times more likely to be admitted to a long-term care facility than are the lowest priority clients. MAPLe also predicts caregiver stress.

Concerns were expressed that funding has not kept pace with rising resident acuity. Annual investment in the acuity-adjusted NPC envelope increased at an average of 2.5 percent per year (from \$82.43 per diem in 2009-10 to \$102.34 per diem in 2019-20, an increase of approximately \$4.53 accounting for inflation).<sup>48</sup> Similarly, funding provided in the PSS envelope (including physiotherapy) increased by an average of 4.4 percent per year (from \$8.11 per diem in 2009-10 to \$12.06 per diem in 2019-20. An increase of \$2.44 in real terms).<sup>49</sup>

In the same timeframe, total long-term care funding for staffing and all other priorities increased by 33.4 percent, from \$3.26 billion in 2009-10 to \$4.35 billion in 2019-20.<sup>50</sup> Accounting for inflation, this is an increase of \$481 million, or 11 percent.

## Staff Shortages

As the demand for long-term care has increased, healthcare staffing levels have not kept pace. The Canadian Institute for Health Information has documented a decline in the nursing workforce, as have Ontario nursing associations.<sup>51,52,53</sup> Shortages have also been noted in PSWs. For example, approximately 6,500 PSWs graduated from an Ontario PSW training program in 2018-19, and each year, approximately 40 percent of PSW graduates leave their job within the year following graduation. In

<sup>45</sup> Statistics Canada, Residential Care Facilities, Table 5.7

<sup>46</sup> Statistic provided by Capacity Planning and Analytics Division, Ministry of Health and Long-Term Care: LTC Homes Case Mix Index 2009-2012. Assessment Fiscal SR Ltd.; LTC Home Level Master Sheet 2015–16, 2017 –18, 2018–19

<sup>47</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Long-Term Care

<sup>48</sup> All inflation data based on the Bank of Canada inflation tool.

<sup>49</sup> Statistics provided by the Operations Division, Ministry of Long-Term Care

<sup>50</sup> Ibid.

<sup>51</sup> CIHI. 2017. Regulated Nurses, 2016: Report. Accessed via <https://www.cihi.ca/sites/default/files/document/regulated-nurses-2016-report-en-web.pdf>

<sup>52</sup> Grinspun, Doris. 2006. Nursing Shortage a formidable but workable challenge. Accessed via [https://rnao.ca/sites/rnao-ca/files/Pages\\_from\\_July-Aug-ED\\_Dispatch\\_0.pdf](https://rnao.ca/sites/rnao-ca/files/Pages_from_July-Aug-ED_Dispatch_0.pdf)

<sup>53</sup> Ontario Nurses Association. 2016. ONA continues to fight for RN jobs. Accessed via [https://www.ona.org/wp-content/uploads/ona\\_fifeature\\_stoptheregisterednursecuts\\_201609.pdf](https://www.ona.org/wp-content/uploads/ona_fifeature_stoptheregisterednursecuts_201609.pdf)

addition, it is estimated that approximately 25 percent of working PSWs who have two or more years of experience leave the profession each year.<sup>54</sup>

In round table conversations, long-term care operators reported that:

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*...homes can be short five to 10 PSWs in every 24-hour period. Some homes [at the meeting said they] are short 20 to 50 PSWs. The situation is worse in Northern Ontario and rural areas, but the crisis exists even in the large cities of Southern Ontario. In one rural town near London, a long-term care home reported that there were only eight days of 365 in which they were fully staffed.<sup>55</sup>*

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As a result of these shortages, staff often do not have enough time to provide high-quality and holistic care to residents. For example:<sup>56</sup>

- Operators reported missed baths, missed personal care, and a lack of toileting, among other basic care functions. This was attributed to a lack of sufficient direct care per resident per day. It was reported that PSWs are often rushed and therefore cut corners to optimize the time they have available. As a result, residents may experience increased falls, levels of depression, infections, errors, complaints, anxiety, and conflict.
- A labour union reported that two-thirds of PSWs and nursing staff that were polled reported that they had to tell a resident they did not have time to take them to the washroom, and the resident would then have to wait.

There was broad consensus from operators, professional associations, labour unions, and sector representatives that to alleviate these situations, increasing the amount of direct care hours per resident per day is critically needed.

Other contributors to staff shortages include:

- **Challenging working/employment conditions for staff:**

The healthcare sector ranks second highest for injuries resulting in time lost in Ontario, and long-term care workers are among the most at risk for physical injury within the sector.<sup>57,58</sup> As of 2015, the Workplace Safety and Insurance Board, reported 3,822 injuries among the long-term care workforce which did not result in the worker needing time off, and 1,747 which did require time off. These injuries represent 27 percent of total injuries resulting in time lost in the health care sector. The most common reasons for injuries requiring leave were musculoskeletal disorders (38 percent), exposure to contaminants or chemicals (31 percent), slips, trips, and falls (11 percent), and workplace violence (9 percent).<sup>59,60</sup>

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<sup>54</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care

<sup>55</sup> Unifor (2019). Caring in Crisis: Ontario's Long-Term Care PSW Shortage. Ontario Health Coalition.

<sup>56</sup> Ibid.

<sup>57</sup> Including long-term care, retirement homes, hospitals, nursing services, supported group residences and other facilities, treatment clinics and specialized services, and professional offices and agencies.

<sup>58</sup> Ministry of Labour, Training, and Skills Development, Health Care Sector Plan 2017-18.

<sup>59</sup> Musculoskeletal disorders are injuries and disorders that affect the human body's movement mechanism. Common musculoskeletal disorders include carpal tunnel, tendonitis.

<sup>60</sup> WSIB Enterprise Information Warehouse (EIW) Claim Cost Analysis Schema and Firm Expense Schema, December 2016 data snapshot for all years

In addition, long-term care staff often face emotionally and mentally taxing working conditions.

Factors which can negatively impact mental health and emotional wellbeing include:

- Work culture: Some professional associations and operators report a lack of interprofessional respect and tension between regulated and unregulated staff.
- Resident behaviour: Eighty-one percent of residents in long-term care homes have some form of cognitive impairment, with nearly one third of these individuals displaying severe cognitive impairment.<sup>61</sup> As many as 86 percent of individuals diagnosed with dementia will display responsive behaviours as the disease progresses.<sup>62</sup> Staff can feel insufficiently prepared or supported to care for these residents.
- End of life care: Most residents reach end of life in long-term care. Staff may not be appropriately prepared to provide palliative care or to work in end-of-life environments. This can also take an emotional toll on staff as they grieve for those they have cared for.
- Abuse by residents: It is reported that staff sometimes experience violence and racism from some residents. For example, hearing racial and ethnic remarks in the workplace, particularly from residents, has been widely reported by PSWs.<sup>63</sup> While these actions are not always purposefully hurtful, they can nevertheless be difficult for staff.

Another issue for staff is the lack of full-time positions for those who want them. Staff often need to work multiple part-time jobs in order to achieve a living wage.<sup>64,65</sup> Scheduling conflicts and insufficient downtime can be a challenge for these staff. The Organization for Economic Co-operation and Development (OECD) reports that across OECD member countries, temporary contracts represent almost 20 percent of employment in long-term care, 25 percent higher than the average rate across all sectors. Comparatively, hospitals are reported to use temporary contracts 11 percent of the time. Staff can also be hired through agencies to fill gaps; however, this is a much smaller proportion of the staff in long-term care.

- **Gaps between educational experience and the work environment:**

Some organizations report a disparity between the PSWs' educational experience and reality of the long-term care work environment. While educators tend to teach to the ideal environment, the pace and nature of work in long-term care can be more challenging than what students are prepared for in training.<sup>66</sup> This is partially due to the rising complexity of resident needs and staffing shortages.

PSWs can also be subject to downloaded responsibilities that fall outside of their scope of education due to lack of staff on the shift. Further, there is scarce shift coverage available to undertake continuing education opportunities to advance their skill set to meet the care needs of residents.<sup>67</sup>

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<sup>61</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care (long-term care staffing report)

<sup>62</sup> Talerico, K, Evans, L, & Strumpf, N. 2002. The Gerontologist: Mental Health Correlates of Aggression in Nursing Home Residents with Dementia.

