



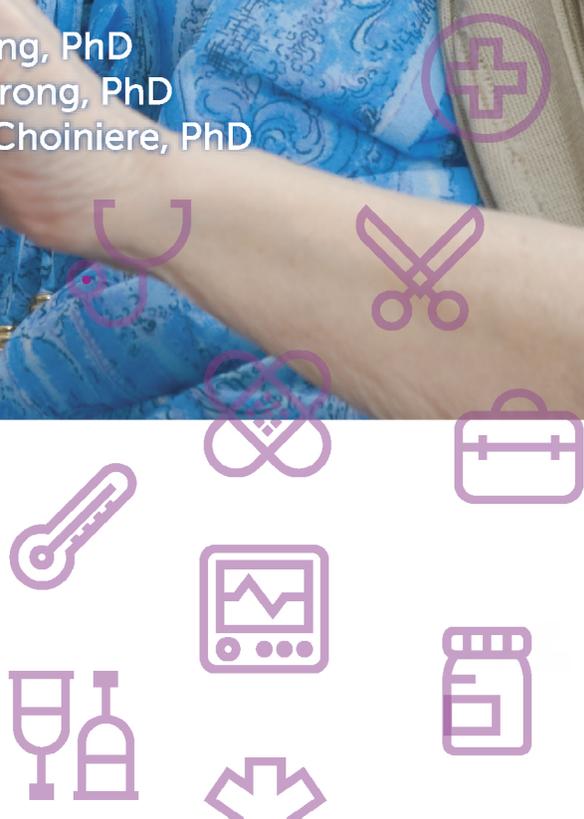
BEFORE IT'S TOO LATE: A NATIONAL PLAN FOR SAFE SENIORS' CARE

Pat Armstrong, PhD
Hugh Armstrong, PhD
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**Vote for the
health care
we deserve.**

**Canada's
Nurses**
STANDING UP
FOR HEALTH CARE



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The Canadian Federation of Nurses Unions (CFNU)

The Canadian Federation of Nurses Unions represents close to 200,000 nurses and student nurses. Our members work in hospitals, long-term care facilities, community health care, and our homes. The CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.



Message from the CFNU

Linda Silas



In recent years, it has become commonplace for governments, health care administrators and pundits to talk about seniors as “the silver tsunami” that poses an imminent threat to the sustainability of our health care system. Derogatory terms like “bed blockers” have become common, even among some health care professionals. Inflammatory language and dire warnings are often used to justify a lack of response or further cuts to health care services or – again another no-win situation – privatization. However, as CFNU’s report, *Before It’s Too Late: A National Plan for Safe Seniors’ Care*, makes clear, while it is true that the seniors population is aging, this is not a cause for alarm, but instead it is a signal that concerted action must be taken to ensure that seniors receive the health care they need, where and when they need it.

As an organization representing close to 200,000 frontline nurses, the CFNU has a long-standing commitment to advocating for seniors’ care. We are increasingly hearing from frontline nurses across the country that seniors are being left behind in our health care system. They are left behind in our planning. Three in four seniors have at least one chronic condition, and almost a quarter have three or more. They need many different providers, treatments and prescription medications. They need continuity and coordination among services. To stay in their homes, they need short-term and

sometimes extended home care support. When they are ready, they need access to quality, publicly funded long-term care. These resources are sorely lacking, and so many seniors await placement in hospital beds at great cost to our health care system. Over a single year, these patients' use of acute care beds exceeds 2.4 million days at a potential cost of upwards of \$2 billion annually.

Nurses report that staffing is wholly inadequate in long-term care. Staff cuts have occurred in many facilities, even as the level of acuity among long-term care residents is rising. The result is to be expected. The quality of care has fallen dramatically with most residents receiving little direct care nursing.

In keeping with the guiding principles of the *Canada Health Act*, seniors' care must be equitable and inclusive across Canada. This means we need a national plan for safe seniors' care, with long-term, dedicated funding and effective enforcement mechanisms. This plan must include a new standard which takes an integrated approach to seniors' care, considering the whole person, their diverse background and history, with the objective of improving the overall quality of seniors' lives. Since most seniors want to age in their homes, we need to help them stay in their homes longer by providing funding for both short-term and long-term home care services. This not only benefits seniors, it is by far the most cost-effective strategy. In both home care and long-term care facilities, we need a stable workforce, adequate staffing levels and an appropriate staff mix.

Nurses know that now is time for action!

We **can do** better – we **must do** better for Canada's seniors.

In solidarity always,

A handwritten signature in black ink, appearing to read 'Linda Silas', with a long horizontal flourish extending to the left.

Linda Silas
CFNU President





Executive Summary

Pat Armstrong, PhD
Hugh Armstrong, PhD
Jacqueline Choiniere, PhD

This report is prompted by a deep concern about the care available to Canadian seniors, now and in the future. As an organization representing close to 200,000 frontline nurses, the Canadian Federation of Nurses Unions (CFNU) has committed to act and advocate for safe, quality seniors' care.

There is no question our population is aging; yet there is no reason to view this as a disaster for our health care system, waiting to happen. It is imperative to recognize and respond to the critical problems seniors are facing in access to services and in obtaining high-quality and appropriate treatment within those services. Our health care system's focus on acute, episodic care too often means continuity and coordination among services are lacking, and long-term care and home care services are critically understaffed. The result is more costly services created largely by the lack of a fully integrated public system, rather than by seniors' need for services. This is the crisis we must deal with now, before it is too late.

Although myth would have it that this is sending care back home, our grandmothers never cleaned catheters and feeding tubes, operated sophisticated equipment or administered controlled substances.

Major federal cutbacks which started in 1995 have had a cascading effect on the health care services within provinces and territories. The cancellation of both the Health Council of Canada and the Health Accord, along with decreased funding transfers from the federal government, are placing even greater pressure on provincial and territorial health care budgets. Meanwhile, home care and long-term care services have not compensated for the reduction in acute care hospital beds and the closure of chronic care, psychiatric and rehabilitation hospitals. Equally important, when seniors seek care outside these hospitals, the *Canada Health Act* principles of universality, accessibility, comprehensiveness, portability and public administration no longer clearly apply.

The absence of a national strategy, principles or funding has resulted in wide variations in access to essential seniors' services across the country. There are long wait times and services denied. Too many seniors simply cannot afford to pay privately for home care or for long-term residential care. Adding to the difficulties, seniors wait longer to access primary care than younger Canadians. As a result, many end up seeking care through hospital emergency rooms that could have been provided by a doctor or a nurse in the community. Current system gaps are leading to growing inequities in access to care among regions, and among seniors.

14% of acute care beds are ALC, occupied by seniors, most of whom are awaiting placement in LTC or home care services.

Inequities are particularly apparent in home care, where home care services with limited resources increasingly focus on acute, short-term care. This means both that resources are siphoned away from seniors' daily needs, and that family and friends – especially women – are pressured to provide more, and more complex, unpaid care. Too often the consequences are deteriorating health and employment opportunities for these unpaid providers, consequences that also cost the system as a whole.

Building Health Care for Seniors

Our vision for a national plan for seniors builds on our commitment to the need for a person-centered, inclusive and culturally appropriate continuing care system. Care continuity is critical, which means understanding that care is a relationship, especially for seniors who are often frail, experience chronic health problems and may suffer from dementia. Continuity of care providers and services can improve quality and satisfaction for both seniors and providers, and, at the same time, reduce wasteful duplication, including the use of emergency rooms. When we recognize the fundamental nature of *care as a relationship*, the road to improving care for our seniors becomes clear.

Promoting care as a relationship requires a stable workforce

Continuity of care is less likely in settings with more casual, temporary and part-time staff. Understanding seniors in the context of their daily life, their health and life histories and their community is very difficult through casual, temporary encounters. Competitive bidding for some home care services encourages staff discontinuity, as does the profit seeking focus of for-profit agencies. Cutbacks in public funding are pressuring not-for-profits to adopt similar practices. Effective teamwork, so important for seniors' complex needs, suffers when there are large numbers of temporary staff, and those working full time face additional pressures in having to assist those less familiar with the setting.

Promoting care as a relationship requires adequate staff and an appropriate staff mix

Staffing levels and staff mix are important for quality of care and the safety of both seniors and care providers. The lower the staffing levels, the less likely seniors are to receive the care they need, particularly if their chronic conditions are competing with others' acute needs. Staff members suffer with the extra burden of care, along with increases in overtime, illnesses and injuries, which, in turn, increases costs. There is a growing recognition of the need to regulate nurse-patient ratios to account for the increasing acuity and complexity of seniors' care in all sectors. Relatedly, it is important to ensure a match between the growing complexity of care needs in all sectors and the formal educational qualifications and competencies required to provide that care.

Promoting care as a relationship requires an integrated system

It is widely recognized that seniors require a coordinated system of care stretching from primary health care to end-of-life care. Team-based care has been particularly effective in addressing seniors' health care needs, but it is undermined in the context of temporary employees and contracting-out of services. Alternatively, the lack of integration and coordination, as well as poorly designed systems, result in a care patchwork and in costly and preventable adverse effects.

Promoting care as a relationship requires standards effectively enforced

Standards promote evidence-informed decisions and also serve to advise seniors and their supporters about their rights to care. Standards should not mean all care is the same. Rather care providers use their expertise to apply these standards to the particular needs and contexts of individual seniors, considering their diverse backgrounds, families and communities. Accountability cannot be reduced to counting or public reporting on counting.

Promoting care as a relationship requires training and education

The links among quality of care, staff access to education and training, and retention are clear. Education and training has not kept pace with the growing complexity and acuity in all sectors: the result can be inappropriate drug prescribing, which may have serious consequences for our elderly. For the health of our seniors, there is a particular need for nurses, doctors and other staff to receive more education about the care of the elderly.

Promoting care as a relationship requires appropriate working conditions

The conditions of work are the conditions of care. The findings that health care aides in Canada suffer more abuse than their counterparts in Nordic countries, and that nurses are more likely than prison guards to be attacked at work, illustrate our need to address working conditions. It is too costly in both human and financial terms to ignore these problems and the resulting serious implications for seniors, staff, agencies and the entire system.

A safe seniors' agenda is needed to ensure that Canada's seniors get the health care they deserve. This can only happen if the federal government assumes its leadership role in health care and implements a national strategy. The CFNU calls on the federal government to work collaboratively with the provinces and territories to implement a federally funded targeted transfer fund for a pan-Canadian continuing care program. This program must be based on new legislation combining health and social services that will ensure provinces and territories develop fully integrated public systems, without for-profit delivery, for our seniors.

Recommendations

A National Plan for Safe Seniors' Care

The CFNU calls on the federal government to work collaboratively with the provinces and territories to implement a federally funded targeted transfer fund for a pan-Canadian continuing care program. This program must be based on new legislation combining health and social services, with the objective of achieving a fully integrated public system, without for-profit delivery.

Canada's frontline nurses, as represented by the Canadian Federation of Nurses Unions, offer the following recommendations:

- 1. That the federal government develop a national plan for safe seniors' care, with long-term, dedicated funding and effective enforcement mechanisms. This plan should include the following elements:**
 - Equity and inclusivity across Canada with access based on need;
 - National standards for safe, quality patient care, especially with respect to staffing and the enforcement of minimum staffing;
 - The creation of a human resources strategy for the long-term care and home care sectors, which addresses working conditions, training and discrepancies in compensation;

- Increased training and education in seniors' care across the health care sector;
- Recognition of the primacy of public or non-profit ownership;
- Strategies to ensure continuity of care and care providers between services;
- Increased support for unpaid caregivers through the funding of more paid caregiver positions.

