

Evaluation of 3.5 Hours of Care Pilot in Nursing Homes

Summary Report

Table of Contents

Introduction	3
Project Purpose	4
Objective	4
Evaluation Methodology	4
Findings	5
Recommendations	9
Conclusion	21

Introduction

Providing access to quality care for seniors is a priority for the Government of New Brunswick.

More than half of the Department of Social Development's \$1.1 billion budget goes toward supporting seniors; money that is well invested in areas such as long-term care and nursing home services.

Across New Brunswick, there are 65 nursing homes where staff and volunteers are providing our seniors with the care and attention they so richly deserve.

The demographics in our province are changing. Census data has shown New Brunswick has Canada's second highest percentage of people aged 65 and older. This increase in our senior population will have significant impact on New Brunswick and our society in the foreseeable future.

The Government of New Brunswick recognizes that meeting the needs of our growing senior population will require a renewed approach that incorporates the concepts of shared responsibility and community involvement.

It has been suggested that one way to ensure high quality of care for nursing home residents is to increase the hours of care residents receive in New Brunswick nursing homes.

In 2010, Social Development began a pilot project to evaluate the approach used by five nursing homes to provide 3.5 hours of care per day per resident. The current standard of hours of care is 3.1 hours per day per resident.

The Department of Social Development contracted Tazim Virani & Associates to conduct the evaluation of the 3.5 Hours of Care Pilot (Project) in Nursing Homes.

This summary report outlines the findings from Tazim Virani & Associates and has been prepared to help inform discussion about the future of 3.5 hours of care in nursing homes in New Brunswick.

Project Purpose

The Department of Social Development increased the funding to 3.5 hours of care per resident per day to two nursing homes in New Brunswick; Central Carleton, a 30 bed home and Foyer-Notre-Dame-de-Lourdes, a 100 bed home.

Three other 72-bed nursing homes, operated by Shannex, Monarch Hall, Embassy Hall and Thomas Hall provided 3.5 hours of care per resident per day within their existing budget, using a different skill mix mode than the other two nursing homes.

These five pilot nursing homes were engaged in the evaluation of the impact of the 3.5 hours of care on resident, staff and system outcomes.

Objectives

1. To evaluate the impact of providing 3.5 hours of care per resident per day.
2. To describe how the 3.5 hours of care were provided.
3. To explore the factors that supported the provision of the hours of care and contributed to the quality of care and quality of life of residents and the work environment for the staff.

Evaluation Methodology

In order to evaluate the pilot project, Tazim Virani & Associates used a pre and post study method.

Pre-intervention information was collected retrospectively. A detailed evaluation plan was used to guide the collection of qualitative and quantitative data on the following:

- Resident outcomes
- Nursing/team outcomes
- Nursing home outcomes
- System outcomes

Data was collected through mail out surveys, interviews, focus group, document analysis and analysis of quality indicator data accessed from nursing homes' usual data collection processes.

The evaluation study is limited by the number of nursing homes in the pilot and the data sources available. However, the comparison of the data from diverse sources lends greater confidence to the analyses and conclusions.

Findings

Resident Outcomes

Adding hours of care has allowed the nursing homes to provide greater attention and care to residents and has improved some aspects of the residents' quality of life and quality of care. The most noticeable area of improvement is that residents' are not being rushed through their day; particularly, as it relates to hygiene, grooming and meals. Residents are also assisted to get up every day and in most instances more than once per day (if they wish) and able to participate in more recreational activities.

These impacts may, at first glance, appear to be minor changes; however, these have immense implications. Staff members get to know the residents better, provide greater choice and dignity to residents and develop meaningful relationships with the residents.

There are mixed findings on the impact of hours of care on specific resident quality indicators (falls, pressure ulcers, urinary tract infections, medication errors, etc.). There is no clear pattern on any specific improvement for any particular indicator.

The findings validate that resident quality indicators are impacted by numerous factors including residents' health status and care requirements; implementation of evidence-based care protocols; intervention practices directed by physicians, pharmacists, dieticians and rehabilitation providers; nature of nursing leadership in conducting advanced assessment; coordination of care including supporting continuity of care; the leadership and culture in the home; the manner in which staff are deployed (staffing model, staff schedules, service delivery model, scope of practice); the capacity of the staff to work as a team; ongoing training and problem solving supports provided to the staff; and, availability of equipment and supplies.