<sup>63</sup> Ejaz, Farida & Rentsch, Julie & Noelker, Linda & Castora-Binkley, Melissa. (2011). Racism Reported by Direct Care Workers in Long-Term Care Settings. Race and Social Problems. 3. 92-98. 10.1007/s12552-011-9045-3.

<sup>64</sup> Heard from long-term care organizations and confirmed by Advisory Group members.

<sup>65</sup> [https://www.ontariolivingwage.ca/living\\_wage\\_by\\_region](https://www.ontariolivingwage.ca/living_wage_by_region)

<sup>66</sup> Based on submissions from operators, the Ontario Personal Support Workers Association, and Advisory Group discussion

<sup>67</sup> Collins, K., Hogan, T., & Piwowski, M. Drifting off Course: Examining Role Drift Among Personal Support Workers in Ontario.

New graduates of PSW programs find the biggest gap is in preparedness for the speed at which tasks need to be completed. Task shifting, ‘working short’, and other pressures can make it difficult to utilize the concepts and techniques learned in the classroom.<sup>68</sup> Registered nursing and registered practical nursing programs may not include education and placement opportunities specific to long-term care. While entry-to-practice requirements include caring for older adults and providing geriatric care, education and placement opportunities may not be tailored to the care required in long-term care homes.

Additionally, nurses who work in long-term care participate in leadership activities to support residents, family and teams. However, new nursing graduates with entry-level leadership experiences may not be fully prepared for the resident, management and sector demands.

The Gillese Report made several recommendations in this regard, including improved nursing education before and during employment, such as caring for the elderly, patient risk management, and providing more long-term care placements.

Appropriate training is also necessary to meet the quality of life needs of residents. For example, while some Indigenous long-term care homes provide onsite cultural training, there is an opportunity to improve cultural competency training within an educational setting to prepare staff prior to their entrance to the workforce. Staff can also lack training in the basic principles of geriatric medicine, or the specialties needed to attend to increasingly complex medical needs.

- **Labour Supply**

The current demand for key positions, such as PSWs and RNs, outpaces the supply. Prior to COVID-19, Ontario government analytics noted slow growth in Ontario’s registered nurse supply. Previous government modelling forecasted that the health system may have required more registered nurses to meet labour market demand and population needs. Further analysis is now needed to understand how COVID-19 has impacted the need for registered nurses across all health sectors, including long-term care.

Long-term care operators highlighted recruitment issues, some saying that when jobs are posted, very few candidates apply, and often some of those are not qualified. This may not be unique to the long-term care sector, as there are overall supply issues. However, it was made clear that this is a recurring challenge in long-term care.

This comes at a time when the population of Ontario is aging. The growth in population over age 65 has outpaced that of labour-force aged Ontarians. This has resulted in a lack of balance in the care sector, felt particularly in long-term care. The OECD estimates that by 2040, Canada will require an 80 percent increase in all healthcare staff (across sectors) in order to maintain the current ratio of healthcare staff to individuals 65 and over.<sup>69</sup>

As long-term care is already experiencing shortages that put resident care at risk, considerable improvements to workforce attraction and retention are needed to address this gap, in addition to increases in the overall pool of qualified candidates from the education sector.

- **Negative Public Image**

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<sup>68</sup> This expression is commonly used to describe a shift that is short-staffed. Staff report that often they are “working short” when some staff scheduled for a shift are not able to report to work or complete their shift.

<sup>69</sup> OECD Health Policy Studies, 2020. Who Cares? Attracting and Retaining Care Workers for the Elderly.

Long-term care is sometimes perceived as a less desirable career choice compared to acute care. This perception may relate to factors such as a social devaluing of elders and elder care, media focus on problems in long-term care rather than successes, and longstanding issues in the culture of the healthcare sector that places more respect and value on hospital-based settings.

There is also a perception that long-term care is low paying, physically challenging, and undervalued work as compared to other healthcare sectors such as the hospital sector, and that long-term care offers chronically casual work without benefits.<sup>70</sup> Long-term care is often spoken of as if it was a “dead end job” with little opportunity for advancement or reward.

The proliferation of these perceptions can negatively impact the desirability of the sector and deter individuals from considering a career in long-term care.

In conclusion, the rate of growth in resident needs has outpaced staffing levels, education and training, as well as funding. Yet, long-term care employees are often passionate about their work and care deeply about the well-being of the residents.

The current staffing framework does not support a consistent, high quality of care for long-term care residents. Over time, working conditions for long-term care staff have become difficult; staff report being overworked, lacking support, and being asked to do ‘more with less’ every day. Many long-term care employees are frustrated that they cannot consistently provide the high-quality care that the residents deserve.

As the long-term care system is set to expand significantly to respond to increasing demand, the current approach to staffing is not adequate.

## **Perspectives on Barriers to Change**

Long-term care partners often cite the legislative and regulatory framework, inspections, and the funding model as interrelated provincial barriers which impact long-term care staffing.

### **Specificity of the Legislative and Regulatory Framework**

The legislation and regulations are the framework for safeguarding resident rights and improving the quality of care. It has, however, been criticized by operators and associations for being overly prescriptive and onerous. In particular, educational requirements in this framework can be a barrier to exploring potential solutions for staffing issues. For example, it is felt that the current regulation does not encourage the use of non-traditional roles like development support workers and PSW aides, which could alleviate workload from PSWs and nurses; nor does the regulation necessarily keep pace with the changing scope of practice for nursing staff.

Operators and associations also cite requirements that they feel are out of alignment with other areas on the continuum of care, particularly around the educational requirements needed to complete certain tasks or fill certain roles.

In general, the legislative and regulatory environment is criticized as being overly prescriptive limiting flexibility in how long-term care staff can respond to the diverse needs and desires of residents.

### **Compliance Culture**

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<sup>70</sup> Unifor. (2019). *Caring in Crisis: Ontario’s Long-Term Care PSW Shortage*. Ontario Health Coalition.



The Long-Term Care Home Quality Inspection Program (LQIP) safeguards residents' well-being by continuously inspecting complaints and incidents within homes. The LQIP ensures each home is inspected at least once a year to make sure that they are in compliance with legislation and regulation. Long-term care partners across the spectrum identify the current compliance culture of long-term care as being punitive, and heavily focused on factors less likely to impact resident safety or security. For example, the regulation has prescriptive requirements around mealtime, which long-term care operators and associations have criticized.<sup>71</sup>

Justice Gillese recommended that long-term care homes should cultivate a “just culture – one in which human error is dealt with openly rather than punitively.”<sup>72</sup> The consequence of a compliance-based culture, as reported by some operators, associations, and labour unions, is that staff can become overly focused on regulated tasks to the detriment of positive resident outcomes, resident rights, safety, security or quality of life.

Professional associations highlight that a focus on compliance and avoiding compliance orders, which are made public, can create a sense of fear among long-term care home leadership and staff. Care providers are often afraid to make errors and may not be comfortable coming forward to colleagues or management with incidents.

### **Funding Model**

Operators have expressed that they find the funding model to be complex, and it has been the subject of criticism in consultations and submissions to government.

Currently, most funding is provided through Level of Care (LOC) funding. As previously mentioned, LOC funds are divided between four envelopes: nursing and personal care, program and support services, raw food, and other accommodations. Funds from each envelope can only be spent on items deemed eligible by the ministry. Some long-term care partners, such as operators and associations, report that the current subcategorization of funding envelopes does not allow homes to hire the types and volume of staff they would prefer, nor provide adequate compensation. The LOC envelopes have also been expanded to allow operators to spend funds on a wider range of items, without additional funding attached, (i.e. the same funding may be used for a wider range of supports for residents but does not increase the overall level of support).

Certain components of homes' funding are adjusted based on resident need. The CMI, which represents the average resource intensity required to care for all residents within a home in a given year, is used to adjust the nursing and personal care (NPC) funding envelope calculation for each long-term care home.

Some long-term care organizations state that the current methodology for documenting and inputting requests for additional needs-based funding is onerous, time consuming, and does not reflect real-time needs, as financial decisions can be based on data from two years prior. In these circumstances, additional funding for staffing to support higher acuity residents may be received after the resident is no longer at the home.

Resident health outcomes can be improved with high quality care, however, there is a perception that the funding model disincentivizes these efforts. The CMI prioritizes funding based on the need for resources. If health outcomes in a home improve, the CMI may show a lower need for resources in that

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<sup>71</sup> The Regulation prescribes a minimum amount of meals and prescribe a window for each meal time.