2. That provincial governments build on the national plan by ensuring the provision of:

a) A stable workforce

- Establish a goal of 70% full-time nurses (and other health care workers) in all sectors. This measure is in recognition of the fact that care is a relationship requiring continuity among care providers. Ideally, the 30% part-time complement would be filled by regular part time staff to ensure effective teamwork and staff familiarity with residents'/patients' care needs;
- Discontinue competitive bidding which encourages discontinuity of care and tends to favor lowest cost over quality care.

b) Adequate staffing levels and appropriate staff mix

- Uphold, and enforce, existing staffing and other regulations for all sectors in which seniors receive care;
- Introduce new regulated minimum standards to increase the quality of care and reduce absenteeism and overtime costs;
- Mandate a minimum standard of 4.5 hours of direct care per resident each day to improve residents' quality of life (worked hours);
- Mandate a minimum of one RN per shift (worked hours) with an increase in RN numbers as required by the acuity level of residents.

c) Training and education

- Develop standards promoting ongoing, consistent in-house education and training for nurses and other providers in all sectors where seniors seek care;
- Encourage employers to promote teamwork among providers and implement team building strategies such as organizing joint education/in-service opportunities;
- Increase education on seniors' care in all health care provider programs.

d) An integrated system

- Ensure better coordination, communication, and collaboration between sectors and settings to avoid costly (in human, as well as financial, terms) complications, including the provision of adequate care/beds/providers in all sectors, with special attention paid to times of transition (e.g., transfers, discharge, admission). Team practices are particularly useful for chronic conditions and seniors.

3. That the federal and provincial governments join together in funding home care to ensure the provision of:

- Adequate and appropriate short-term and extended home care services available for seniors who need them in order to reduce avoidable complications and adverse outcomes, and decrease the care burden on family members, which, in turn, negatively impacts caregivers' work lives and health.

4. That the federal government introduce and enforce a new seniors' care standard

- Introduce and enforce new standards that go beyond traditional clinical standards, to promote a person-centered culture that takes a holistic approach to seniors' care, considering the whole person, their diverse background and history, with the objective of improving the overall quality of seniors' lives.



Before It's Too Late: A National Plan for Safe Seniors' Care

Pat Armstrong, PhD

Hugh Armstrong, PhD

Jacqueline Choiniere, PhD

Based on extensive research and consultations with Canadians, Mr. Justice Emmett Hall's 1964 Royal Commission on Health Services recommended that "as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without let or hindrance of any kind."¹ The research demonstrated a federal government move towards a comprehensive range of public health services that would not only be the most equitable but also the most efficient and effective. A half century later, we are still waiting for an integrated public health care system without hindrance of any kind, and seniors in particular are suffering as a result.

Seniors' Need for Care

There is no question that we have an aging population and that there will be more people requiring health care services as a result. According to the 2011 Census, there are nearly 5 million (4,945,000) Canadians age 65 and over, representing almost 15% (14.8%) of the total Canadian population.² The low-income seniors' rate in 2012 was 12.1%; 28.5% of seniors who were unattached were in the low-income bracket.³ While

these demographics create challenges, there is no reason to see this aging as a disaster waiting to happen. “Economic models suggest that growth in health care costs due to population aging will be about 1% per year between 2010 and 2036.”⁴ The aging population is wealthier and healthier than past generations, making them less likely to need care. Moreover, seniors make enormous contributions to care, with those age 65 and over providing almost 30% of unpaid care for seniors.⁵ As Michel Grignon (October 29, 2013), writing in the *National Post*, puts it,

*The yearly increases in total health care spending in Canada – approximately \$10 billion per year nowadays – does not result from aging per se, but the costs of treatment, including diagnostic tests, drugs and doctors, for all patients, young and old. It’s not that we have too many seniors that will break the bank, but how those seniors, and others, are treated in the health system that affects the bottom line.*⁶

While our aging population alone is not a disaster waiting to happen, the critical problems seniors do face are about access to services, high-quality, appropriate treatment within services, continuity between services, and the critical understaffing of long-term care and home care. Seniors are more likely to have multiple chronic health conditions, requiring transitions between providers and settings, and the need for various therapies and prescription medications. “In 2009, about two thirds of seniors in public drug programs were claiming five or more drug classes, and nearly one quarter were claiming 10 or more.”⁷ Older Canadians, also more likely to have decreased liver and renal functions, are more susceptible to adverse drug reactions.⁸ Given these complex and ongoing needs, the current health system focused on acute, episodic care can fail to provide the necessary coordination and continuity to keep seniors healthy and to respond to their health care needs in an effective and timely manner, resulting in too many seniors falling through the cracks.⁹ It is this crisis we must deal with now, before it is too late.

Seniors’ Access to Health Care Services

National funding and organization can make a difference in access to health services. Major cutbacks in the 1995 federal budget had a cascading effect on provincial and territorial health services. The result was a reduction in access to care for seniors. The 2004 Health Accord did lead to some expansion of and improvement in services. The

Health Council of Canada, a product of the 2004 Accord, concluded that “continued coordination efforts and greater use of effective management tools could make wait times management one of the success stories of the health accord”.¹⁰ The Council has also documented a wide range of individual strategies across Canada, which, with national leadership, could lead both to better access and lower costs.¹¹ However, both the Health Council and the Accord have been cancelled. Beginning in 2017, the federal government will reduce the 6% escalator for health care to the level of nominal GDP growth (with a baseline minimum of 3%) at a cost to provincial and territorial coffers of an estimated 36 billion over 10 years.¹² According to the Parliamentary Budget Officer, this measure will download billions of dollars in debt onto the provinces and territories, and ultimately onto Canadians, forcing the premiers to rein in their health care budgets even further.¹³ The consequences of these federal cuts will soon be felt by seniors.

Whatever money is saved through short-term restraint will be lost in panicked spending down the road. That’s been the lesson of the past 20 years.¹⁴

The *Canada Health Act* sets out the primary objective of Canadian health care policy, which is “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers,”¹⁵ but cutbacks and reforms have meant more and more seniors do not have reasonable access to care.

Hospitals. The number, cost and location of services are critical factors in seniors’ access to care. Beginning in the 1990s, federal cutbacks and subsequent provincial ones have significantly reduced access to health services. “Hospitals were particularly affected at that time by fiscal restraint measures, as federal and provincial/territorial governments focused on reducing or eliminating budget deficits. This was a period of hospital consolidation, restructuring and bed closures. Chronic care and rehabilitation hospitals were closed, and acute care was redefined to include only those requiring immediate medical intervention. There was systematic shifting from inpatient to outpatient care, especially to day surgery procedures and ambulatory clinics in hospital settings.”¹⁶ By 2009, Canada had only 3.3 hospital beds per 1,000 population, compared to the OECD average of 4.9.¹⁷ As a result, seniors have difficulty getting hospital care.

Emergency department access is only part of the story. “One in four of the seniors who visited an ED was admitted to hospital. Of these patients, one in 10 spent more than 31 hours in the ED before being admitted, compared with more than 25.4 hours for one in 10 younger patients.”¹⁸ At the same time, as much as 14% of the beds were occupied by those defined as requiring alternative levels of care, and most of them were seniors.¹⁹ Those most likely to wait for residential care had a diagnosis of dementia, or behavioral symptoms associated with dementia, suggesting this group is especially limited in its access to specialized services.²⁰

In sum, there has been a major decline in the number of hospital beds. In hospitals, care is delivered by non-profit organizations, access is based on health care needs, and seniors are protected both by care standards and the principles of the *Canada Health Act*, which requires accessible, comprehensive, universal, portable and publicly accountable care. The alternatives for seniors now are home and long-term care, increasingly delivered by for-profit and less regulated organizations where fees are charged and care is no longer clearly covered by the principles of the *Canada Health Act*. The result is growing inequities among regions and among seniors in access to care.

Home care. The wait for hospital care is not surprising, given that neither home care nor long-term residential care has compensated for the reduction in hospital beds and the growing numbers of seniors who need health care. Nearly half a million Canadians with a chronic health condition – many of them seniors – have unmet home care needs.²¹ However, as the Health Council of Canada notes, we lack “information in Canada to tell us how many seniors may be falling through the cracks – people who don’t have home care support but probably should.”²²

When a frail elderly person walks into an emergency room with an impending heart attack, the system is instantly primed to spend tens of thousands of dollars for tests, surgery and a hospital stay. However, that is often the same person who languished at home, mildly depressed, isolated, physically inactive and malnourished – someone for whom the system refused to spend a few hundred dollars a month on home care to prevent the catastrophe that ended up in the emergency room and the operating room.²³

The 2004 Health Accord agreed on providing first-dollar coverage for two weeks of care after hospital discharge and for mental health home care, as well as some end-of-life home care. But as the Health Council also points out, “the focus on short-term acute home care alone falls short of addressing the challenges currently facing the longer-term home care of seniors.”²⁴ In addition, targeting resources without significant enough increases in other areas to compensate means more limited access to care. Community consultations conducted by the Ontario Health Coalition indicate that even the seniors receiving active care are not getting timely care.

One participant has a friend who had surgery. This friend has mobility impairment, uses a wheelchair and could get from the chair to the bathroom. They have no family in the area. The CCAC told this friend it would take a week to assess her after the surgery. Her daughter who lives out of town was unable to take vacation days. This person was left without help while waiting for assessment.²⁵

This focus on short-term care also shifted resources away from those with chronic care needs,²⁶ most of whom are older women. The lack of public home care services places increased demands, especially on women in the family and on volunteers, with often significantly negative consequences for their health as well as for their current and future employment.²⁷ Nearly a quarter did not get the support they needed, and more than a third experienced distress, anger or depression as a result of their unpaid care work.²⁸ Over eight million Canadians are unpaid care providers, mostly to those suffering from age-related conditions.²⁹ Ten percent – many of whom are seniors – spend 30 hours or more per week taking care of others.³⁰ Unpaid care accounts for more than 80%³¹ of all home care in Canada and estimates of the savings to the public purse range from between \$5 billion³² to \$25 billion.³³ While seniors in all provinces and territories are facing significant limits on access to home care, the lack of a national strategy and funding means that there are variations across Canada in what services people get, what criteria are applied for getting those services and how much they pay for services. Indeed, regional services applying different criteria may mean neighbors have different rights to care. And those in rural and remote areas face major barriers in accessing home care.

The alternative to public home care is a private service, and many such services have appeared as the public system sends seniors home quicker and sicker. As the following chart from the Canadian Life and Health Insurance Association (CLHIA) indicates, the average costs for private home care vary by province. If a senior requires 24-hour care, every day, they are likely to pay well over \$3,000/week:

Cost of Home Care Services by Province³⁴

Jurisdiction	In home meal preparation	Personal Care (bathing/dressing)	Skilled nursing
	\$ per hour		
Alberta	19.90 – 30.00	19.90 – 32.00	27.00 – 80.00
British Columbia	16.50 – 36.95	15.00 – 36.95	35.00 – 75.00
Manitoba	16.50 – 25.00	19.00 – 25.00	40.00 – 75.00
New Brunswick	15.25 – 20.00	15.25 – 20.00	36.00 – 71.25
Newfoundland and Labrador	15.00 – 20.00	15.00 – 20.00	33.00 – 70.00
Nova Scotia	10.00 – 23.50	14.00 – 23.75	25.00 – 80.00
Ontario	13.00 – 30.00	13.00 – 30.00	22.85 – 70.00
Prince Edward Island	17.25 – 17.65	18.50 – 20.25	25.00 – 47.00
Quebec	3.00 – 25.25	12.50 – 25.25	15.00 – 85.00
Saskatchewan	18.00 – 28.00	22.00 – 27.00	(not available)

Source: LifestageCare™ (lifestagecare.ca)

In sum, too many seniors do not get access to the home care they need and want. Polls show that Canadians support the expansion of home care services in Canada as a necessary step to improve our health care system,³⁵ but there remain significant variations across and within jurisdictions that result in inequities among seniors. Both those seniors who need care and those who provide both paid and unpaid care suffer as a result. The alternative of paying privately for home care is well beyond most seniors' resources.