Qualitative data indicate that residents' skin integrity seems to be better as a result of frequent changes in positions, better feeding/nutrition and hydration. The use of mechanical restraints is down mostly due to adherence to least-restraint policy but also

auditing/monitoring practices. It is very likely that having additional staff has enabled these practices to occur more frequently. Hence, additional staff time and the implementation of good/best practices have a synergy effect and need to be implemented hand-in-hand.

Residents' quality of life has improved as they are more engaged in recreational activities and are getting more attention from staff. This, however, is limited because of constraints in the late evenings, nights and weekends where there is less care staff but also little or no recreation staff available to run programs. Similarly, residents receive little or no rehabilitation supports on the weekends. This is further compounded by short shifts during the weekends when it is difficult to replace staff members that are absent. Adding additional care staff has only assisted one out of the five homes to significantly reduce short shifts. This is a concern that homes must address and be supported by appropriate policies that create disincentives for absenteeism.

Nursing Home/System Indicators

The findings indicate that nursing homes are meeting most of the service standards and that the majority of the homes are diligent in responding to citations. The implementation of 3.5 hours of care was unique to each home. All homes were able to hire enough additional staff to meet the 3.5 hours of care based on their established staffing schedules; and within the budget available to them. There was general staff agreement and appreciation for having more care staff such as resident attendants (RAs) or client care attendants (CCAs).

All homes recognized the need for additional hours of care for direct resident care. Only one home added hours in the Licensed Practical Nurse (LPN)/restorative category in addition to the RA category. The flexibility provided to each home to decide where and how to add the additional hours of care was an important dimension to the implementation of the pilot. It is important to encourage management to work closely with staff and other stakeholders (residents, families) to make these decisions as well as promote broader quality of care agenda for the residents. Keeping residents' needs in mind should be a central variable in making staffing decisions and not staff workload alone.

Challenges across all homes included the ability to replace staff when there were unexpected absences. This was of particular concern during the weekends. This issue had direct impact on the home's ability to provide 3.5 hours of care; and for some homes, this also resulted in high levels of overtime hours and expenses. The inability to replace staff causes challenges in providing consistent quality of care and attention to

residents. In addition, the unscheduled staff absence creates inefficiencies in how staff members work as a team; and, breaks the continuity of caregiver for the resident.

Although overall, the five nursing homes did not indicate concerns at the present time with respect to availability of the workforce in their geographic area, there were several workforce and system changes that have broader implications. In rural settings, the availability of Registered Nurses (RNs) is limited and particularly RNs who are willing to work part-time and be available to pick up extra shifts to cover for absences. Most of the part time staff have other positions in other organizations and therefore do not have a lot of flexibility. The issue of flexibility applies to both LPNs and RAs as well.

Another workforce challenge is the lack of standardized curriculum for the RAs. This means that nursing homes have to expend upfront time and resources to train the RA to meet the nursing home standards and expectations. This also creates delays in optimal productivity during the time that the RAs are being trained on the job; and, adds additional stress/pressure on other staff. The impact of new RAs on resident care was difficult to assess within the scope of this evaluation.

Resident care is also compromised when other categories of staff are not replaced when they are on vacation or on scheduled or unscheduled absences. Such staff includes LPN-Rehab or rehab assistant and recreational staff. Some homes also deploy LPN-Rehab to direct care responsibilities or to cover a LPN absence when they are not able to find replacements. These practices are ill-advised and create significant interruption in rehabilitation and quality of life for residents. Moreover, lack of such staff during the weekends (as part of normal schedule) also sets back residents' rehabilitation potential.

Staff Outcomes

Interview and survey data demonstrate that staff members at all homes are generally satisfied with their work environment. There are some differences among staff in how they perceive specific aspects of the work environment. Staff at some homes who are older or with longer tenure gave lower scores in many aspects of the work environment compared to those who were younger or who were junior. The overall satisfaction ratings and willingness to recommend the home to others were above seven on a scale of one to ten.