<sup>72</sup> Gillese Report, Recommendation 78.

home than elsewhere in the province. Consequently, the home's funding may fall the following year. This may inadvertently provide disincentives to homes from doing the best work they can.<sup>73</sup>

The perception of an impediment persists despite ministry stabilizing mechanisms, such as the five percent cap on year over year changes in CMI (higher or lower) so that funding cannot drastically change. In addition to this cap, 40 percent of funding is not adjusted for CMI, so it remains stable over time.

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<sup>73</sup> As reported by some long-term care operators and associations.

## **Key Findings & Recommendations from the Advisory Group**

We recognize that staffing issues in long-term care are complex and systemic in nature. Solutions are not easy and a multi-pronged approach that addresses a range of underlying issues concurrently will be most successful. The ministry should prioritize its plan to develop a comprehensive staffing strategy, concurrent with other aspects of the sector. Given the severity of staffing challenges within the sector, a combination of immediate and longer-term actions should be pursued.

Long-term care staffing issues need to be considered within the context of the broader continuum of care and the mobility of the labour force across the health care system and beyond. Care should be taken to ensure that measures intended to improve staffing in the long-term care sector do not have unintended consequences on other sectors such as home and community care.

### **Staffing in the long-term care sector is in crisis and needs to be urgently addressed**

Not all long-term care homes have a staffing crisis, but all are experiencing challenges. This situation existed long before the COVID-19 outbreak, although the pandemic further exposed these issues. Many reports have documented the difficulties in attracting and retaining staff, particularly for PSW and RN positions. Staffing challenges, including challenging working conditions, were highlighted by Justice Gillese in the Report of the Inquiry into the Safety and Security of Residents in the Long-Term Care Home System (The Gillese Inquiry).

It would be inaccurate to say that all long-term care homes are experiencing a staffing crisis. But considering the sector as a whole, the word “crisis” is appropriate. Change is urgently needed, not only to address current issues, but also to prepare for the planned development of new long-term care beds. There is a need for immediate action to stabilize and augment staffing, but also to support longer-term reform.

### **We need to make long-term care a better place to live, and a better place to work.**

The long-term care sector exists to meet the needs of residents, the vast majority of whom are elderly, frail and experiencing complex medical conditions, and to support them to achieve a high quality of life.

Most homes are warm, caring communities providing excellent care for their residents, and most staff are highly-skilled and motivated, experiencing rewarding and fulfilling careers.

There are also incredible volunteers and family members who make up an important part of the long-term care community, supporting residents and staff and often providing direct resident care. Many of the homes that experienced COVID-19 outbreaks provided exceptional care in managing the outbreak and preventing significant disease spread.

But it is also clear that resident experiences are not consistent across the sector, and that many dedicated and skilled staff struggle with their conditions of work. Collectively, we can and must do better to create the conditions where staff can provide the quality of care they aspire to provide and where there is greater consistency in care. We need to work together to create the kind of long-term care sector that Ontario residents and families want and deserve.

## **Staffing approaches need to reflect and respond to the diversity of the sector and the diversity of the residents who live in long-term care**

All of Ontario's 626 long-term care homes serve a vulnerable population with increasingly high care needs. These approximately 78,000 residents are a diverse group of individuals with unique interests and aspirations. They are of different backgrounds, cultures and sexual orientation. Sixty-nine percent of residents are female.<sup>74</sup> While they all have medical needs that require them to live in a long-term care setting, each resident has a unique combination of medical needs and/or cognitive impairments, as well as individual personalities, personal needs, interests and goals.

Long-term care homes themselves are quite varied, ranging in size from small homes with fewer than 20 beds to larger homes of over 300. Homes were built to different standards over time. Some homes have rooms with three to four residents, while others have exclusively semi-private and private rooms. Homes are in urban and rural communities throughout the province, including Northern Ontario and other remote communities. They are owned and operated by large and small not-for-profit and for-profit organizations, as well as municipalities. Some homes address the needs of First Nations and specific ethno-cultural communities.<sup>75</sup>

Given this diversity, long-term care reform, including staffing reform, cannot have a "one-size-fits-all" approach. We need to balance between setting the baselines or standards required to promote desired outcomes and providing the flexibility needed to respond to legitimate and appropriate variations in needs and support ongoing innovation.

### **Priority Areas for Action**

The study itself is broad in scope, reflecting a wide range of inter-related and complex issues. It is impossible to address all of the issues we have heard about in one study under limited time. As such, we have identified five key priorities for immediate action.

- 1. The number of staff working in long-term care needs to increase and more funding will be required to achieve that goal**
- 2. The culture of long-term care needs to change – at both the system and individual home level**
- 3. Workload and working conditions must get better, to retain staff and improve the conditions for care**
- 4. Excellence in long-term care requires effective leadership and access to specialized expertise**
- 5. Attract and prepare the right people for employment in long-term care, and provide opportunities for learning and growth**

### **1. The number of staff working in long-term care needs to increase and more funding will be required to achieve that goal**

Quality of care and quality of life for long-term care residents are significantly impacted by the long-term care labour force, which is currently spread far too thin. The acuity of residents has risen 20%

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<sup>74</sup> Statistic provided by provided by the Capacity Planning and Analytics Division, Ministry of Health/Long-Term Care

<sup>75</sup> First Nations may establish long-term care homes subject to the Minister's approval under the LTCHA.

between 2004 and 2018 based on CMI data, and the need for long-term care has also increased. Staffing has not kept pace with the medical needs of increasingly frail and elderly residents, neither in number of staff or in specialized expertise.

The current level of care cannot consistently support a high quality of life or care for all residents. Staff are frustrated because they cannot provide the care needed by residents and are often rushed. This can also lead to a higher prevalence of workplace incidents and injuries, and create unmanageable workloads for staff, which leads to burnout and high turnover. The focus on administrative tasks also takes time away from direct care.

Long-term care cannot become a better place to work, nor a better place to live, without increases to staffing levels. It is important to note that higher numbers of staff can only be achieved if there is an increased pool of interested and qualified potential employees, ready to pursue a career in long-term care. Moving forward with these priority recommendations should make it easier to attract and retain staff to work in long-term care.

- **Staffing Investment**

Addressing staffing shortages in long-term care cannot happen without additional funding. The government can be confident that any increased investment will go directly to staffing by placing that funding in the dedicated envelopes which support staff costs (e.g. the NPC and PSS envelopes). If homes do not spend funding provided through these envelopes on staff, the funding is recovered.

- **A Minimum Daily Average of Four Hours of Direct Care Per Resident**

We heard broad consensus from operators, professional associations, labour unions and sector representatives that the number of direct care hours per resident per day needs to increase to alleviate staffing pressures and support resident quality of life.

We urge the ministry to move towards a minimum daily average of four hours of direct care per resident as quickly as possible. Achieving this objective will require funding support, in addition to a larger pool of trained staff. This number should be based on hours worked, rather than hours paid.

The current measure of direct care hours in Ontario includes PSW, nursing, and allied health professionals. Given rising resident acuity, some think that this minimum daily average of four hours should be provided to residents by PSW and nursing staff, with allied health professionals captured as additional direct care hours.

- **Staffing Ratios & Skill Mix**

We heard about the value of the varied expertise among long-term care staff, including registered staff, PSWs and other allied professionals such as physiotherapists, occupational therapists and social workers, among others. We recognize there are differences of opinion about optimum staffing ratios and skill mix. Some long-term care partners recommend increasing the ratio of nursing staff to address higher acuity needs, in the place of some PSWs; while others want to see PSW levels maintained or increased to recognize the role of PSWs in supporting a range of daily physical and emotional needs.

We believe that all care providers in long-term care have valuable expertise to support resident care needs, and the appropriate mix may depend on the specifics of the community and home – provided overall hours of direct care are increased. The ability of a group of staff to provide quality

care is not just dependent on the number and types of staff, but also the combination of skills and expertise they bring and the way they work together as a cross-functional team under effective clinical leadership.

Residents would benefit from more involvement by allied health and other professionals such as occupational therapists, physiotherapists, social workers, and recreation therapists on staff teams. Increased access to these professions is reported to increase strength and mobility, reduce trips and falls, improve sleep quality, and promote resident independence and quality of life. Improvements in medical outcomes, reductions in medication use and reductions in responsive behaviours may also be associated with increased involvement of these professional staff.