Long-term care. Home care is not necessarily the most cost-effective or appropriate form of care for seniors.³⁶ Long-term residential care, or nursing home care, is often the best and only option for those who require more frequent care. The Canadian Institute for Health Information (CIHI) offers the following definition of this sector: "Nursing homes

serve seniors and others who do not need to be in a hospital but who do need access to 24-hour nursing care not generally available in home care programs or retirement homes.”³⁷

Like home care, access to long-term residential care varies significantly across the country and even within provinces and territories, creating fundamental inequalities. How much of their resources jurisdictions spend on long-term care covers a wide range. “Public LTC spending as percentage of total public health care spending range(d) from 5.1 in British Columbia to 15.8 spent in Nova Scotia in 2013.” British Columbia and Alberta spent the least.³⁸ The following table illustrates the percentages for each province.

Public LTC Spending as % of Total Public Health Care Spending, 2013³⁹

BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
5.1%	8.6%	12.2%	12.8%	10.1%	13.4%	12.6%	15.8%	12.3%	13.4%

Although investment varies, everywhere the number of beds available has not expanded to meet the demand. Indeed, many jurisdictions have actually cut beds.

In the 1990s, the Alberta government reduced the number of LTC beds per capita by over 40%. Between 1999 and 2009, the number of LTC beds per Albertan aged 75 and over decreased by 20%.⁴⁰

The following table illustrates the number of nursing home beds per 1,000 of the 65 and older population, calculated using nursing home bed data from the Canadian Institute for Health Information (CIHI) and Statistics Canada Census data, 2011.

Number of Nursing Home Beds per 1,000 of the 65+ Population⁴¹

BC	AB	SK	MB	ON	NB	NS	PE	NL	Territories
32	39	49	51	40	36	40	51	38	111

The result is long waits for care, even as the criteria for entry have tightened so that only those with the most complex care needs are eligible. In Nova Scotia, the province with the highest proportion of seniors in the country, “there were approximately 1,284 people waiting for long-term care beds in April 2007. That increased to approximately 1,740 clients in April 2010 – an increase of 35.5%”,⁴² with some waiting more than a year. Since then, this number has risen even further to a waitlist of over 2,400 individuals.⁴³ In Ontario median wait times from home were as low as 68 days in 2004-2005 and have increased over the decade to 111 days. From hospital, median wait times for long-term care home beds rose in the last four years by 16 days to 65 days.⁴⁴

But there can be huge differences among homes, according to Ontario government data. In the Central CCAC (2014), for example, wait times for a basic room range from 56 days to over 3,147 days, based on calculations for nine out of 10 people and depending on the home. The main option, as BC’s Fraser Health Authority’s website suggests, is a private facility:

Depending on individual circumstances, private pay residential care may be the right option for either temporary or permanent care. There are many private pay residences to choose from, each offering a variety of services and features. Some residences have both publicly subsidized and private pay rooms. It is important to know that choosing to pay privately on a temporary basis does not guarantee you will be transferred to a subsidized bed in the same building.⁴⁵

According to the Sun Life Financial website, private pay homes range in price from \$2,275 to \$9,500 a month, with admission based on ability to pay, compared to a minimum rate of just under \$960.00 a month for publicly funded nursing care (B.C. costs).⁴⁶ Moreover, such facilities can make people leave if they cannot pay or if their care needs increase significantly. In other words, access to the alternative facilities is based primarily on income rather than on need, and those most in need may be excluded. Such costs are particularly problematic for women and other equity seeking groups because they are

the least likely to have employment pensions and are likely to have received low pay if they had paid employment. Moreover, access is not secure even with higher incomes.

How seniors get into long-term residential care and who qualifies is often a regional matter. How much you pay depends on where you live, not what you need. There is no consistency in what residents are expected to pay, how much of their assets they are required to give up, and the extent to which they are subjected to means tests before entry. Nor is there consistency in what kind of care is provided as part of the service. For the most part, the public funding is assumed to cover most direct care costs, while residents are expected to pay what is often referred to as accommodation costs. The justification for these fees is that these care facilities are really homes and, as you do at home, you should pay for housing, food, etc. There is general agreement that long-term residential care should be affordable for everyone who needs it, and that everyone should have a little leftover after they pay their fees. However, this often requires demonstrating that residents cannot pay out of the total of other income, including the federal, universal Old Age Security plan and the means-tested Guaranteed Income Supplement. Unlike the case with hospital and doctor care, then, all jurisdictions require user fees, and financial support for these fees often requires a means test. The result is inequity across and within jurisdictions.

In sum, there are not enough beds in long-term residential care to meet seniors' needs, and there is considerable variation across Canada in both the access to and cost of residential care. Cost will not keep people out of residential care, but lack of beds will, and the alternatives of retirement homes and private home care are too expensive for many, if not most, seniors. According to Toronto's Advocacy Centre for the Elderly, "The problem here isn't seniors holding up beds (in hospitals). The problem is that the system hasn't been managed properly, and there's not enough long-term care homes."⁴⁷

Primary care. There has been an increasing emphasis on primary care teams that include nurses and other professionals, and some care can be accessed through nurse practitioners and social workers. There are multiple examples of their capacity to extend access to care while reducing costs in the long run. Saskatchewan, following on Nova Scotia's model, for example, is "developing collaborative emergency centres to improve access to health care services in rural and remote communities. During the day, the public has access to a primary health care team,

including physicians and nurse practitioners, with extended hours on evenings and weekends. Overnight care is handled by a registered nurse and paramedic team with physician oversight by phone.⁴⁸

However, access to care is still mainly through doctors. Older Canadians were more likely than younger ones to have a regular doctor. Indeed, 96% said this was the case in 2014. However, seniors waited longer than younger people to get primary care, with more than half waiting at least two days to see a doctor or nurse, and nearly a third waiting at least another six days or giving up, making them wait longest, compared to those in ten other high-income countries. As a result, 37% went to emergency for a condition that could have been treated by a doctor or a nurse. Getting an appointment with a specialist was even harder. A quarter of older Canadians waited for at least two months to see one.⁴⁹

Access to specialists is an even greater problem for those who live in rural and remote areas. Moreover, although the primary care team approach has shown promise in terms of quality, health promotion and access as well as cost reductions,⁵⁰ in some provinces such as Ontario complicated payment models can undermine the team approach, and the province is backing away from the team promotion strategy.⁵¹

Pharmaceuticals. Medically necessary drugs are covered in hospitals and in most public care homes. In fact, most jurisdictions have some forms of public drug coverage for seniors, although what is covered and eligibility criteria vary significantly. However, there is a trend towards income-based drug benefit plans. British Columbia, Saskatchewan, Manitoba, and Newfoundland and Labrador have replaced public drug plans that provided seniors with medicines at little or no charge with income-based public drug benefit plans for everyone. Replacing age-based public plans with income-based drug benefits results in deductibles, which is a disincentive for seniors to fill needed prescriptions. Even minimal fees can create significant barriers for seniors living on our universal pension plan.⁵² Indeed, among high-income countries Canada is second only to the U.S. in the proportion of older people who did not fill out a prescription because of costs, and 15% did not receive the dental care they needed.⁵³

In sum, public coverage of primary care and pharmaceuticals have significant benefits for seniors, but costs create some barriers to care, as does the failure to develop more, and more effective, primary care teams. The quality of care is equally important and is a factor in costs.



Building Health Care for Seniors

CFNU's vision for a national plan for seniors builds on our work from 2011, when Canadian nurses represented by the CFNU signaled that the status quo with respect to long-term care was no longer an option, and that reforms were needed to address the serious gaps that exist in our continuing care system.⁵⁴ This was followed by a consultation on continuing care in Canada with participants from across the country. The one-day forum in March 2012 afforded participants the opportunity to share perspectives, engage in dialogue, and determine the common ground, set of principles, and potential actions that would allow Canada to move forward to improve continuing care. In addition to being person-centered, the forum concluded that continuing care must be inclusive, culturally appropriate and account for the full range of disabilities.⁵⁵

Continuity is critical to care. A focus on continuity means understanding care as a relationship, especially for seniors who are often frail, experience chronic health issues and may have forms of dementia.⁵⁶ Promoting care as a relationship requires continuity with care providers and continuity among services. Continuity can improve care quality, safety, outcomes and satisfaction for both seniors and care providers.⁵⁷ It can also reduce the cost of expensive duplication and use of emergency rooms. "All health services must be adequately funded, effectively organized, and appropriately interconnected in order to function optimally."⁵⁸

Promoting care as a relationship requires a stable workforce. The more casual, part-time and temporary the staff, and the more staff hired from agencies, the less likely continuity of care and the possibility of establishing a relationship with seniors. It is difficult to base care on an understanding of seniors in the context of their daily life, their health history and their community through casual, temporary encounters. Competitive bidding for some home care services and within hospitals and long-term care homes virtually guarantees discontinuity in staff because each new contract can mean entirely new providers.⁵⁹ Moreover, for-profit companies focused on profit are more likely to rely on precarious employment strategies as cost-saving measures. As well, cutbacks in public funding are pressuring more of those in the non-profit sector to follow these practices. Large numbers of casual, part-time, temporary and agency staff also put increased pressure on full-time staff that have to teach these new arrivals about the organization and about individual seniors. At the same time, with more precarious employees, it is difficult to promote the kind of teamwork shown to promote quality care and health promotion approaches. Research shows a link between quality of care (as defined by total direct care hours per resident day) and ownership, with public facilities having the highest level of quality (4.1 hours), followed by not-for-profits (3.41 hours) and private facilities (2.94 hours).⁶⁰

Promoting care as a relationship requires adequate staff and an appropriate staff mix.

There is plenty of research showing that staffing levels and staff mix are fundamentally related to the quality of care and safety of both seniors and care providers. Appropriate staffing levels and staff mix are also cost-effective, especially if we look at the system as a whole and over the longer term. At the same time, there is considerable evidence demonstrating that staffing levels are often too low to provide quality care and foster relationships.

Staffing Levels and Staff Mix

We can assume that overall staffing levels apply to seniors, and that the lower the staffing levels, the more likely those with chronic conditions are to receive less attention than those with acute care needs. More and more nurses, who make up the majority of hospital staff, are working overtime because there are not enough hands. Public sector nurses worked 19.4 million hours of overtime in 2014, the equivalent of 10,700 full-time jobs at an annual cost of \$871.8 million. The overtime rate was 26.3% in 2014, up from 15.6% in 1997. Unpaid overtime makes up a significant portion of total overtime, with a cost of \$192.5 million borne by nurses.⁶¹ Low staffing levels also mean more absenteeism due to illness and injury, disrupting continuity and adding to the costs of care. There is compelling research demonstrating the effectiveness of nurse-patient ratios,⁶² and yet there are no national, provincial or territorial standards for hospital staffing levels.

A report commissioned by the CFNU argues the following:

Standardized, legislated nurse-patient ratios and dynamic, shared decision making models of staffing have provided nurses with something lacking in the traditional staffing processes. They have given nurses at all levels direct and autonomous input into patient care decisions... Growing research evidence shows that these processes have resulted in safer care and improved outcomes for patients and their families.⁶³

Long-Term Care. Increasing acuity levels in this sector mean that each resident requires more care. In Canadian long-term care homes (as defined by CIHI) 60% of the residents suffer from dementia, and of the 95% of residents who need assistance, 80% need extensive assistance with the activities of daily living such as dressing, bathing and eating, which increases the workload for staff.⁶⁴ In residential care, U.S. research has linked high total staffing levels and having RNs on staff to improved resident function and other positive outcomes, such as fewer hospitalizations. U.S. research, tracking over 5,000 facilities, indicates that in order to maintain residents' level of health, direct care staffing levels should be set at 4.1 direct care hours per resident per day⁶⁵ – this is the “threshold below which poorer outcomes such as weight loss and pressure ulcers were more likely to occur.”⁶⁶ Other research suggests that to improve residents' quality of life, the level should be set at 4.5 hours per resident per day.⁶⁷ There are no national standards in Canada for the mix and number of staff required on any shift. Not all provinces require

a registered nurse on site each day, and only a minority have legislated a minimum number of care hours per day for each resident (Alberta,⁶⁸ Nova Scotia⁶⁹ and PEI⁷⁰). For example, Alberta's legislation requires a minimum of 1.9 hours of paid care per resident per day; on average, facilities are funded for 3.6 paid hours,⁷¹ but in practice, no provinces come close to the evidence-based recommended standards.