All staff rated low to moderate on whether they had enough staff in their home. The rating ranged from three to six on a scale of one to ten. RAs and LPNs were less satisfied compared to other staff as it related to having enough staff in the home; this is

despite having additional hours of care deployed in LPN and RA hours of care. RNs tended to be more frustrated and emotionally drained as well as more concerned about how the staff worked as a team. These findings were consistent with the overall qualitative comments and demonstrate that there continue to be pressures in providing consistent levels of care.

Most staff indicated that weekends were the most stressful. In addition, two particular homes had more concerns. The general assessment at one of the homes is that the resident care burden appears to be higher; while at the second home, the staff to resident ratio was amongst the better ratios in the nursing home sector but the staff members continue to be dissatisfied with the adequacy of staff. In this latter home, it was assessed that the issue is not hours of care but how the staff work together to provide the care.

Nursing and care staff competencies were not directly improved as a result of increased hours of care. There were other factors that had greater impact such as the manner in which staff worked together (scope of practice, service delivery model, team work between all staff, relationships with management) and availability of educational and team building opportunities.

All five homes have worked diligently to organize the service delivery so that there is optimal continuity of care and caregiver. To achieve the continuity of caregiver along with some accountability, regular staff members tend to be assigned as much as possible to one unit or home area. Within that, they are assigned as much as possible to the same resident group on the consecutive days that they are working. For staff and resident safety, working in pairs (buddy system) was instituted. This was particularly beneficial for residents requiring two people to transfer, bathe, or generally to provide care. There usually is only one registered staff of each designation in each home area and so they have responsibility for the whole population.

Context

The contexts in which the nursing homes operate have significant impact on how the homes were able to appropriately implement and leverage the additional staffing resources. These include but not limited to community engagement, staff availability, labour union involvement, philosophy of care at the organization, past and present experiences of staff working together as a team and working relationships with management. In addition, staff schedules, skill mix, extent to which staff work to their optimal scope of practice, the use of evidence-based practices and the capacity to be

creative and address problems through a process of ongoing learning are factors that contribute towards better practices and care for residents.

Although the hours of care pilot had a small sample of nursing homes, it was evident that each home had different combination of variables that facilitated and/or challenged the extent to which the home was able to provide high quality resident care and support residents' quality of life. Assessing contextual variables as part of readiness assessment is therefore important in the allocation of additional investments in nursing home staff.

Recommendations

Considering all of the data and its analyses, Tazim Virani & Associates has proposed 14 recommendations in the following four areas:

- Hours of Care Based on Residential Need
- Nursing Home Human Resources
- Supports and Investments
- Cultural Change

Hours of Care Based on Resident Needs

Investments in nursing home staffing levels can result in better outcomes if other aspects of nursing home operations, resident care and supports are aligned. Significant collaboration is expected when the recommendations in this section are considered and implemented as a package of interventions.

Recommendation 1

Invest in nursing home staffing levels based on resident need and an assessment of specific environmental readiness factors; link these investments to specific monitoring requirements.

It was evident from the hours of care pilot that nursing homes differed to the extent to which the additional staffing resources impacted resident care, quality of life and work

environment for staff. It is therefore important that investments in staffing are moderated as follows:

- Resident level of care requirements are assessed to identify homes that have higher needs.
- Homes are assessed for their readiness to implement staffing changes for the optimal benefit for residents and those who provide care to residents.
- Investments are linked to specific monitoring requirements.

Recommendation 1.1

Investigate Mechanisms to Assess Resident Needs and Associated Workload

The hours of care pilot revealed that not all nursing homes required the same level of staffing resources. As it may be necessary to increase staffing beyond 3.5 hours for some homes and/or for particular units in the home where there are resident needs that surpass this target, an investigation of appropriate mechanisms to assess resident needs and associated workload is required.

As part of a focused investigation on workload measurement tools, it is recommended the inclusion of MDS-RAI as one of the potential tools to consider. It is possible to have a New Brunswick designed/adapted tool that is based on the principles of MDS-RAI (link to outcomes recommendations) to assess specific target homes where satisfaction and outcome data are poor. Such homes must require baseline assessment and ongoing assessments on a quarterly basis before funding beyond 3.5 hours is allocated.

Recommendation 1.2

Address Nursing Home Readiness Factors to Optimize Staffing Investments

In order to optimize the impact of staffing investments, it is advisable to assess and strengthen factors that create “readiness” for these investments. These include nursing practice model factors, structural factors and professional development factors.