Taking this into consideration, *we do not recommend regulating a specific staff mix or staff to resident ratios*. Instead, we recommend that the ministry establish staffing guidelines to allow some degree of flexibility to address the following factors:

- **Resident Population:** In a home area with higher levels of cognitive impairment, residents may require more PSWs and recreation staff. Alternatively, in a home area with higher medical needs, more registered staff could be required. Regardless, all home areas need sufficient staff to address the medical complexity and vulnerability of their residents, as well as their social and emotional needs.
- **Staff Availability:** In circumstances where PSWs are difficult to hire, inability to meet a targeted staffing ratio may be addressed for a period of time by involving different staff members with relevant training.
- **Shift Challenges:** Ratios may appropriately vary at different times of day. While there is consensus that ratios can appropriately be lower on the night shift, there is concern these levels are often too low.
- **Workload Management:** Task delegation and adjustment to workloads for specific staff may allow for some staff to increase the amount of direct care they can provide. For example, if some current administrative burdens on staff can be removed, they will be able to provide more hours of direct care. Team-based approaches to care may also impact the mix of staff.
- **“Working Short”:** Staff report that often they are “working short” when some staff scheduled for a shift are not able to report to work or complete their shift. There is no evidence on how prevalent this is and to what extent absenteeism needs to be taken into account in determining staffing levels.

Given all these considerations, we recommend the following:

1. A guideline of one PSW to eight residents be adopted for the day and evening shifts. Given the considerations above, this ratio would not be regulated. Over time, the government should work towards a guideline of one PSW to six residents. Overnight shifts can accommodate a higher ratio, but we are concerned that the current typical ratios for night coverage, sometimes as high as one PSW to 32 residents puts residents and staff at risk. The ministry should identify a more appropriate ratio for the overnight shift, and work towards it.
2. The current requirement for at least one RN to be present and on duty at all times should be maintained. However, the requirement should be updated to consider home size as one RN is not sufficient to meet resident needs in larger homes.

3. Sufficient levels of registered nursing staff are needed to provide greater clinical oversight and expertise to the care team, as well as to enhance direct care. Consideration should be given by homes to the mix of specialized expertise among registered staff, such as geriatric or wound care specialties.
4. Additional access should be provided to allied health professionals as fully integrated members of the care team. Ensuring resident access to the expertise these professions bring is an important focus of geriatric medicine and an elder approach to care.

## **2. The culture of long-term care needs to change – at both the system and individual home level**

The existing culture in the long-term care sector overall has been described as oriented towards regulatory compliance. The consequence, as reported by long-term care partners, is that staff become overly focused on regulated tasks sometimes at the expense of positive resident outcomes. This culture leads to care providers who may be afraid to speak up to report incidents or errors, out of fear of being reported for non-compliance.

In order to best meet the needs of residents and build a high-performing workforce, the culture of the long-term care sector needs to change. A continuous quality improvement approach that places residents at the centre of care should be adopted. This kind of approach would encourage the culture change that would support staff to feel respected and experience more job satisfaction.

Some long-term care homes already work hard to focus on quality improvement. Achieving a more consistent quality improvement approach will require action and leadership at both the system level and in individual homes.

System opportunities to support a culture of excellence include:

- **Regulatory Modernization**

The goal of the legislation, regulation, and policies is to ensure all homes meet minimum standards. They create the standards, procedures and requirements for operations and provide the mechanisms for oversight and correction when necessary. A regulatory regime is important to ensure resident safety is maintained, while providing assurance to residents and their families that long-term care homes and the sector operate in the best interests of the people of Ontario.

However, the current regime is not consistently achieving the desired result and has been widely criticized. It is a significant factor in the current culture of long-term care in Ontario.

We recommend the ministry review the regulatory framework to ensure it is consistent with, and supports, the goal of true resident-centered care. The regulatory environment can set minimum requirements while also encouraging continuous quality improvement in the sector. Not only can this contribute to culture change, it can also contribute to improved desirability of the sector as a career destination.

- **A Quality Improvement Approach to Sector Oversight**

Effective oversight is crucial to ensure that minimum standards of care are met. However, we heard consistently that the approach in recent years has contributed to a sense of fear and a focus on compliance, sometimes to the detriment of resident outcomes.

Adopting a quality improvement model, where compliance is understood as part of a journey to continuously improved care, could improve the culture in the sector. It is important to note that this type of approach does not disregard the importance of compliance nor the ability for the province to take corrective action where necessary. Instead, it positions compliance as one element in a broader model focused on moving homes towards excellence and placing residents' needs at the centre of care.

We recommend that the ministry adopt a quality improvement approach to sector oversight, and that inspection protocols be reviewed in that context. Inspectors should be able to identify issues and act as a resource, as well as work with operators to identify appropriate improvement strategies moving forward.

- **Renewed Performance Measurements**

Measuring what matters is key in any quality improvement model and there are many examples in long-term care and the broader health care sector to be considered and built upon.

Measuring resident quality of life is essential to understanding how the long-term care sector is performing. Yet, no standardized approach is currently used. Homes are required to conduct patient satisfaction surveys annually. However, these are not standardized, and the data is not shared to help homes understand how their results compare, and where they can improve, relative to their peers.

There are some standardized metrics that can be leveraged within the long-term care sector. For example, there are some long-term care organizations that use the interRAI quality of life measurements and compare themselves internationally in collaboration with the Seniors Quality Leap Initiative.<sup>76</sup> These evidence-based indicators can be used to provide accurate benchmarking for Ontario long-term care homes. Additionally, quality of life improvements have been included in Health Quality Ontario's Quality Improvement Plan (QIP) program for long-term care homes, and resident experiences has been recently added.

Quality of Clinical Care could also be a focus of performance measurement. Current evaluations are heavily based on clinical outcomes and could be expanded to include mental health and wellbeing metrics.

Finally, consideration should be given to staff reporting. The Long-term care staffing report is currently an optional annual survey conducted by the Ministry of Long-Term Care and does not include staff satisfaction as a metric of performance. Given that workplace culture is critical to quality of care and quality of life for residents, as well as recruitment and retention, staff satisfaction should also be measured.

We recommend that the ministry review performance measurements in the sector to consider:

1. A standardized approach, where data can be shared among long-term care homes and with the government; and
2. Including measures of quality of life, quality of care, and workplace satisfaction in order to promote a quality improvement model and understand the impact of new policies.

Opportunities to improve culture at the home level include:

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<sup>76</sup> More information at <https://www.seniorsqualityleapinitiative.com/index.php>



- **Strong, Coherent Philosophy of Care**

The overall goal of the long-term care sector should be to provide an environment centred around resident care. This philosophy of care should allow staff to focus on individual needs of residents and provide appropriate and respectful care to address the physical, psychological, social, spiritual and cultural needs of residents, as described in the Residents' Bill of Rights in the LTCHA. In addition, the philosophy of care needs to reflect a deep understanding of the specific needs of the older population the sector serves.

Staff need to understand the philosophy of care, how their work fits into that philosophy and how they work with others to provide a holistic approach to care.

In some cases, homes have implemented relational or emotional models of care, such as the 'Butterfly Model', 'Eden's alternative', P.I.E.C.E.S. Learning and Development Model, and the Gentle Persuasive Approach (G.P.A.). These models focus on the benefits of meeting the emotional needs of residents, making the living environment more enriching, and more like a home. As such, they represent a strong philosophy of care based around emotional care and relationship building.

Homes that implement emotional models of care have shown improvements to the well-being and quality of life of residents, reduced the number of falls and use of anti-psychotic drugs, as well as increased staff engagement and reduced staff turnover, sickness and absenteeism.<sup>77</sup> Operators reported that their staff frequently request working in homes that have implemented emotional models of care as they feel better supported, more collaboration within the team, and are able to spend more time with residents.<sup>78</sup>

- **Recognition of the Critical Role of Personal Support Workers**

In 2018, PSWs accounted for 58.5 percent of long-term care home staff and provided on average 2.3 hours of the 3.73 hours of direct care provided to residents per day.<sup>79</sup> They make up the largest group of workers in the sector and spend the most time with residents. Long-term care associations, operators, residents, families and labour partners all often refer to PSWs as the 'backbone' of the long-term care system.

The work they undertake is physically and emotionally taxing, which is exacerbated by the severe shortages of PSWs in many long-term care homes. PSWs report the need for support so they can deliver the holistic, quality care that residents deserve, and that they wish to provide.