Some provincial governments have an affirmative action plan to promote for-profit nursing home ownership, even though the evidence shows they have lower staffing levels than non-profit or government-owned homes, more verified complaints, and more transfers to emergency departments.⁷² "Across Canada, public LTC facilities have 0.76 FTE health care staff per bed, compared with 0.566 in for-profit facilities and 0.632 in non-profit facilities. In other words, public facilities have 34% more staff than for-profit facilities."⁷³

Despite this, Ontario is moving towards a for-profit model for long-term care – 61% of the facilities in Ontario are for-profit, and 370 of the 591 for-profit facilities across Canada are found in Ontario. At 0.598 staff per bed, Ontario falls well below the national average of 0.641 staff per bed.⁷⁴ In light of two recent homicides in LTC facilities in Ontario, the Ontario Nurses Association has called for adequate staff to ensure a regulated minimum level of care averaging 4 worked hours per resident per day of nursing and personal care, with 0.78 hours of this to be RN direct care.⁷⁵

In contrast to Ontario, Manitoba has more LTC beds per population and more of them publicly funded than many other Canadian provinces. This province also enjoys a high rate of staff satisfaction with the quality of care. In a recent poll of staff, "24.7% of respondents rated quality of care in their facility as excellent, and 61.6% rated it as good. Overall, most nurses think that quality of care is good or above average in their facility," an increase over 2006.⁷⁶

The issue of appropriate staff mix is currently a major focus in Alberta, where there has been a steady decline in both RNs and LPNs and an increase in the numbers of health care aides in long-term care facilities.⁷⁷ Alberta saw a 17% decrease in the number of RNs in direct LTC between 2007 and 2009.⁷⁸ In March 2015, the issue came to a head when United Nurses of Alberta decided to go to court to force the provincial government to enforce *Nursing Homes Operation Regulation* requirements on the presence of RNs in nursing homes which state "an operator shall have at least one

nurse on duty at all times in his nursing home, and if at any time none of the nurses on duty are registered nurses or certified graduate nurses, the operator shall ensure that a registered nurse or certified graduate nurse is on call during that time. (...)79 In spite of this regulation, United Nurses of Alberta reports that a private, for-profit nursing home run by Extendicare in Athabasca has been refusing since fall 2014 to staff the site with RNs at any time.⁸⁰

Newfoundland and Labrador and Nova Scotia governments are also changing their approach to continuing care. In Newfoundland and Labrador, in response to recent changes in staff mix at LTC facilities, staff surveys indicate considerable unease about both staffing levels and staff mix in response to provincial changes, as well as the increasing level of acuity of the residents.⁸² In Nova Scotia, a survey of LTC nurses found

that more than 50% believe the quality of care has declined. Survey participants cite the sharp rise in the acuity of patients over the past 3-5 years; at the same time staff levels declined. Perhaps not surprisingly, staff report an increase in safety concerns over the same period.⁸³ Despite the negative effects of recent changes in a number of provinces, sadly the government of Newfoundland and Labrador has announced that it will be moving towards public-private partnerships (P3s) in its overhaul of the long-term care system in the province. In proposing this model, Newfoundland and Labrador pointed to Ontario's extensive use of P3s, despite the fact that Ontario's Auditor General has reported that the privatization of facilities cost Ontario's taxpayers 8 billion more than if the same facilities had been publicly financed.⁸⁴

These examples highlight the importance of safe staffing to ensure safe and quality patient care. To ensure appropriate safe staffing, base safe staffing in LTC facilities should be determined by

In a Calgary case that prompted a review, "family members of the 75-year-old have said she was stricken with septicemia when her wounds became badly infected from urine that ran down her legs from diapers that were changed infrequently." Three reviews of this facility found that "insufficient staffing was compromising care."⁸¹

matching nurses' formal educational qualifications and competencies to patient needs as determined by patient needs assessment tools applied on a real-time, shift-by-shift basis.⁸⁵

Home Care. Research on home care clearly demonstrates that lack of staff continuity lowers the quality of care for seniors and the quality of work for employees.⁸⁶ While we have less research establishing appropriate levels of staffing for home care, in part because of the great variety in care provided and required, study after study has shown that low wages, lack of job security and poor conditions lead to high turnover in staff. This turnover simultaneously demonstrates the workload pressures and the lack of continuity in care. With multiple reports also testifying to the brief hours of care, each involving a different provider, there is little evidence that home care is adequately staffed. There is evidence that staff struggle to provide continuity of care, based on an understanding of seniors' individual care needs.

Acuity in home care is also rising. Many seniors have chronic conditions, and nearly a third have high or very high needs. Almost all have difficulty with daily activities, and as many as 40% need help with bathing, toileting and eating.⁸⁷ Each senior requires more care, but there has not been a significant increase in staff to compensate for that increase. This can mean, for example, that care providers do not have time to learn about personal histories related to falling, and to develop strategies to avoid the falls that are a major cause of hospitalization.⁸⁸ Fifty percent of falls happen at home. Falls were the leading cause of injury hospitalization for seniors across Canada, contributing to 73,190 total hospitalizations, with an average length of stay of 16 days, most of which time was spent waiting for a residential care bed.⁸⁹

Restructuring and cutbacks have profoundly altered home care staffing by shifting care work to unpaid providers, most of whom are women without formal training. While the majority of these unpaid workers already have a relationship with those for whom they provide care, that relationship is too often threatened by the heavy demands of care and the stress of doing work for which they have no formal training. Although myth would have it that this is sending care back home, our grandmothers never cleaned catheter and feeding tubes, operated sophisticated equipment or administered controlled substances. The shift in this care work not only creates heavy burdens and time poverty for many women, most of whom now also have paid work, but also renders invisible and undervalues the skilled work of paid providers.



Promoting care as a relationship requires an integrated system. There is a host of research and lots of community consultations demonstrating the need for a more integrated care system to benefit seniors and staff as well as to reduce costs overall. For seniors, a coordinated system needs to include "...chronic disease management and primary health care, home care, long-term care, end-of-life care, and acute care and rehabilitation."⁹⁰ Within organizations, teamwork can promote a focus on care as a relationship based on knowledge of the individual senior. "Research shows that team-based care can offer better access to services, shorter wait times, better coordination of care and more comprehensive care than a single health care professional alone."⁹¹ However, teamwork can be undermined not only by reliance on part-time, casual and temporary employees, but also by different employers delivering different services within organizations, which results from the contracting out of some work. Integration among services is frequently prevented by private ownership as well and by the claim that conditions of contracts and other aspects of the service must be kept secret to protect competitive advantages. "Delivery system fragmentation is associated with a lack of coordination between health and social services, a mismatch between care needs

and the intensity of care and poorer patient outcomes.”⁹² According to the Canadian Patient Safety Institute (CPSI), “lack of integration of HC teams, lack of care coordination across health care sectors and failures in communication,” along with “system design issues that force clients and caregivers to deal with a patchwork” of services, result in costly and preventable adverse events.⁹³ Notably, “one in 200 seniors was hospitalized because of an adverse drug reaction (ADR) in 2010–2011, compared with one in 1,000 of all other Canadians.”⁹⁴ Integration across services requires leadership at the top and someone near the seniors who coordinates care across the continuum.

Promoting care as a relationship requires standards, effectively enforced. Although there are calls across Canada for “person-centered care,” there are no national, provincial or territorial standards to ensure such care. Standards can provide the basis on which individual care providers and health services can make decisions in an equitable and evidence-informed manner. They can also serve to inform seniors and their supporters about their rights to care and forms of care. Staffing provides one example of an area where there is sufficient evidence to establish and enforce standards. Standards applied to the use of restraints have proven effective in reducing the unnecessary and undignified confinement for seniors. There is growing pressure to provide standards to limit the use of psychotropic drugs, which, research indicates, are not only overused but also often ineffective at addressing health issues.⁹⁵ The rate of psychotropic drug use, including antipsychotics and antidepressants, stands at 40% and close to 60% respectively in LTC facilities.⁹⁶ Ironically, such drugs may be linked to increased falls and other health declines.

Standards need not, and should not, mean all care is the same. Individual care providers can use their knowledge of standards and of individual seniors to respond in ways that treat seniors as whole people with diverse backgrounds, embedded in families and communities. Accountability cannot be reduced to counting and public reporting on counting. Rather it requires the right to be involved at multiple levels, a contact person responsible for individual seniors, and a process for not only complaining but for ensuring responses to those complaints.

Promoting care as a relationship requires training and education. Research shows clear links among quality of care, staff access to education and training, and retention strategies.⁹⁷ Training has not kept up with the dramatically changing needs of seniors in the health care system. Nor has it kept up with the increasingly diverse population

or recognized the importance of gender in care needs. The closure of chronic care, rehabilitation and mental health hospitals, along with severe cuts to acute care hospital beds, mean today's home care and residential care seniors would have qualified for hospital care twenty years ago, and those in hospital require more sophisticated care than ever before. In those hospitals, the care was mainly provided by RNs and RPNs/LPNs.* In home care and long-term residential care, most of the direct care work is provided by Personal Support Workers.** As skilled, dedicated, and experienced as many of them are, PSWs have not had to deal with such a population in the past. Yet we have not developed consistent in-house additional training for care providers nor do we have consistent educational programs for PSWs across the country. We are not training enough nurses and doctors in senior care either. Indeed, "recruitment into care-of-the-elderly and geriatric medicine training programs has been poor over the past decade."⁹⁸

One indicator of the lack of training is the inappropriate prescription of drugs. More than a third of seniors on public drug plans are using drugs defined as inappropriate for seniors.⁹⁹ More than 40 % of those in long-term residential care are prescribed antipsychotics with little evidence of positive effects and considerable evidence of adverse ones.¹⁰⁰ In shifting care to unpaid providers we too often fail to recognize the skills involved in the work, leaving both the unpaid provider and the senior at risk.

Promoting care as a relationship requires appropriate working conditions. The conditions of work are the conditions of care. Without decent conditions, it is hard to provide good care. Yet reform strategies have undermined working conditions throughout health services.

Studies on the impact of cost-reduction strategies report significant increases in staff depression, anxiety and emotional exhaustion among HCWs. Key job stress factors associated with ill health among HCWs were work overload, pressure at work, lack of participation in decision-making, poor social support, unsupportive leadership, lack of communication/feedback, staff shortages or unpredictable staffing, scheduling or long work hours and conflict between work and family demands.¹⁰¹

* RPNs = Registered Practical Nurses (Ontario only); LPNs = Licensed Practical Nurses (all other provinces)

** Also referred to as health care aides in some provinces

Violence against workers increases as other conditions deteriorate. Even though residents in Nordic long-term care residences have health issues similar to their Canadian counterparts, PSWs in Canada are more than 6 times as likely to say they face violence on a daily basis.¹⁰² Furthermore, “health care workers are more likely to be attacked at work than prison guards or police officers.”¹⁰³ Beyond the significant human cost to members of the health care team, the economic cost of workplace violence should make all employers take notice. Appropriate conditions allow care providers to do their jobs and to stay in their jobs, promoting continuity in care.

Poor conditions influence how many staff are there now, as well as how many will be there in the future. There are significant differences among provinces and territories in terms of the nurse/population ratio, which can only be addressed by national strategies. Without attractive conditions, it is difficult to ensure good care will be there, especially given the aging of the health care workforce. In 2009, 47% of those employed in residential care were aged 55 or over, and this was the case for 39% of those employed in hospitals.¹⁰⁴ “It is likely to remain difficult to recruit and retain competent direct care workers... because of the negative industry image, non-competitive wages and benefits, a challenging work environment, and inadequate education and training.”¹⁰⁵

Extensive research demonstrates that decent working conditions contribute directly not only to patient health but also to the health of health care providers, health care services and the country as a whole. Absenteeism, turnover, and injuries increase with poor conditions, while performance and the mental health of care providers decline as adverse events for patients increase. The result is a less efficient system and higher costs for the system as a whole.¹⁰⁶ Similarly, poor conditions at home and little support in terms of either finances or paid health providers can result in poor care, poor health for the unpaid care providers and more costs to the system.