Recommendation 1.3:

Link Investments with Appropriate Impact Monitoring

Provide homes the flexibility and creativity as to how the investments can be deployed to meet the following outcomes (also see recommendation 10):

- Improve wait times – residents should receive attention, care and support in a timely manner (e.g. responding to call bells, feeding and toileting).
- Improve staff interaction time with residents beyond providing care (e.g. developing relationships, participating in therapeutic activities, supporting rehabilitation/ restoration, providing extra attention such as polishing nails).
- Get residents out of bed, supporting mobility and/or getting up and about and building flexibility in ‘bedtime’ care schedule as per resident needs and not based on standard routines that are staff centered.
- Support resident specific needs and habits/personal schedules for when they get up in the morning.
- Increase health status monitoring and discussions with resident/family and interdisciplinary team.
- Opportunities for staff to learn with, from and about each other’s profession in order to foster improved collaborative care for residents and thereby increasing understanding and support for each other’s scope of practice while decreasing conflicts among staff.
- Optimize scope of practice of all care providers (also see recommendation 3).

Nursing Homes’ Human Resources

Four critical factors were identified that increase the stresses in the effective planning and deployment of nursing home human resources. There are multiple stakeholder expectations on how nursing homes are staffed; the inconsistency in how RNs are supported to practice at full scope of practice; inadequate rehabilitation/restorative staff supports; and, the impact that high absenteeism has on the deployment of staff.

Gaps in nursing home human resources need to be addressed using a multi-stakeholder approach such as the establishment of a staff planning committee.

Involvement of stakeholders will create a collaborative approach to addressing human resource concerns while increasing the knowledge base of all stakeholders on the standards, evidence, challenges and opportunities in staff planning in nursing homes.

Additionally, there are opportunities to optimize the scope of practice of all staff and particularly the RN; and enhance rehabilitation/restorative care across the nursing home sector.

It is also important to develop effective absenteeism management practices to proactively address predictable patterns while dealing with long-term chronic staff attendance issues.

Recommendation 2

Establish Staff Planning Committees at each Nursing Home

Staff planning should take into account both resident and staff quality of life as well as efficient operations of the home. A fine balance of these three components needs to be supported by all stakeholders including administration, staff and unions.

The establishment of a staff planning committee at each home is recommended that comprises of resident/family representatives, staff representatives and leadership. The committee can use a consultative approach to discuss and understand rationale and perspectives of different stakeholders. A key role of such a committee can be to conduct annual review of resident needs, staff deployment and make constructive recommendations. New Brunswick can leverage experiences of such approaches developed in other jurisdictions.

Recommendation 3

Optimize Staff Scope of Practice

There are various opportunities to increase/improve the scope of practice of all care staff including RAs, LPNs and RNs.

Previous work done to optimize the roles of LPN and RAs should continue to be supported while optimizing the scope of practice of the RN. This work should be undertaken in collaboration with various stakeholders including the nursing home associations, unions and regulating bodies, and should be designed to ensure that scopes of practice are implemented consistently across the province.

The RN scope of practice should include:

- Advanced clinical assessment
- Leadership of inter-professional teams (including physicians, pharmacists, physiotherapists, occupational therapists, restorative and others)
- Communication and coordination with families and others external to the home
- Supervising and coaching skills to support collaborative care, team development
- Coordination of resident care

Recommendation 4

Increase and Protect the Funding for Rehabilitation/Restoration

In addition to ensuring hours of care are targeted to meet specific outcomes, it is important to increase and protect the funding provided to rehabilitation/restoration.

One way to do this is to support the hiring of appropriately trained rehab assistants to the role instead of LPNs. LPN-Rehab are frequently absorbed to cover for sick time, vacation and when care levels are high. This results in residents not getting appropriate rehabilitation/restoration and further adding to the care levels of residents.

This cycle can be broken with a policy to protect the hours allocated to rehabilitation/restoration.

All stakeholders need to buy into the value of rehabilitation/restoration and not treat this component of care as a “nice to have” but rather a “must have” service to residents.

Rehabilitation assistants in the province should have a unique set of standards and competencies and only those who have gone through certified educational programs should be hired as nursing home rehabilitation assistants. It is important that such roles not be diluted by assigning RA/CCAs to fulfill this role if they are not appropriately trained.