Despite being critical to the success of the long-term care sector, PSWs are often not acknowledged as full members of the team. In order to better recognize their critical role, homes should fully integrate PSWs into the care team, drawing on their perspectives and knowledge of residents in care planning and case conferencing. Homes should also explore leadership opportunities for PSWs such as mentorship and preceptorship roles for new PSWs, education and auditing, peer-to-peer support, and "lead hand" positions which would provide guidance to PSW teams.

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<sup>77</sup> Region of Peel Long-Term Care, Submission to the Staffing Study Advisory Group 2020

<sup>78</sup> Ibid.

<sup>79</sup> Statistics provided by the Capacity Planning and Analytics Division, Ministry of Health/Ministry of Long-Term Care (long-term care staffing report 2018)

A number of our recommendations throughout this study are intended to recognize and support the critical role of PSWs. However, consideration should be given to additional ways to further professionalize the PSW role within the long-term care sector.

- **Respectful Team Environment**

Each staff member and specialty can play their own role in providing care, directly or indirectly, within the home. An ideal work environment has a team-based approach, where the value of each member is recognized, respected and valued, where relationships between staff can improve, and quality of care can be enhanced.

Instead of compartmentalizing duties, staff can work together on cross-functional teams - leveraging individual skills and expertise to support the residents. This strategy will create an environment where staff work to the full extent of their scope of practice and appreciate one another's voices and contributions.

### **3. Workload and working conditions must get better to retain staff and improve the conditions of care**

Poor working conditions are a key contributing factor to staff dissatisfaction, turnover, and the overall poor perception of long-term care as a career choice. Staff report feeling burnt out, overwhelmed, and unrecognized. The sector will likely continue to struggle with shortages should conditions not improve.

Our recommendations regarding overall staffing levels and hours of direct care per resident, should assist in addressing some concerns around workload. In addition, we highlight the following areas:

- **Compensation**

Some organizations, including labour unions, emphasize that compensation (salary and benefits) is an important factor to improve working conditions, particularly for PSWs. In some cases, full-time staff are taking on additional part-time work or casual work.

In Ontario, employment contracts within long-term care homes on average feature wages similar to or lower than acute care, and higher than those offered in home and community care. Lack of wage and benefit parity across the care continuum can contribute to labour challenges, and could be a possible deterrent, to working in long-term care. Any steps to address compensation need to consider the labour market across the health care sector as a whole. For example, increasing PSW wages in the long-term care sector only, would likely have a significant negative impact on recruitment and retention in the home and community care sector, leading to instability in the health care system as a whole.

Taking this into account, we recommend the ministry take an evidence-based, and systemic approach to compensation across health care settings and across occupations. Compensation parity should be strongly considered across settings and occupations to reduce compensation-related labour shortages.

Further, staff benefits can differ between full-time and part-time positions as well as across sectors. Full-time staff are typically offered full benefits, and part-time staff are typically provided either pro-rated benefits, or additional pay in-lieu. However, these practices may not be universal.

Consideration should be given to standardizing benefit minimums to remove any real or perceived financial incentive to disproportionately hire part-time staff.

In addition, paid sick leave is not universal. As highlighted during the COVID-19 pandemic, staff who are ill need to be supported so they can remain away from the workplace until it is safe to return.

Benefits should be included in the consideration of compensation parity between sectors.

- **Full-Time and Part-Time Employment**

Many staff and long-term care partners call for more full-time positions to allow for more stable working conditions, and to reduce the number of individuals working multiple part-time jobs. Increasing the proportion of full-time, permanent positions would improve working conditions for staff and reduce the likelihood of spreading viruses, such as COVID-19, between homes.

Long-term care homes operate on a 24-hours a day, seven days a week basis, which can present scheduling challenges. Homes must also have staffing approaches which enable backfilling of staff for statutory holidays, vacation and training leaves. Scheduling in this environment is reported to present a barrier to having an exclusively full-time workforce. Long-term care home staffing requires some balance between full-time, part-time and casual staff. However, there may be opportunities to increase full-time employment.

Some homes have experimented with 12-hour shifts as one way to increase full-time positions. While some staff may be willing to work 12-hour shifts, workload of PSWs may be too physically intensive for this shift length. Anecdotally, where implemented, 12-hour shifts result in increased injuries and absenteeism.

We recommend that the sector work to share experiences and leading practices in maximizing opportunities for full-time hours.

- **Protection from Physical, Mental, and Emotional Risk**

It is important to acknowledge the physical, mental, and emotional risks of working in long-term care. Health care is the second highest sector to report injuries requiring leave, and long-term care is a close second to hospitals within the sector.<sup>80</sup>

Protecting staff against health risk factors is critical to staff retention and lower absenteeism. Two ways to support this are:

- Increased Access to Bedside Support Equipment

PSW injuries are common from repeatedly performing resident transfers without proper equipment, such as ceiling lifts. Homes should increase the usage of ergonomic physical infrastructure, and supportive technology – which also helps residents receive dignified and safe care.

- Adopting the National Standard for Psychological Safety in the Workplace

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<sup>80</sup> WSIB Enterprise Information Warehouse (EIW) Claim Cost Analysis Schema and Firm Expense Schema, December 2016 data snapshot for all years

A psychologically safe workplace is one which safeguards staff from experiencing injuries to their psychological health and reduces risk for negative mental health experiences.

To promote a more psychologically safe work environment for employees,<sup>81</sup> the National Standard of Canada for Psychological Health and Safety in the Workplace (the Standard) was developed by the Mental Health Commission of Canada in 2013. It addresses thirteen factors of workplace psychological safety to better prevent psychological risk and injury to staff. Psychosocial factors include organizational culture, psychological supports, and civility and respect. Organizations that have implemented this standard have seen improved retention and workplace satisfaction.

In addition to working conditions reforms, workload may be improved through:

- **Charting and Documentation**

The CMI, the method of calculating resource needs in homes across the province, requires staff members to complete extensive charting and documentation which takes time away from resident care. In addition, as CMI provides more funding for residents with higher acuity, it creates a disincentive to maintain or improve the overall health and independence of their residents.<sup>82</sup>

Through roundtable discussions and stakeholder consultations, it was made clear that many find current charting requirements to be onerous, and not conducive to a quality improvement approach. Modifications to this process, including streamlining metric requirements, and leveraging electronic charting, could ease efficiency and resident-focus issues. This would free up valuable time for increased direct care to residents and support a quality improvement approach.

Further, charting should be used primarily for clinical or medical purposes, not as a condition for funding. We recommend the ministry remove CMI from the funding methodology. Given the overall high and increasing level of acuity of residents across the sector, the ministry should consider whether it is necessary to have an acuity factor as part of the funding methodology.

- **Medication Management**

One of the responsibilities that falls to nursing staff is the management of medications, which includes the stocking, administration, and reconciliation of drugs. The time requirements to support medication management can impact a nurse's ability to complete other important tasks, such as clinical oversight and direct care.

To better manage this workload, consideration could be given to how pharmacy personnel could be brought onsite to manage pharmaceutical stock, address issues of polypharmacy, complete investigations of medication incidents, and improve medication safety practices such as medication

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<sup>81</sup> Low psychological safety in the workplace poses a greater chance for poor mental health and is linked to absenteeism and turnover, while higher psychological safety can support a more resilient and sustainable work force.

<sup>82</sup> For more information on Case Mix Index, see Appendix A.

reconciliation (often completed by nurses).<sup>83,84,85</sup> The transition of these tasks from nursing staff to pharmacy staff would allow more time for direct resident care and clinical oversight.<sup>86</sup>

As well, there is a role for geriatric medicine as physicians and pharmacists should work together with the team to ensure that medications are reviewed, and prescriptions modified in order to optimize drug therapy for each resident.

#### **4. Excellence in long-term care requires effective leadership and access to specialized expertise**

Effective medical, clinical, and administrative leadership is integral to making long-term care a better place to live and work. Leaders set the tone for the workplace, provide direction and oversight on how work is to be performed and are critical drivers of organizational culture. Leaders also have a role in ensuring access to the kinds of additional expertise needed to support quality resident care that is not available within the in-house team.

While there are many important leadership roles within long-term care homes and many types of external expertise to be leveraged, we would direct the ministry's attention to the following priority areas.