Conclusion

RECOMMENDATIONS: A NATIONAL PLAN FOR SAFE SENIORS' CARE

The CFNU calls on the federal government to work collaboratively with the provinces and territories to implement a federally funded targeted transfer fund for a pan-Canadian continuing care program. This program must be based on new legislation combining health and social services, with the objective of achieving a fully integrated public system, without for-profit delivery.

Canada's frontline nurses, as represented by the Canadian Federation of Nurses Unions, offer the following recommendations.

1. That the federal government develop a national plan for safe seniors' care, with long-term, dedicated funding and effective enforcement mechanisms. This plan should include the following elements:
 - Equity and inclusivity across Canada with access based on need;

- National standards for safe, quality patient care, especially with respect to staffing and the enforcement of minimum staffing;
- The creation of a human resources strategy for the long-term care and home care sectors, which addresses working conditions, training and discrepancies in compensation;
- Increased training and education in seniors' care across the health care sector;
- Recognition of the primacy of public or non-profit ownership;
- Strategies to ensure continuity of care and care providers between services;
- Increased support for unpaid caregivers through the funding of more paid caregiver positions.

2. That provincial governments build on the national plan by ensuring the provision of:

a) A stable workforce

- Establish a goal of 70% full-time nurses¹⁰⁷ (and other health care workers) in all sectors. This measure is in recognition of the fact that care is a relationship requiring continuity among care providers. Ideally, the 30% part-time complement would be filled by regular part time staff to ensure effective teamwork and staff familiarity with residents'/patients' care needs;
- Discontinue competitive bidding which encourages discontinuity of care and tends to favor lowest cost over quality care.

b) Adequate staffing levels and appropriate staff mix

- Uphold, and enforce, existing staffing and other regulations for all sectors in which seniors receive care;
- Introduce new regulated minimum standards to increase the quality of care and reduce absenteeism and overtime costs;
- Mandate a minimum standard of 4.5 hours of direct care per resident each day to improve residents' quality of life (worked hours);

- Mandate a minimum of one RN per shift (worked hours) with an increase in RN numbers as required by the acuity level of residents.

c) Training and education

- Develop standards promoting ongoing, consistent in-house education and training for nurses and other providers in all sectors where seniors seek care;
- Encourage employers to promote teamwork among providers and implement team building strategies such as organizing joint education/in-service opportunities;
- Increase education on seniors' care in all health care provider programs.

d) An integrated system

- Ensure better coordination, communication, and collaboration between sectors and settings to avoid costly (in human, as well as financial, terms) complications, including the provision of adequate care/beds/providers in all sectors, with special attention paid to times of transition (e.g., transfers, discharge, admission). Team practices are particularly useful for chronic conditions and seniors.

3. That the federal/provincial governments join together in funding home care to ensure the provision of:

- Adequate and appropriate short-term and extended home care services available for seniors who need them in order to reduce avoidable complications and adverse outcomes, and decrease the care burden on family members, which, in turn, negatively impacts caregivers' work lives and health.

4. That the federal government introduce and enforce a new seniors' care standard:

- Introduce and enforce new standards that go beyond traditional clinical standards, to promote a person-centered culture that takes a holistic approach to seniors' care, considering the whole person, their diverse background and history, with the objective of improving the overall quality of seniors' lives.

Sources

- ¹ Royal Commission on Health Services. (1964, June 19). In *Making Medicare: The History of Health Care in Canada* (press release). Canadian Museum of History. Retrieved from <http://www.historymuseum.ca/cmhc/exhibitions/hist/medicare/medic-5h16e.shtml>
- ² Statistics Canada. (2013). Living Arrangements of Seniors. *Census in brief*: No. 4. Retrieved from http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.cfm
- ³ Statistics Canada. (2014). Canadian Income Survey, 2012. *The Daily*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/141210/dq141210a-eng.htm>
- ⁴ Canadian Health Services Research Foundation (CHSRF). (2011). Myth: The aging population is to blame for uncontrollable healthcare costs. Retrieved from http://www.cfhi-fcass.ca/Libraries/Mythbusters/Myth_AgingPopulation_EN_FINAL_1.sflb.ashx
- ⁵ Turner, A. and Findlay, L. (2012). Informal Caregiving for Seniors. Statistics Canada. *Health Reports* 23(3). Table 1. Retrieved from <http://www.statcan.gc.ca/pub/82-003-x/2012003/article/11694-eng.htm>
- ⁶ Grignon, M. (2013, October 30). The health care aging tsunami myth. *National Post*. Retrieved from <http://news.nationalpost.com/2013/10/30/michel-grignon-the-health-care-aging-tsunami-myth/>
- ⁷ Canadian Institute for Health Information (CIHI). (2011). *Health Care in Canada, 2011: A focus on seniors and aging*. Ottawa, ON: Author, p.50.
- ⁸ Ibid. p. 60
- ⁹ Health Quality Ontario (2015). *Experiencing integrated care: Ontarians' views of health care coordination and integration*. Toronto: Author.
- ¹⁰ Health Council of Canada. (2013). *Progress Report 2013. Health Care Renewal in Canada*. p. 5. Retrieved from <http://www.healthcouncilcanada.ca/>
- ¹¹ Health Council of Canada. (2014). *Access and Wait Times: Vol. 2*. Retrieved from <http://www.healthcouncilcanada.ca/>
- ¹² Council of the Federation Working Group on Fiscal Arrangements. (2012). *Report of the Council of the Federation Working Group on Fiscal Arrangements*. Retrieved from www.conseildelafederation.ca/en/featured-publications/76-premiers-support-national-disaster-mitigation-funding-program
- ¹³ Parliamentary Budget Office. (2013). *Fiscal Sustainability Report 2013*. p. 3. Retrieved from www.pbo-dpb.gc.ca/files/files/FSR_2013.pdf
- ¹⁴ Lewis, S., Sullivan, T. (2013). How to Bend the Cost Curve in Health Care. *IRPP Insight*. May 2013, No. 1. p. 1. Retrieved from <http://irpp.org/wp-content/uploads/assets/research/faces-of-aging/how-to-bend-the-cost-curve-in-health/Lewis-Sullivan.pdf>
- ¹⁵ Health Canada. The Canada Health Care Act. Retrieved from <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/index-eng.php>
- ¹⁶ Canadian Institute for Health Information (CIHI). (2014). *National Health Expenditure Trends, 1975 to 2014*. p. 46. Retrieved from http://www.cihi.ca/web/resource/en/nhex_2014_report_en.pdf
- ¹⁷ Organization for Economic Co-operation and Development (OECD). (2011). *Health at a Glance 2011: OECD Indicators*. OECD Publishing. Table 4.3.1. Retrieved from <http://www.oecd.org/els/health-systems/49105858.pdf>
- ¹⁸ Canadian Institute for Health Information (CIHI). (2014, October 7). *Patients Admitted to Hospital Spend Almost 5 Times Longer in ED than Non-Admitted* (press release). Retrieved from http://www.cihi.ca/cihi-ext-portal/internet/en/document/types+of+care/hospital+care/emergency+care/release_07102014

- ¹⁹ Sutherland, J.M., Crump, R.T. (2011). *Exploring Alternative Level of Care (ALC) and the Role of Funding Policies: An Evolving Evidence Base for Canada*. Canadian Health Services Research Foundation. p. 2. Retrieved from <http://www.cfhi-fcass.ca/SearchResultsNews/11-09-20/29f5b70f-e94f-4986-9455-231888e40f4a.aspx>
- ²⁰ Canadian Institute for Health Information (CIHI). (2012). *Seniors and Alternate Level of Care: Building on Our Knowledge*. p. 12. Retrieved from https://secure.cihi.ca/free_products/ALC_AIB_EN.pdf
- ²¹ Turcotte, M. (2014). *Canadians with unmet homecare needs*. Statistics Canada. Retrieved from www.statcan.gc.ca/pub/75-006-x/2014001/article/14042-eng.pdf
- ²² Health Council of Canada. (2012). *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* p. 20. Toronto: Health Council of Canada.
- ²³ Lewis, S., Sullivan, T. (2013). How to Bend the Cost Curve in Health Care. *IRPP Insight*. May 2013: No. 1. p. 6. Retrieved from <http://irpp.org/wp-content/uploads/assets/research/faces-of-aging/how-to-bend-the-cost-curve-in-health/Lewis-Sullivan.pdf>
- ²⁴ Health Council of Canada. (2012). *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* p. 7. Toronto: Health Council of Canada.
- ²⁵ Ontario Health Coalition. (2015). *The Care We Need*. p. 31. Retrieved from <http://www.ontariohealthcoalition.ca/wp-content/uploads/home-care-the-care-we-need-report-final.pdf>
- ²⁶ Health Council of Canada. (2012). *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* p. 7. Toronto: Health Council of Canada.
- ²⁷ Armstrong, P. (2013). *Unpaid Health Care Work: An Indicator of Equity*. Pan American Health Organization. Office of Gender, Diversity and Human Rights. Retrieved from <http://healthcoalition.ca/wp-content/uploads/2013/12/CHC-Article-Pat-Armstrong.pdf>.
- ²⁸ Canadian Institute for Health Information (CIHI). (2015). *How Canada Compares: Results from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults*. p. 9. Retrieved from <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2786&lang=fr&media=0>
- ²⁹ Sinha, M. (2013). Portrait of caregivers, 2012. *Spotlight on Canadians: Results from the General Social Survey*. Catalogue no. 89 652 X — No. 001. Statistics Canada. p. 4. Retrieved from <http://www.statcan.gc.ca/pub/89-652-x/89-652-x2013001-eng.htm>
- ³⁰ Ibid. p. 7.
- ³¹ MacDonald, M., Lang, A., Storch, J., Stevenson, L., Donaldson, S. & Lacroix, H. (2010). *Safety in Home Care for Unpaid Caregivers: A Scoping Literature Review*. Canadian Patient Safety Institute (CPSI). p. 5. Retrieved from http://www.patientsafetyinstitute.ca/English/research/commissionedResearch/SafetyinHomeCare/Documents/MacDonald/MacDonald,%20Marilyn_Caregiver%20Safety_Final%20Report%20ENG.pdf
- ³² Canadian Caregiver Coalition. Caregiver Facts. Retrieved from <http://www.ccc-ccan.ca/content.php?doc=43>
- ³³ Hollander, M.J., G. Liu, and N. Chappell. 2009. Who Cares and How Much? The Imputed Economic Contribution to the Canadian Healthcare System of Middle-aged and Older Unpaid Caregivers Providing Care to the Elderly. *Healthcare Quarterly*, 12 (2): 42-9.
- ³⁴ Canadian Life and Health Insurance Association (CLHIA). *A Guide to Long-Term Care Insurance*. p. 6. Retrieved from [http://www.clhia.ca/domino/html/clhia/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/\\$file/Brochure_Guide_Long-Term_Care_ENG.pdf](http://www.clhia.ca/domino/html/clhia/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/$file/Brochure_Guide_Long-Term_Care_ENG.pdf)
- ³⁵ Conference Board of Canada. (2013, October 9). *Homecare is a Top Priority for Canadians*. (press release). Retrieved from http://www.conferenceboard.ca/press/newsrelease/13-10-09/home_care_a_top_priority_for_canadians.aspx

³⁶ Health Council of Canada. (2012). *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* p. 52. Toronto: Health Council of Canada.

³⁷ Canadian Institute for Health Information (CIHI). (2014). *Health Spending – Nursing Homes*. Retrieved from https://secure.cihi.ca/free_products/infosheet_Residential_LTC_Financial_EN.pdf

³⁸ MacDonald, M. (2015). Regulating individual charges for long-term residential care in Canada. *Studies in Political Economy*, Vol. 95. (2015).

³⁹ Regulating individual charges for long-term residential care in Canada, by MacDonald, 2015, *Studies in Political Economy*, Vol. 95. Adapted with permission.