- **Clarifying the Role and Accountability of the Medical Director**

The LTCHA requires that each home employs a Medical Director who advises on matters of medical care and consults with the Director of Nursing and Personal Care (often referred to as the Director of Care) and other health professionals. During the recent experience with COVID-19 outbreaks, it has become apparent that there is a substantial degree of variability in how this role is carried out among homes across the province.

We recommend that the ministry clarify the role and accountability of the Medical Director position to bring greater consistency in medical leadership to the staff team. This role should work closely with the Director of Care who provides critical day-to-day on-site clinical care leadership in collaboration with the Assistant Director of Care, Nurse Practitioners, and/or Nursing Supervisors with expertise in geriatric medicine.

- **Expanding Use of Nurse Practitioners**

Some long-term care homes have implemented a nurse practitioner (NP) model to support clinical leadership in long-term care homes. A NP augments the clinical leadership present in a home and may provide an effective link with the Medical Director who is typically less physically present in the home, especially when the NP has expertise in geriatric medicine. NPs support education and coaching of the clinical team as well as providing direct care. They can also assist with medication

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<sup>83</sup> Polypharmacy is the concurrent use of multiple medications by a patient

<sup>84</sup> Medication Reconciliation is a structured exercise of comparing current medication lists to previous medication lists, and then reconciling these medications with the patient's present conditions and needs. This occurs before prescribing medications, and after there has been a transition of care from one provider (the hospital or primary care prescriber) to another (the long-term care home).

<sup>85</sup> Vuong V, O'Donnell D, Navare H, et al. BOOMR: Better Coordinated Cross-Sectoral Medication Reconciliation for Residential Care. *Healthc Q.* 2017;20(1):34-39.

<sup>86</sup> Medication management issues are being considered by the Ministry of Long-Term Care in a separate strategy.

management, reduction in polypharmacy, and have been associated with the reduction in need to transfer residents to hospital, reducing hospital costs and improving the resident experience.

We recommend the ministry move forward with phase three of the Attending Nurse Practitioners Program in long-term care homes and consider opportunities for further expansion.<sup>87</sup>

- **Ensuring Access to Strong Infection Prevention and Control (IPAC) Expertise**

Early lessons from COVID-19 demonstrate a distinct need for improved infection prevention and control (IPAC) expertise in all long-term care homes. Homes routinely deal with influenza A and B outbreaks, and registered and PSW staff learn infection control as part of their training. However, rapid spread of COVID-19 in some homes suggests that many initial infection prevention and control efforts were insufficient. Hospital resources were able to be deployed in many sites to assist, but this is not an appropriate long-term solution, except in urgent situations.

While larger homes might be able to hire a fulltime IPAC specialist, many homes may not be able to do so. The ministry should take immediate action to ensure all homes can directly access IPAC expertise, whether through centralized or regional teams of long-term care IPAC experts and/or increasing training to existing home staff.

- **Accessing Specialists**

It would be difficult for any long-term care home to have access within its walls to all of the specialized expertise that may be required to meet resident needs. While efforts should continue to be made to build up internal expertise in key areas including geriatric care specialists, wound management, mental health, behavioural supports and palliative care, attention should be given to facilitating greater use of networks and virtual care options to augment the clinical expertise available within each long-term care home.

Organizations such as Behavioural Supports Ontario and the Ontario Palliative Care Network have become valuable resources and supports to many homes. The ministry should continue to explore opportunities to connect long-term care homes staff with relevant external expertise to augment the care experience.

All homes should be working to build up geriatric expertise within their direct care staff, for example, through the hiring of geriatric specialty nurses. Consideration should also be given to how to better connect homes with geriatricians who can support a holistic approach to resident quality of life specific to residents' demographic needs and can provide guidance to other clinicians towards age-appropriate care plans. Geriatric psychiatry is another highly relevant area of expertise that could be beneficial in addressing mental health needs in long-term care.

The recent pandemic experience has augmented some homes' experience with virtual access to specialized supports. One example of an existing government initiative is the provincial eConsult program. eConsult is a secure, web-based tool led by the eConsult Centre of Excellence with funding support by the Ministry of Health. It enables physicians and nurse practitioners to access specialists' advice digitally, often eliminating the need for in-person visits. Of the 570 long-term care cases across 31 homes, submitted between January 1, 2017 and March 31, 2020, 81 percent of these were resolved without the need for the resident to attend a face-to-face visit with a specialist. There are

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<sup>87</sup> Ontario provided funding for up to 75 new attending nurse practitioners in long-term care homes over 3 years. To date, 60 positions have been funded through phase one and two.

over 90 specialties available for consultation, including professionals in infection prevention and control, dementia, and gerontology.

In the three years it has been in operation, this service has increased access to specialist advice (an average response of two days), improved care coordination and collaboration between clinicians, avoided unnecessary resident transfers to acute care settings, and lowered costs to homes, residents, and caregivers.

This eConsult service is available to all Ontario doctors and nurse practitioners and should be promoted in long-term care homes, as residents face an above-average need for specialty care and travel to external appointments is challenging. It could help the sector address critical care gaps, reduce system strain, particularly in rural and remote areas, and enhance access to the generally less available specialists.

## **5. Attract and prepare the right people for employment in long-term care, and provide opportunities for learning and growth**

A key strategy for success is to attract, prepare, and invest in people who want to work in long-term care and who reflect the diversity of the resident population they serve. The current labour pool for many long-term care staff positions does not meet demand, and this will be exacerbated as staffing levels are increased and as the development of new homes proceeds. Current shortages are particularly acute for PSWs and RNs. However, careful health human resource planning will be required to ensure that adequate pools of staff are available and high turnover and industry exit rates are addressed. This requires simultaneous planning and action regarding recruitment and retention since low retention rates are a key driver of the need for high recruitment rates.

The recommendations in previous sections should collectively improve the perceptions of long-term care as a career destination of choice. However, attention needs to also be given to the curriculum, onboarding, and ongoing support and development for staff.

### **● Attracting People with the Right Personal Attributes**

Not only are staffing levels integral to successful care, but the staff themselves would bring an aptitude for caring professions. We have observed attributes such as empathy, understanding, patience, respect, conscientiousness, and teamwork in many of our long-term care homes finest employees. When staff bring an aptitude and passion for their work, as well as skill, they are more likely to build a career in the sector.

When staffing pools are extremely limited, homes will hire whomever is available with the required qualifications. Building excellence in long-term care requires the ability to target and attract individuals with the ideal attributes and a passion for elder care. A variety of strategies may help to attract people with such skills into educational programs and into a career in long-term care.

#### **○ Improved Public Perception**

As noted, the negative perception of living and working in long-term care homes, and of long-term care as a valued career choice, has discouraged potential new employees. The recent negative media attention on long-term care homes may have further contributed towards negative stereotypes.

A public campaign targeting the positive and rewarding aspects of living and working in long-term care homes may improve the likelihood of attracting people into long-term care as a career.

- Stronger Relationships with Secondary Schools

Developing relationships between secondary schools and long-term care homes could improve the perception of the sector and encourage young people to pursue careers in long-term care. For example, through co-operative education programs for the long-term care sector, or through PSW aide roles, high school students could gain valuable work experience concurrently with their studies. They could develop skills, gain job experience and learn about the sector as an appealing place to work.

- Stronger Supports for New Graduates

Evidence suggests that a high proportion of new graduates that enter the long-term care sector leave within a short period of time. This may be due to conflating factors related to the demands of the job and lack of adequate support structures to support people entering the sector.

In the United Kingdom, “Proud to Care” is a program that aids in the recruitment and retention of personal care workers (e.g., support workers, personal assistants, rehabilitation workers) within the local Health and Care sector. This program focuses on obtaining employment for qualified people within the growing health and social sector by promoting the range and number of jobs, as well as helping new employees progress through their careers. This program has helped employers recruit, retain and develop a quality workforce that keeps pace with the ever-growing demand of the sector.

Similarly, the provincial government’s “Nursing Graduate Guarantee” program is available to RNs and RPNs who are within 12 months of registering with the College of Nurses of Ontario, to help ease the transition of RN and RPN graduates into the workforce. This program relies on an online portal to connect newly registered nurses and registered practical nurses with potential full-time employment opportunities and employers. A similar strategy could be implemented for PSWs and allied health workers to help with onboarding within the long-term care sector.

- Expanding the Labour Pool

With many job openings anticipated, and demand for services rising as the aging population increases, current shortages can be expected to grow. This may require a different approach that moves beyond the reliance on traditional sources of labour.

There are untapped groups such as parents and family caregivers looking to re-enter the job market, and foreign-educated allied health professionals, which could be further leveraged. Outreach to other non-traditional labour pools could also be considered, including volunteers, new immigrants to Ontario, and social assistance recipients who may be seeking employment opportunities.

- **Meeting the Staffing Needs of the Long-Term Care Sector**

To increase the number of staff available to support long-term care residents, we recommend that the Ministry of Long-Term Care work together with the Ministry of Health and Ministry of Colleges and Universities to review the numbers of graduates from relevant post-secondary education



programs and monitor and report if there are sufficient new entrants to meet the growing needs of the sector.

- **Educational Requirements for the Long-Term Care Sector**

We heard from various organizations about whether the educational programs for PSWs, nurses and physicians provide sufficient long-term care exposure and specific training to effectively transition into their respective roles within the long-term care home. It is difficult for a generic program to sufficiently prepare students for all possible employment settings. However, there may be opportunities to provide students with greater opportunities to build their skills and knowledge. The following opportunities should be considered and expanded:

- Onsite Experiences for Students

Integrating onsite education and job training may be particularly beneficial for PSW education, as full-time schooling for the duration of the program length (minimum of 600 hours) takes potential PSWs out of the paid workforce and may be a deterrent for some potential students. Options where a trainee could work as a personal care aide while pursuing their PSW certification have been suggested.

For post-secondary students generally, onsite experience is a valuable tool that can help facilitate a seamless integration into the sector. For example, the Living Classroom program provides a PSW educational program delivered in the long-term care home. It is led by a post-secondary educator and provides an interactive learning experience. This model could be considered for other health training programs.

PSW, and RN students complete a number of placement hours in long-term care, however RPN and medical students may not. Health training programs should include or increase placement hours in long-term care, to help ensure the graduates have the appropriate experience for the sector. To better prepare physicians to work in the long-term care sector, there is an opportunity to create incentives for medical students to complete a rotation within a long-term care home during their training.

- Preceptorships<sup>88</sup>

On-site education can be very beneficial for students but is not a viable model where existing staff do not have time to provide mentorship and guidance. Preceptorship roles could be more widely introduced as *additional* staffing roles outside of the regular staffing complement. This can also offer important career development or enrichment for experienced staff looking for new challenges.

For example, in early 2020, two Ontario long-term care homes that incorporate educational preceptor roles were hosting 143 student placements, including RNs, RPNs, PSWs, massage therapists, and social workers. Completing the preceptor program and overseeing students was seen as a benefit by staff and was considered a contributor to improved recruitment and retention. Training was required to take part as a mentor.

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<sup>88</sup> The “preceptor” is described as a staff member who serves as a role model and aids in the socialization for a new member of the same profession. Preceptorships are commonly used in placements for nursing students, however this role may be of use for graduates of nursing, and other professions.

It is important to recognize that on-site learning can be a challenge for some homes, due to limitations in physical space and staff capacity.

- **Ability for Staff to Stay Current, Gain New Skills and Develop Specialized Expertise**

As mentioned, staff turnover and industry exit rates are problematic in long-term care. To ensure that trained staff within the sector are motivated to remain in long-term care, we propose the following strategies to keep skills up to date and reduce staff turnover:

- Continuing Education

Once staff are employed in a long-term care home, continuing education can help ensure they are up to date on current practices and prepared for the care requirements of residents. It can also reduce apprehension and anxiety, which supports better retention as staff feel more equipped to take on the job at hand.

Current ongoing training practices may not be as effective as they could be, due to insufficient support to backfill the individual who is training. A home must 'work short' when a trainee is away, and this can create stress for all staff involved. It is reported anecdotally that individuals may rush through their training so they can return to work.

In order to improve the efficacy of continuing education, the government should leverage existing infrastructure such as the Ontario Centres for Learning, Research and Innovation (CLRI). Research and innovation platforms can support homes in delivering training to enhance the quality of care and living for residents across the province, and build sector capacity through training, education and knowledge mobilization of long-term care staff. Staffing levels, as mentioned earlier, need to be bolstered in order to support trainees in their courses, as well.

- Micro-Credentialing & Job Laddering

Micro-credentialing refers to the creation of short-term certification programs that can be available to existing employees to enhance their skills and their ability to work in a particular context or with residents who have specific care needs. In the long-term care context, micro-credentials for staff could include a geriatric or long-term care specialty or a dementia specialty. The development of accessible, specialty micro-credentials could enhance the professionalism of the PSW workforce.

Job laddering programs are designed to give current employees the opportunity to apply their current knowledge, work towards a higher level of education and move into higher skilled jobs. Current programs are limited in number, time intensive and often make it difficult for students to work concurrently. This can present a financial barrier that impedes many employees from upskilling and finding upward mobility in their careers.

Offering all employees more options for micro-credentials and upskilling could support a more skilled workforce and improve retention and career satisfaction.

While RPN and PSW roles are critical and rewarding careers, areas of key focus should be upskilling from RPN to RN, given current RN supply challenges. Supporting the progress of PSWs into RPN roles through this type of program is also an option.

## **Conclusion**

Staffing is critical to creating a higher quality of life and care for residents. There is a broad consensus among long-term care organizations about the range of complex and inter-related issues that have contributed to a staffing crisis in Ontario's long-term care sector.

The Long-Term Care Staffing Study Advisory Group concludes that if barriers to optimal staffing are addressed, as recommended in this report, the sector could more consistently deliver safe, quality and resident-centered care, to better meet the needs of long-term care residents.

## **Acknowledgement**

The Government of Ontario would like to thank the Long-Term Care Staffing Study Advisory Group for their expertise and insight. This study will help inform a comprehensive staffing strategy for Ontario, which when implemented, would ensure that residents and families receive the compassionate and skilled care they deserve.

# Appendices

## A: Long-Term Care Terminology Definitions

Diverse terminology is used to discuss staffing levels in long term care homes. In order to improve the readability of this report, standardized language has been used as follows.

**Activities of Daily Living (ADLs)** refers to essential self-care tasks, such as bathing, dressing and going to the bathroom. Impairment in ADLs is measured on a seven-point scale, where a higher score indicates greater degrees of impairment.

**Allied Health Care Staff** refers to both professional and non-professional workers who are not 'core staff', such as Physiotherapists (PT), Occupational Therapists (OT), Social Workers, Dietitians, Respiratory Therapists, Recreation Therapists, Music and Art Therapists, Recreation Aides, Activity Workers and Rehab Assistants, among others. Core staff are funded through the Nursing and Personal Care envelope, whereas allied health care staff are funded through the Personal Support Services envelope.

**Benefit Hours** are hours for which the employee receives payment but is not available for service provision. This includes vacation, statutory holidays, sick time, education, bereavement, and other paid absence. This is only applicable to full-time, part-time staff and casual categories.

**The Case Mix Index (CMI)** is a standardized method for calculating the intensity of resources required to meet the needs of a resident and reflects the clinical complexity of the resident population. A higher score indicates a greater intensity of resources are required to meet the needs of the resident population.

**Casual** employees work irregular hours and have no guaranteed hours of work, are not entitled to leave and are not required to provide statutory notice for termination unless otherwise stated in the employment agreement.

**Direct Care Hours (DCH)** is a staffing measure used to define the time spent providing hands on support for residents. This includes activities like bathing, transferring, administering drugs, completing wellness checks, etc. Indirect care would include tasks such as meal planning, case conferencing and pharmaceutical ordering.

**Full-time** employees have ongoing employment and work at least 37.5 hours per week. Full-time employees are entitled to benefits such as sick leave and annual leave, minimum notice requirements for termination, redundancy, flexible working hours and overtime pay for working outside of regular hours. This can be on a contract basis, or permanent.

**Health Care Assistants (HCAs)** are unregulated health care workers that work under the supervision of health care professionals such as Registered Nurses. They have many job titles in Canada and internationally, including Nursing Assistant (CNA), Community Health Worker (CHW), Resident Care Aides (RCAs), and Continuing Care Assistants (CCAs), among others.

**Long-term care** services provide 24-hour professional supervision and care in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence. Long-term care is also referred to as nursing care, aged care, residential care, and complex care.