⁴⁰ Bower, Shannon S., Campanella, D. (2013). *From Bad to Worse: Residential Elder Care in Alberta*. Parkland Institute. p. 15. Retrieved from http://parklandinstitute.ca/research/summary/from_bad_to_worse

⁴¹ Adapted from CIHI Table 1.1: Selected Characteristics of Selected Residential Long-Term Care Facilities, by Province and Territories, 2012. Residential Long-Term Care Financial Data Tables. Retrieved from http://www.cihi.ca/web/resource/en/data_tables_ltc_en.xlsx
See also: Statistics Canada. Population by broad age groups and sex, 2011 counts for both sexes for Canada, provinces and territories. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/hit-fst/as-sa/Pages/highlight.cfm?TabID=3&Lang=E&Asc=1&PRCode=01&OrderBy=999&Sex=1&View=1&tableID=21&queryID=1>

⁴² CBC News Nova Scotia. (2011, November 22). Wait Lists for Long-Term Care Growing: Report. *CBC News*. Retrieved from <http://www.cbc.ca/news/canada/nova-scotia/wait-lists-for-long-term-care-growing-report-1.981595>

⁴³ Nova Scotia Legislature. (2013). Standing Committee on Public Accounts. January 9, 2013. *Hansard*. Retrieved from http://nslegislature.ca/index.php/committees/committee_hansard/C7/pa2013jan09

⁴⁴ Health Quality Ontario. (2014). *Measuring Up: HQO's 2014 Yearly Report*. Ontario: Ministry of Health and Long-Term Care. p. 72. Retrieved from www.hqontario.ca/public-reporting/yearly-reports

⁴⁵ Fraser Health. (2011). *Options for Residential Care*. Retrieved from http://www.fraserhealth.ca/your_care/residential_care/options_for_residential_care/

⁴⁶ Sun Life Financial as cited in BlueShore Financial. *Navigating the Elder Care Maze*. September Issue. Retrieved from <https://www.blueshorefinancial.com/ToolsAdvice/Newsletters/Lifespringinsights/2014/September/>

⁴⁷ Cook, M. (2013, January 1). Daughter fights Ottawa Hospital's plans to discharge ailing mother. *Ottawa Citizen*. Retrieved from <http://www.ottawacitizen.com/health/Daughter+fighters+Ottawa+Hospital+plans+discharge+ailing+mother/7767363/story.html>

⁴⁸ Craig, Meaghan. (2015, January 29). Seniors Access to Health Care a Concern. *Global News*. Retrieved from <http://globalnews.ca/news/1801676/timely-access-to-primary-health-care-for-older-adults-continues-to-challenge/>

⁴⁹ Canadian Institute for Health Information (CIHI). (2015, January 29). *How Canada Compares: Results from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults*. (press release). Retrieved from <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2786&lang=fr&media=0>

⁵⁰ Dinh, T., Stonebridge, C. and Theriault, L. (2014). *Recommendations for Action: Getting the Most Out of Interprofessional Primary Health Care Teams*. The Conference Board of Canada. Retrieved from <http://www.conferenceboard.ca/e-library/abstract.aspx?did=5988>

⁵¹ Grant, K. (2015). Ontario's Curious Shift Away from Family Health Teams. *The Globe and Mail*, February 15, 2015. Retrieved from <http://www.theglobeandmail.com/life/health-and-fitness/health/ontarios-curious-shift-away-from-family-health-teams/article22989363/>

⁵² Morgan, S., Daw, J., Law, M. (2014). *Are Income Based Public Drug Programs Fit for an Aging Population?* IRPP. Study No. 50. pp. 1, 4. Retrieved from <http://irpp.org/wp-content/uploads/2014/12/study-no50.pdf>

⁵³ Canadian Institute for Health Information (CIHI). (2015). *How Canada Compares: Results from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults*. pp. 24, 26. Retrieved from <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2786&lang=fr&media=0>

- ⁵⁴ Silversides, A. (2011). *Long-term care in Canada: status quo no option*. CFNU. Retrieved from <https://nursesunions.ca/report-study/long-term-care-in-canada-status-quo-no-option>
- ⁵⁵ Canadian Federation of Nurses Unions (CFNU). (2012). *Continuing Care in Canada: towards shared understanding and action*. Retrieved from https://nursesunions.ca/sites/default/files/cfnu_march_8_forum_on_cont._care_report_0.pdf
- ⁵⁶ Beach, M.C. and Inui, T. (2006). Perspectives: Relationship-Centered Care. A Constructive Reframing. *Journal of General Internal Medicine* 21.S1 (January 2006):S3–S8. Safran, Dana Gelb, William Miller, and Howard Beckman. (2006). Organizational Dimensions of Relationship-Centered Care. Theory, Evidence, and Practice. *Journal of General Internal Medicine* 21.S1 (January 2006): S9–S15. Cooper, L.A., Beach, M.C., Johnson, R.L., and Inui, T. (2006). Delving Below the Surface. Understanding How Race and Ethnicity Influence Relationships in Healthcare. *Journal of General Internal Medicine* 21.S1 (January 2006): S21–S27.
- ⁵⁷ Nundy, Shantanu and John Oswald. (2014). Relationship-Centered Care: A New Paradigm for Population Health Management. *Healthcare* 2 (4) December: 216–219.
- ⁵⁸ Canadian Health Care Association. (2009). *New Directions for Facility Based Long Term Care*. p. 9. Retrieved from http://www.healthcarecan.ca/wp-content/uploads/2012/11/CHA_LTC_9-22-09_eng.pdf
- ⁵⁹ Keefe, J., Martin-Matthews, A; Legare, J. (2011). *Home Support Workers: Human Resource Strategies to Meet Chronic Care Needs of Canadians: Final Report*. Canadian Homecare Association. Retrieved from <http://www.cdnhomecare.ca/media.php?mid=2798>
- ⁶⁰ Bower, S., Campanella, D. (2013). *From Bad to Worse: Residential Elder Care in Alberta*. Parkland Institute. p. 30. Retrieved from http://parklandinstitute.ca/research/summary/from_bad_to_worse
- ⁶¹ Canadian Federation of Nurses Unions. (2015). *Quick Facts: Overtime and Absenteeism Report*. Report prepared for the CFNU by Paul Jacobson Consulting. Retrieved from <https://nursesunions.ca/factsheet/absenteeism-and-overtime-fact-sheet-2015>
- ⁶² Aiken, L.H. et al. (2010). Implications of the California Nurse Staffing Mandate for Other States. *Health Services Research* 45(4) August: 904-921.
- ⁶³ Berry, L & Curry, P. (2012). *Nursing Workload and Patient Care*. CFNU. p. 12. Retrieved from https://nursesunions.ca/sites/default/files/cfnu_workload_paper_pdf.pdf
- ⁶⁴ Canadian Institute for Health Information. (2014). *Health Spending – Nursing Homes*. Retrieved from https://secure.cihi.ca/free_products/infosheet_Residential_LTC_Financial_EN.pdf
- ⁶⁵ Elliott-Buckley, Stephen. (2014). *Long-Term Care Staffing Takes a Hit in BC*. Canadian Union of Public Employees. Retrieved from <http://cupe.ca/long-term-care-staffing-takes-hit-bc>
See also: Institute of Medicine. (2003). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: National Academy of Medicine.
- ⁶⁶ Statistics Canada. Findings. Retrieved from <http://www.statcan.gc.ca/pub/82-003-x/2010004/article/11390/findings-resultats-eng.htm>
- ⁶⁷ Elliott-Buckley, Stephen. (2014). *Long-Term Care Staffing Takes a Hit in BC*. Canadian Union of Public Employees. Retrieved from <http://cupe.ca/long-term-care-staffing-takes-hit-bc>
See also: Schnelle, J.F. et al. (2004). Relationship of Nursing Home Staffing to Quality of Care. *Health Serv. Res.* 2004 Apr; 39(2): 225-25.
- ⁶⁸ Government of Alberta. (2010). *Stakeholder Provider Data Set*. From the Alberta Nursing Homes Operation Regulation and Health Information Standards Committee for Alberta.
- ⁶⁹ Nova Scotia Government. (2011). *Nova Scotia Homes for Special Care Regulations (HFRSC) and Act*. Nova Scotia Continuing Care Strategy: Long-Term Care Facility Program Requirements
- ⁷⁰ PEI Department of Health. (2009). *Operational and Care Service Standards for Community Care facilities*.
- ⁷¹ Auditor General of Alberta. (2014). *Auditor General's Report*. October 2014. Retrieved from <http://www.oag.ab.ca/webfiles/reports/October%202014%20Report.pdf>

- ⁷² Berta, W., Laporte, A., Valdmanis, V. (2005). Observations on Institutional Long-Term Care in Ontario: 1996-2002. *Canadian Journal on Aging* 24(1) Spring:71-84.
See also: McGregor, M.J., Tate, R., Ronald, L., McGrail, K. and Cox, M. 2010. Trends in Long-Term Care Staffing by Facility Ownership in British Columbia, 1996 to 2006. *Health Reports* 21(4) December:27-33.
- ⁷³ Ontario Council of Hospital Unions. (2015, January 1). *Defend Public Healthcare*. Retrieved from http://ochuleftwords.blogspot.ca/2015_01_01_archive.html
- ⁷⁴ Ibid.
- ⁷⁵ Ontario Nurses Association (ONA). (2013, November 30). *Stopping Long-Term Care Home Violence* (press release). Retrieved from http://www.ona.org/news_details/stop_LTC_home_violence_20131120.html
- ⁷⁶ Manitoba Nurses Union. (2014). *Frontlines*. Issue 3. 2014. p. 10. <http://www.nursesunion.mb.ca/files/Frontlines%20Issue%203%202014.pdf>
- ⁷⁷ Bower, S., Campanella, D. (2013). *From Bad to Worse: Residential Elder Care in Alberta*. Parkland Institute. p. 31. Retrieved from http://parklandinstitute.ca/research/summary/from_bad_to_worse
- ⁷⁸ Smith, H. (2011). No Place to Age: the costs and indignities of long-term care in Alberta. *Alberta Views*. Retrieved from <https://albertaviews.ab.ca/2011/10/04/no-place-to-age/>
- ⁷⁹ Province of Alberta. (1985). Nursing Homes Operation Regulation 258. Retrieved from www.qp.alberta.ca/documents/Regs/1985_258.pdf
- ⁸⁰ United Nurses of Alberta website. (2015, March 10). *UNA asks court to force Alberta government to enforce nursing home staffing law*. (press release). <http://www.una.ab.ca/466/una-asks-court-to-force-alberta-government-to-enforce-nursing-home-staffing-law>. See also <http://www.cbc.ca/news/canada/edmonton/nurses-union-takes-alberta-to-court-over-nursing-home-staffing-1.2989119>
- ⁸¹ McClure, M. (2014, January 24). Province says Patient Deaths at Calgary Nursing Home were 'Isolated Incidents'. *Calgary Herald*. Retrieved from http://parklandinstitute.ca/media/comments/province_says_patient_deaths_at_calgary_nursing_home_were_isolated_incident
- ⁸² MarketQuest Research. (2010, December). *LTC Care in Newfoundland and Labrador: the View from Nurses in LTC Settings*. A report prepared for Registered Nurses Union of Newfoundland and Labrador (RNUNL). Unpublished Research.
- ⁸³ Curry, P. (2014, June). *CFNU Research Network Meeting: Presentation on the NSNU LTC Care Project*. Ottawa. Unpublished Research.
- ⁸⁴ RNUNL. (2015, April 28). *Registered Nurses' Union reacts to province's announcement on public-private partnerships in long-term care*. (press release). Retrieved from <http://www.rnunl.ca/news-releases.asp?ID=859>
- ⁸⁵ MacPhee, M. (2014). *Valuing Patient Safety: Responsible Workforce Design*. CFNU. Retrieved from <http://nursesunions.ca/news/valuing-patient-safety-responsible-workforce-design>
- ⁸⁶ Keefe, J., Martin-Matthews, A., Legare, J. (2011). *Home Support Workers: Human Resource Strategies to Meet Chronic Care Needs of Canadians: Final Report*. Canadian Homecare Association. Retrieved from <http://www.cdnhomecare.ca/media.php?mid=2798>
- ⁸⁷ Health Council of Canada. (2012). *Seniors in Need, Caregivers in Distress: What are the Homecare Priorities for Seniors in Canada?* pp. 13-14. Toronto: Health Council of Canada.
- ⁸⁸ Canadian Institute for Health Information. (2010). *Seniors and falls*. Retrieved from http://www.cihi.ca/CIHI-ext-portal/pdf/internet/SENIORS_FALLS_INFO_EN
- ⁸⁹ Ibid.
- ⁹⁰ Canadian Institute for Health Information (CIHI). (2011). *Health Care in Canada, 2011: A focus on seniors and aging*. p. 130. Retrieved from https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf

- ⁹¹ Health Council of Canada. (2009). *Teams in Action: Primary Health Care Team for Canadians*. p.5. Retrieved from http://www.healthcouncilcanada.ca/rpt_det.php?id=335
- ⁹² Sutherland, J.M., Crump, R.T. (2011). *Exploring Alternative Level of Care (ALC) and the Role of Funding Policies: An Evolving Evidence Base for Canada*. CHSRF. p. 4. Retrieved from <http://www.cfhi-fcass.ca/SearchResultsNews/11-09-20/29f5b70f-e94f-4986-9455-231888e40f4a.aspx>
- ⁹³ Canadian Patient Safety Institute (CPSI). (2013). *Safety at Home. A Pan-Canadian Homecare Safety Study*. Retrieved from <http://www.patientsafetyinstitute.ca/English/research/commissionedResearch/SafetyatHome/Documents/Safety%20At%20Home%20Care.pdf>
- ⁹⁴ Canadian Institute for Health Information (CIHI). (2013, March 26). *Seniors five times more likely to be hospitalized for adverse drug reactions*. (press release) Retrieved from http://www.cihi.ca/cihi-ext-portal/internet/en/document/types+of+care/pharmaceutical/release_26mar13
- ⁹⁵ Lexchin, J. (2013). Living Better Through Chemistry: Dementia, Long-term Care, and Antipsychotic Medication Use. pp. 117-127 in *Troubling Care: Critical Perspectives on Research and Practices*, edited by Pat Armstrong and Susan Braedley. Toronto: Canadian Scholars' Press Inc.
- ⁹⁶ Canadian Institute for Health Information (CIHI). (2014). *Drug Use Among Seniors on Public Drug Programs in Canada, 2012*. p. 32. Retrieved from https://secure.cihi.ca/free_products/Drug_Use_in_Seniors_on_Public_Drug_Programs_EN_web_Oct.pdf#page=20&zoom=auto,-92,720
- ⁹⁷ Park, J., Stearns, S. (2009). Effects of State Minimum Staffing Standards on Nursing Home Staffing and Quality of Care. *Health Services Research* 44(1) February: 56-78.
- ⁹⁸ Hogan, D. (2007). Proceedings and Recommendations of the 2007 Banff Conference on the Future of Geriatrics in Canada. *Canadian Journal of Geriatrics* 10(4):133-148
- ⁹⁹ Canadian Institute for Health Information (CIHI). (2014) *Drug use among seniors on public drug programs, 2012*. p. 26. https://secure.cihi.ca/free_products/Drug_Use_in_Seniors_on_Public_Drug_Programs_EN_web_Oct.pdf
- ¹⁰⁰ Monette, J. et al. (2007). *Optimization of the management of behavioural and psychological symptoms of dementia in nursing homes*. Canadian Patient Safety Institute. Retrieved from <http://www.patientsafetyinstitute.ca/English/research/cpsiResearchCompetitions/2005/Documents/Monette/Report/Monette%20Full%20Report.pdf>
- ¹⁰¹ Yassi, A. & Hancock, T. (2005). Patient safety – worker safety: building a culture of safety to improve healthcare worker and patient well-being. *Healthcare Quarterly*. 8 (32): Spec No:32-8, p.35. Retrieved from <http://www.longwoods.com/content/17659>
- ¹⁰² Armstrong, P. et al. (2009). They Deserve Better. *The long-term care experience in Canada and Scandinavia*. Canadian Centre for Policy Alternatives. Figure 28.
- ¹⁰³ International Council of Nurses (ICN). Violence: a worldwide epidemic. *Nursing Matters*. Retrieved from http://www.icn.ch/images/stories/documents/publications/fact_sheets/19k_FS-Violence.pdf
- ¹⁰⁴ Calculated from the Survey of Labour and Income Dynamics, Statistics Canada.
- ¹⁰⁵ Stone, R., and Bryant, N. (2012). The Impact of Health Care Reform on the Workforce Caring for Older Adults. *Journal of Aging & Policy* 24: 188–205.
- ¹⁰⁶ Shamian, J. and El-Jardali, F. (2007). Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice. *Healthcare Papers*, 7(Sp) January 6-25.doi:10.12927/hcpap.2007.18668. Retrieved from <http://www.longwoods.com/content/18668>
- ¹⁰⁷ Canadian Nursing Advisory Committee. (2002). *Our health, our future: creating quality workplaces for Canadian nurses*. p. 37. Retrieved from <http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2002-cnac-cccsi-final/index-eng.php>

Appendix A

Message from the CFNU (French)



Linda Silas

Ces dernières années, les gouvernements, les administrateurs du secteur de la santé, et les pontes de la presse qualifient couramment les personnes âgées de « tsunami argenté » représentant une menace imminente à la viabilité de notre système de soins de santé. Des expressions de nature à discréditer, par exemple « monopolisateurs de lits », sont communes même chez certains professionnels de la santé. Un discours incendiaire et des prophéties de malheur sont souvent utilisés pour justifier l'absence de réponse ou d'autres compressions aux services de soins de santé ou – encore une fois une situation perdante – la privatisation. Toutefois, dans le rapport de la FCSII, *Avant qu'il ne soit trop tard : Un programme national pour assurer la sécurité des soins dispensés aux personnes âgées*, il est clair que le vieillissement de la population n'est pas une raison pour s'alarmer. C'est plutôt un appel à l'action concertée nécessaire pour que les aînés reçoivent les soins dont ils ont besoin, à l'endroit et au moment où ils en ont besoin.

En qualité d'organisation représentant près de 200 000 infirmières et infirmiers de première ligne, la FCSII est déterminée, depuis longue date, à assurer les soins aux aînés. De plus en plus d'infirmières et d'infirmiers de première ligne, de partout au pays, nous disent que les aînés sont laissés derrière dans notre système de soins de santé. Et ils sont aussi oubliés dans la planification. Trois personnes âgées sur quatre ont au moins une maladie chronique, et près du quart en ont trois ou plus. Elles ont besoin de différents fournisseurs de soins, traitements et médicaments prescrits. Elles ont besoin de continuité dans les services et de coordination des services. Pour demeurer dans leur domicile, elles ont besoin de soins à domicile à court terme et parfois à plus long terme. Lorsqu'elles sont prêtes, elles ont besoin d'avoir accès à des soins de longue durée de qualité et financés par l'État. Malheureusement, ces ressources sont rares. C'est pourquoi

autant de personnes âgées occupent des lits en soins actifs dans les hôpitaux en attente d'une place dans un établissement de soins de longue durée. Cela représente un grand coût pour le système de soins de santé. En une seule année, plus de 2,4 millions de lits en soins actifs sont occupés par des aînés, et le coût annuel peut atteindre jusqu'à plus de 2 milliards de dollars.

Le personnel infirmier signale combien la dotation en personnel est inadéquate en soins de longue durée. Plusieurs établissements ont réduit leur personnel même si l'acuité des besoins des résidents augmente. Et on pouvait prévoir le résultat : la qualité des soins s'est grandement détériorée, et la plupart des résidents reçoivent peu de soins infirmiers directs.

Afin de s'harmoniser aux principes directeurs de la *Loi canadienne sur la santé*, les soins aux aînés doivent être équitables et inclusifs dans tout le Canada. C'est pourquoi nous avons besoin d'un programme national pour assurer la sécurité des soins aux personnes âgées, assorti de fonds dédiés et à long terme, et de mécanismes efficaces en matière de mise en application. Ce programme doit comprendre une nouvelle norme, soit une approche intégrée en matière de soins aux aînés. Ainsi, la personne est considérée dans son ensemble où on tient compte de ses antécédents et de son histoire. L'objectif étant d'améliorer la qualité de vie générale des personnes âgées. Plusieurs aînés veulent vieillir dans leur domicile, et nous devons les aider à y demeurer plus longtemps en fournissant des services de soins à domicile à court et à long terme. Non seulement est-ce un avantage pour les personnes âgées mais c'est, de loin, la stratégie la plus économique. Dans le secteur des soins à domicile et des soins de longue durée, nous avons besoin d'une main-d'œuvre stable, de niveaux adéquats de dotation, et d'une bonne composition du personnel (éventail des compétences).

Les infirmières et les infirmiers savent que le temps est venu d'agir!

Nous **pouvons faire** mieux – nous **devons faire** mieux pour les personnes âgées du Canada.

Toujours solidaire,



Linda Silas
Présidente de la FCSI



Appendix B

Executive Summary

(French)

Ce rapport est motivé par une vive inquiétude par rapport aux soins disponibles pour les personnes âgées du Canada, maintenant et dans l'avenir. À titre d'organisation représentant près de 200 000 infirmières et infirmiers de première ligne, la Fédération canadienne des syndicats d'infirmières et infirmiers (FCSII) s'est engagée à agir et à préconiser des soins sûrs et de qualité pour les aînés.

Le vieillissement de la population ne fait aucun doute; or, il n'y a aucune raison de penser que ce sera désastreux pour notre système de soins de santé. Non seulement est-il impératif d'agir mais il faut aussi reconnaître les graves problèmes auxquels les aînés sont confrontés en matière d'accès aux services ou à des traitements pertinents et de grande qualité au sein de ces services. Notre système de soins de santé met l'accent sur les soins actifs et ponctuels. Or, trop souvent, cela signifie un manque de continuité et de coordination entre les services, et un manque flagrant de personnel dans le secteur des soins de longue durée et des soins à domicile. Il en résulte des services plus coûteux. La raison principale est l'absence d'un système public complètement intégré, et non pas les besoins des personnes âgées en matière de services. Il faut gérer cette crise dès maintenant avant qu'il ne soit trop tard.

Bien que, selon le mythe, cela voudrait dire ramener les soins à la maison, nos grands-mères n'ont jamais nettoyé de cathéters ni de sondes d'alimentation, elles ne se sont jamais servies d'équipements sophistiqués, et n'ont jamais administré des médicaments contrôlés.

D'importantes réductions par le gouvernement fédéral, amorcées en 1995, ont eu un effet cascade sur les services de soins de santé offerts par les provinces et les territoires. L'élimination du Conseil canadien de la santé et le non-renouvellement de l'Accord sur la santé, ainsi que la diminution des transferts fédéraux en matière de santé, mettent encore plus de pression sur les budgets en santé des provinces et des territoires. Entre-temps, les services de soins à domicile et de soins de longue durée n'ont pas compensé la réduction de lits en soins actifs dans les hôpitaux, ni la fermeture des hôpitaux de soins chroniques, psychiatriques et de réadaptation. Il est tout aussi important de souligner que lorsque les aînés veulent se faire soigner à l'extérieur de ces hôpitaux, les principes de la *Loi canadienne sur la santé*, notamment universalité, accessibilité, intégralité, portabilité et administration publique, ne s'appliquent plus très clairement.