**Paid Hours** is a combination of worked and benefit hours.

**Part-time** employees work less than 37.5 hours on regular hours each week and are entitled to the same benefits as full-time employees on a pro rated basis. For example, if an employee works for 3 days a week, they are entitled to accrue leave for those 3 days. This can be on a contract basis, or permanent.

**Polypharmacy** is the concurrent use of multiple medications by a patient

**Preceptor** is described as a staff member who serves as a role model and aids in the socialization for a new member of the same profession. Preceptorships are commonly used in placements for nursing students, however this role may be of use for graduates of nursing, and other professions, as well.

**Staffing Mix** refers to the proportion of different categories (Registered Nurses, Licensed Practical Nurses, Personal Support Workers, physiotherapists, social workers, etc.) of healthcare personnel involved in the provision of care to residents in long term care homes.

**Worked Hours** are the hours that are spent by staff carrying out the mandate of the service, i.e. staff are present and available for work. Worked hours include regular worked hours, worked statutory holidays, relief/replacement hours for vacation and sick days, overtime and callback hours paid and banked and attendance at committee meetings and informal education.

**Working Short** is an expression is commonly used to describe a shift that is short-staffed. Staff report that often they are “working short” when some staff scheduled for a shift are not able to report to work or complete their shift.

## **B: Staffing Study Approach<sup>89</sup>**

This staffing study relied on the experience and expertise of an advisory group comprised of operators, trainers, researchers, and resident and family voices, and was asked to meet the following objectives:

- Bring a broad sector perspective and work collectively to offer strategic advice and input;
- Hear from stakeholders, including professional associations, to ensure that the needs and concerns of all impacted groups are reflected;
- Provide strategic advice on the potential staffing model, skill mix, distribution and training for staff required to meet the current and future needs of Ontario’s long-term care sector, ensuring resident safety and quality of care, responding to increasing resident acuity, and supporting an expanded system;
- Identify key factors in optimizing recruitment and retention of long-term care staff;
- Support the ministry in responding to Recommendation #85 in the Public Inquiry into the Safety and Security of Residents in the Long-Term Care System; and
- Provide a report to the Deputy Minister that presents the key findings, evidence and advice of the Group.

### **In-scope:**

- Evidence-based recommendations for staffing models, ratios/mixes, in both the current and expanded LTC system.
- Current staffing thresholds, leading practices and issues.
- Canadian and international best practices in long-term care homes related to staffing.
- Approaches/challenges based on long-term care home size, geographic location, age of home, for profit/not-for-profit.
- Current state of staffing models/mix in Ontario long-term care homes; best practices based on current models.
- Workflows (e.g., staffing routine, work schedules, scope of practice).
- Factors related to improving recruitment and retention of staff.

### **Guiding principles:**

1. The government’s vision for long-term care, which is to create a 21st century long-term care sector that is resident-centered and provides access to the highest quality of care for our most vulnerable.
2. The paramount importance of the safety and the physical, psychological, social, spiritual, and cultural wellbeing of long-term care residents.
3. The recognition that each long-term care home is distinct with unique residents’ needs, and that solutions should be flexible, in order to reflect local dynamics and variations across the province.
4. The need for sustainable approaches that reflect the fiscal situation of the province.

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<sup>89</sup> Excerpts from Advisory Group Terms of Reference

## **C: Advisory Group Membership**

**Zubin Austin**, Professor, Leslie Dan Faculty of Pharmacy, University of Toronto

**Melissa Donskov**, Executive Director at the Saint-Louis Residence and Élisabeth Bruyère Residence long-term care homes

**Sharon Goodwin**, Senior Vice President, Home & Community Care, Victorian Order of Nurses

**Akos Hoffer**, CEO, The Perley and Rideau Veterans' Health Centre

**Anita Plunkett**, RPN, PSW instructor, Ontario Association of Adult and Continuing Education School Board Administrators (CESBA) PSW co-chair

**Kevin Queen**, CEO and District Administrator, Kenora District Homes

**Dr. Paula Rochon**, Vice-President Research and Senior Scientist, Women's College Research Institute

**James Schlegel**, President and CEO, Schlegel Health Care

**Arthur Sweetman**, Ontario Research Chair in Health Human Resources, McMaster University

**Grace Welch**, Chair of the Champlain Region Family Council Network Advocacy Committee

## **D: Organizations Engaged by the Advisory Group**

### **Care Providers**

Ontario Personal Support Workers Association (OPSWA)

Neighbourhood Pharmacy Association of Canada (NPAC)

Ontario Physiotherapy Association (OPA)

Ontario Society of Occupational Therapists (OSOT)

Therapeutic Recreation Ontario (TRO)

### **Residents/Family**

Ontario Association of Residents' Council (OARC)

Family Councils Ontario (FCO)

### **Training/Research**

Institute for Safe Medication Practices (ISMP)

Colleges Ontario

### **Labour Unions**

Ontario Nurses Association (ONA)

Service Employees International Union (SEIU)

Canadian Union of Public Employees (CUPE)

Christian Labour Association of Canada (CLAC)

Healthcare, Office, and Professional Employees Union (HOPE)

Ontario Public Service Employees Union (OPSEU)

Unifor

### **Nursing Organizations**

Registered Nurses Association of Ontario (RNAO)

Nurse Practitioners of Ontario (NPAO)

Registered Practical Nurses Association of Ontario (RPNAO)

### **Operators**

Ontario Long-Term Care Association (OLTCA)

AdvantAge Ontario

Yee Hong Centre for Geriatric Care

Foyer Richelieu

Ontario Retirement Communities Association (ORCA)

City of Toronto Seniors Services and Long-Term Care

Region of Peel Long-Term Care

Tsionkwanonhso:te Long-Term Care Facility

Iroquois Lodge Nursing Home



## E: International Trends

On an international level, the long-term care sector faces similar issues to Ontario. The Organization for Economic Co-operation and Development (OECD) reports that:

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*“vacancy rates in social care in the United Kingdom are twice as high as in other sectors. In the United States, between two and three out of five home-health aides leave the job within a year, and over two-thirds leave in the first two years. For Certified Nursing Assistants, the turnover was 71 percent annually, leading to staffing shortage. Similarly, turnover in the Japanese long-term care sector (27.5 percent) is higher than in other industries especially for non-permanent employees in institutional care.”<sup>90</sup>*

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Many of those leaving a long-term care job typically leaves the sector completely. This results in critical staffing gaps on the front lines as well as in middle management.

At the same time, the care needs of individuals who require long-term care, as well as home care, have increased and become more complex in recent years, while the number of workers per care recipient and the qualification skill mix has remained stable. This has translated to heavier workloads for staff already burdened by staffing shortages.

Aggregate trends across the OECD labour markets also show an increase in part-time work within long-term care between 2000 and 2009, while the annual hours worked decreased. Long-term care workers, particularly those with less qualifications, tend to hold multiple jobs. In New Zealand, roughly 17 percent of long-term care staff hold multiple jobs, and social-care workers in England typically work an average of 1.6 jobs, concurrently.

OECD Countries across the world reported high psychological pressure on staff caused by high work pressures, a lack of labour satisfaction, and often high instances of violence.

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*“The European Nurses Early Exit Study (NEXT) found that 22 percent of nurses experience violence by patients or family at least once per month, with nursing aides more often experiencing violence. Frequent work interruption, high workload, longer working-week duration, working in night shifts, all increased the likelihood of experiencing violence.”<sup>91</sup>*

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In Canadian settings this number was much higher – with nearly half of the institutional care workers experiencing verbal, sexual, or racial violence on a daily basis.<sup>92</sup> Similar levels of violence were also reported by Japan.

Despite the prevalence of staffing shortages, high workload, and psychological and physical risk, long-term care workers consider their work meaningful and rewarding. Staff report that teamwork, the responsibility of care, providing dignity and respect to others were strong positive motivators to work in the sector. Family satisfaction, learning from residents’ experiences, the variety of work they perform were also seen as beneficial.

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<sup>90</sup> Colombo, F. (2011). Help Wanted?: Providing and Paying for Long-Term Care. OECD Health Policy Studies.

<sup>91</sup> Ibid.

<sup>92</sup> Banerjee, A., Daly, T., Armstrong, H., Armstrong, P., Lafrance, S., & Szebehely, M. (2008). Out of Control: Violence against Personal Support Workers Long-term Care, York University/Carleton University.

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