L'absence de stratégie nationale, de principes ou de financement s'est traduite en grandes différences d'accès aux services essentiels pour les aînés du pays. Il y a de longs délais d'attente, et certains services sont refusés. Trop de personnes âgées ne peuvent pas payer de leur poche les soins à domicile ou les soins de longue durée en établissements. De plus, les aînés doivent attendre plus longtemps pour obtenir des soins primaires que

14 % des lits en soins actifs sont NSA, occupés par des aînés. La plupart attendent une place en soins de longue durée ou en soins à domicile.

les Canadiens et les Canadiennes plus jeunes. Ainsi, plusieurs se retrouvent à la salle d'urgence des hôpitaux pour des soins qui auraient pu être dispensés par un médecin ou une infirmière dans la collectivité. Les lacunes actuelles au sein du système ne font qu'augmenter les iniquités par rapport à l'accès dans les régions et parmi les aînés.

Les iniquités sont particulièrement évidentes dans le secteur des soins à domicile. Étant donné les ressources limitées, les services de soins à domicile mettent l'accent sur les soins actifs et de courte durée. Ainsi, les ressources ne sont plus disponibles pour répondre aux besoins quotidiens des aînés, et les familles et les amis – particulièrement les femmes – doivent dispenser, sans rémunération, des soins de plus en plus complexes. Trop souvent, la santé de ces soignants naturels se détériorent, les possibilités d'emploi diminuent, et ces conséquences représentent aussi un coût pour l'ensemble du système.

Soins de santé pour les aînés

Notre vision d'un programme national pour les aînés s'appuie sur notre engagement à mettre en place un système de soins continus, axé sur la personne, inclusif et culturellement adapté. La continuité des soins est essentielle. Cela signifie comprendre que *la prestation de soins est une relation*, particulièrement pour les personnes âgées souvent frêles et souffrant de maladies chroniques ou de démence. La continuité par rapport aux fournisseurs de soins et aux services peut améliorer la qualité et la satisfaction à la fois des aînés et des fournisseurs de soins et, en même temps, diminuer le gaspillage lié au chevauchement des tâches, y compris le recours aux salles d'urgence. Lorsque l'on reconnaît la nature fondamentale de la prestation de soins en tant que *relation*, la route à emprunter pour améliorer les soins aux aînés devient claire.

Promouvoir la prestation de soins en tant que relation nécessite une main-d'œuvre stable

La continuité des soins est moins probable dans les milieux de travail ayant davantage de personnel occasionnel, temporaire et à temps partiel. Comprendre les aînés dans le contexte de leur vie quotidienne, leur santé, leur histoire et leur collectivité est très difficile si les rencontres sont occasionnelles et temporaires. Les appels d'offre concurrentiels pour certains services de soins à domicile encouragent le manque de continuité par rapport au personnel, tout comme la recherche de profits pour les agences à but lucratif. Les réductions du financement public exercent une pression sur les organismes à but non lucratif pour qu'ils fassent de même. Trop de personnel temporaire nuit au travail d'équipe efficace, tellement important pour les besoins complexes des personnes âgées. De plus, le personnel à temps plein subit une pression supplémentaire car il doit aider le personnel moins familier au milieu de travail.

Promouvoir la prestation de soins en tant que relation nécessite suffisamment de personnel, et une composition pertinente du personnel (éventail des compétences)

Les niveaux de dotation et la composition du personnel sont importants pour assurer la qualité des soins et la sécurité des aînés et des fournisseurs de soins. Moins les niveaux de dotation sont élevés, moins les aînés sont susceptibles de recevoir les soins dont ils ont besoin, particulièrement si leurs maladies chroniques sont en concurrence avec d'autres besoins graves. Les membres du personnel doivent porter un fardeau supplémentaire,

il y a augmentation des heures supplémentaires, des maladies et des blessures, et tout cela se traduit en une augmentation des coûts. On reconnaît de plus en plus l'importance de réglementer les ratios infirmière-patients afin de tenir compte de la plus grande acuité des besoins, et de la complexité des soins aux aînés dans tous les secteurs. De plus, il est important de s'assurer que le personnel qui dispense les soins ait la formation et les compétences nécessaires pour bien gérer la complexité croissante des besoins dans tous les secteurs.

Promouvoir la prestation de soins en tant que relation nécessite un système intégré

Il est généralement reconnu que les personnes âgées ont besoin d'un système coordonné de soins, allant des soins primaires aux soins de fin de vie. Les soins dispensés par des équipes sont particulièrement efficaces pour répondre aux besoins des aînés, mais cela s'avère difficile dans un contexte d'employés temporaires et de services contractuels. De plus, les systèmes mal conçus et l'absence d'intégration et de coordination se traduisent en une mosaïque de soins, et en réactions indésirables coûteuses et évitables.

Promouvoir la prestation de soins en tant que relation nécessite des normes qui sont mises en application efficacement

Les normes facilitent les décisions fondées sur les données probantes et servent aussi à informer les aînés, et les personnes qui les soutiennent, de leur droit aux soins. Les normes ne devraient pas signifier que tous les soins sont similaires. Les fournisseurs de soins utilisent leur expertise pour mettre ces normes en pratique selon le contexte et les besoins particuliers de chaque personne âgée, tout en tenant compte des antécédents, de la famille et de la collectivité. La reddition de compte ne peut pas se limiter aux chiffres ou aux rapports chiffrés destinés au public.

Promouvoir la prestation de soins en tant que relation nécessite formation et éducation

Les liens sont très clairs entre la qualité des soins, l'accès du personnel à la formation et à l'éducation, et le maintien en poste du personnel. L'éducation et la formation n'ont pas marché de pair avec l'augmentation de la complexité et de l'acuité des besoins dans tous les secteurs : un des résultats probables est de prescrire les mauvais

médicaments, ce qui peut avoir de graves conséquences chez les personnes âgées. Pour assurer la santé de nos aînés, les infirmières, les médecins et les autres membres du personnel ont particulièrement besoin de plus de formation sur les soins aux aînés.

Promouvoir la prestation de soins en tant que relation nécessite de bonnes conditions de travail

Les conditions de travail sont les conditions de soins. Les données selon lesquelles les aides-soignants du Canada font l'objet de plus de violence que leurs homologues des pays nordiques, et que le personnel infirmier est plus susceptible que les gardiens de prison de faire l'objet de violence au travail, illustrent bien le besoin d'améliorer les conditions de travail. Il est trop coûteux, sur le plan humain et financier, d'ignorer ces problèmes et leurs graves conséquences sur les aînés, le personnel, les agences et l'ensemble du système.

Un programme pour assurer la sécurité des soins aux aînés est nécessaire afin que chaque personne âgée au Canada puisse recevoir les soins de santé dont elle a besoin. Cela peut seulement se faire si le gouvernement fédéral assume son rôle de leadership dans le secteur de la santé et met en œuvre une stratégie nationale. La FCSII demande au gouvernement fédéral de collaborer avec les provinces et les territoires pour mettre en œuvre un fonds de transfert ciblé, financé par l'État, pour la mise en œuvre d'un programme pancanadien de soins continus. Ce programme doit être fondé sur une nouvelle législation qui combine les services de santé et les services sociaux qui permettront aux provinces et aux territoires de créer des systèmes complètement intégrés de prestation, sans but lucratif, de soins aux aînés.

Appendix C

Recommandations

(French)

Programme national pour assurer la sécurité des soins dispensés aux personnes âgées

La FCSII demande au gouvernement fédéral de collaborer avec les provinces et les territoires pour créer un fonds de transfert ciblé, financé par l'État, pour la mise en œuvre d'un programme pancanadien de soins continus. Ce programme doit être fondé sur une nouvelle législation qui combine les services de santé et les services sociaux. L'objectif étant un système public complètement intégré de prestation, sans but lucratif, de soins.

Les infirmières et les infirmiers du Canada, représentés par la Fédération canadienne des syndicats d'infirmières et infirmiers, soumettent les recommandations suivantes :

1. Que le gouvernement fédéral élabore un programme national pour assurer la sécurité des soins dispensés aux personnes âgées, assorti de fonds dédiés et à long terme, et de mécanismes efficaces de mise en application. Ce programme devrait comprendre les éléments suivants :
 - Équité et inclusivité dans tout le Canada, et accès fondé sur les besoins;
 - Normes nationales en matière de qualité et de sécurité des soins aux patients, particulièrement par rapport à la dotation et à un niveau minimal obligatoire de dotation;

- Élaboration d'une stratégie en matière de ressources humaines pour les secteurs des soins de longue durée et des soins à domicile. Cette stratégie tient compte des conditions de travail, de la formation et des disparités de salaires;
- Plus grande formation ou éducation en matière de soins aux aînés, dans tous les secteurs des soins de santé;
- Reconnaissance de l'importance d'un système public ou d'agences à but non lucratif;
- Stratégies pour assurer la continuité des soins et des fournisseurs de soins, d'un service à l'autre;
- Soutien accru aux soignants non rémunérés par l'intermédiaire du financement ou davantage de postes de soignants rémunérés.

2. Que les gouvernements provinciaux tirent profit du programme national en assurant :

a) Une main-d'œuvre stable

- Fixer un objectif de 70 % d'infirmières et d'infirmiers à temps plein (et autres travailleurs de la santé) dans tous les secteurs. Ce chiffre reconnaît le fait que la prestation de soins est une relation qui nécessite une continuité chez les fournisseurs de soins. Idéalement, le 30 % de postes à temps partiel serait pourvu par le personnel régulier à temps partiel afin d'assurer un travail d'équipe efficace, et permettre au personnel d'être familiarisé avec les besoins des résidents ou des patients;
- Mettre fin aux appels d'offre concurrentiels qui encouragent la discontinuité des soins et ont tendance à privilégier le coût le plus bas et non la qualité des soins.

b) Des niveaux pertinents de dotation et une composition adéquate du personnel (éventail des compétences)

- Maintenir et mettre en application les règles de dotation actuelles, et autres règles, dans tous les secteurs offrant des soins aux aînés;

- Mettre en place de nouvelles normes minimales réglementées pour augmenter la qualité des soins et réduire les coûts liés à l'absentéisme et aux heures supplémentaires;
- Établir une norme minimale obligatoire de 4,5 heures de soins directs par jour par résident afin d'améliorer la qualité de vie des résidents (heures travaillées);
- Un minimum obligatoire de une (1) IA par quart de travail (heures travaillées), et une augmentation du nombre d'IA, tel que requis par le niveau d'acuité des besoins des résidents.

c) Formation et éducation

- Élaborer des normes pour promouvoir la formation continue et l'éducation, en milieu de travail, du personnel infirmier et autres fournisseurs de soins, dans tous les secteurs offrant des soins aux aînés;
- Encourager les employeurs à faciliter le travail d'équipe chez les fournisseurs de soins, et mettre en œuvre des stratégies de promotion du travail d'équipe, par exemple organiser des ateliers de formation regroupant les différents fournisseurs, offrir des occasions de formation sur place;
- Faire plus de place aux soins aux aînés dans tous les programmes de formation destinés aux fournisseurs de soins.

d) Un système intégré

- Assurer une meilleure coordination, communication et collaboration entre les secteurs et les milieux de travail afin d'éviter les complications coûteuses (sur le plan humain et financier), y compris fournir des soins adéquats, des lits et des fournisseurs de soins dans tous les secteurs, et en portant une attention spéciale aux temps de transition (par exemple : transferts, congés de l'hôpital, admissions). Le travail d'équipe est particulièrement utile pour gérer les maladies chroniques chez les personnes âgées.

3. Que le gouvernement fédéral et les gouvernements provinciaux s'unissent pour financer les soins à domicile et assurer :

- Des services de soins à domicile, à court et à long terme, qui soient pertinents, adéquats et accessibles aux personnes âgées qui en ont besoin, afin de diminuer les complications et les effets indésirables, diminuer le fardeau des soignants naturels qui, à la longue, voient leur vie professionnelle et leur santé se détériorer.

4. Que le gouvernement fédéral établisse une nouvelle norme en matière de soins aux aînés :

- Mettre en œuvre et en application une nouvelle norme dépassant les normes cliniques traditionnelles afin de promouvoir une culture axée sur la personne et une approche holistique par rapport aux soins aux aînés. Ainsi, on tiendra compte de la personne dans son ensemble, de ses antécédents et de son histoire. L'objectif étant d'améliorer la qualité de vie générale des personnes âgées.

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