Funding for rehabilitation/restoration should be provided to support services seven days a week and support the appropriate continuing education of such personnel. Additionally, there is a need to review the supports homes receive from the extramural program such as resident assessments, care planning, problem solving, training, supervision of staff and advocacy for specific resident equipment.

Recommendation 5

Enhance Absenteeism Management

The current absenteeism management approaches take time, effort and continuous attention. Although these are based on well accepted practices, there is a need to establish bold policy measures. To do so, there will need to be collaborative and trusting relationships between government, nursing home operators, unions and other stakeholders.

It is no longer enough to react to unscheduled absences and look for replacement staff. There needs to be proactive trend analysis of such absences to have a better understanding of “predicted absences” and decrease uncertainty.

For example, it is already apparent that weekends have predicted absences. Strategies can be developed to staff for these predicted absences such as the use of a “reserve full-time line”. Such reserved lines can also be negotiated for use between nursing homes and include transportation cost provisions if needed. Such strategies can be used while continuing to use traditional absenteeism management programs and working with unions on “cutting back on sick time”.

Incentive/disincentive approaches should also be considered such as the use of maximum sick time allocations. Appointing Safety/Wellness Officers at regional levels can be used to support nursing homes in managing their absenteeism approaches.

Supports and Investments

Five gaps were identified across stakeholder groups that impact on how nursing home staff is able to provide high quality care to residents: training/continuing education, equipment/supplies, adequate recreational/therapeutic staff support, adequate volunteer support and public accountability through provincial quality monitoring. Staff requires continuing education to enhance knowledge and skills as well as to remain current on the latest evidence based practices.

An annual staff education plan could be a basic requirement of all nursing homes which should address mandatory education as well as home specific capacity development needs. Nursing homes require the necessary equipment and supplies to provide care to the residents.

Residents' quality of life is enhanced when nursing homes have adequate recreation/therapeutic programs and activities. In this regard, investments are required to increase recreation therapist staffing in nursing homes based on resident needs. Additionally, volunteers play a critical role in supporting residents' quality of life.

Recommendation 6

Enhance Investments in Continuing Education

All homes recognized the need for robust and ongoing education/training/capacity development. Investments in continuing education need to be enhanced at the provincial level with requirements to ensure all homes have minimal mandatory education and annual education plans based on resident needs and staff capacity development needs. Such annual education plans should be part of the inspector's assessments. Specific areas of education identified in this evaluation included the following:

- Responsive behaviours
- Palliative care
- Mediation/conflict
- Leadership skills – change agent role – empowerment and working with interprofessional relationships

- Integrating rehabilitation/recreation in daily activities.

Recommendation 7

Review of Equipment Needs in all Nursing Homes

Nursing homes continue to require improvements in availability of therapeutic beds, mattresses and other supportive equipment such as lifts, slings, rehabilitation and recreational equipment. Establish an overall review of equipment across all nursing homes to ensure all homes have a baseline of equipment with a home-by-home plan to reach specific targets over a period of 3 to 5 years while conducting annual review of resident needs and requirements. In addition, the current process for requesting resident specific equipment/supplies/services requires review and improvement so that the approvals occur in a timely manner.

Recommendation 8

Improvements in Recreation/Therapeutic Supports

Recreation/therapeutic activities are a vital component of quality of life of all residents in nursing homes. These need to be planned according to the residents' physical and cognitive limitations. In addition, these activities need to be available throughout the day, evening and weekends. Sufficient staff allocation along with creative approaches should be supported. The following are some suggestions:

- Deployment of recreation staff should include evening hours and weekends.
- Active use of volunteers for both group and one-on-one activities. A specific program of one-on-one volunteer support should be established at each home for those residents who can benefit from such approaches.

- Involvement of families in supporting recreational activities for their loved one and for other residents in the home. Provide family members the skills to engage in activities that can engage residents with dementia and for sensory stimulation.
- Contribution to the care plan by the recreational therapist by integrating sensory stimulation and other strategies as part of ongoing activities. This could include sensory stimulation gadgets at the bedside, involving residents in activities of daily living such as folding laundry, setting table, arranging recreational equipment in baskets, etc.

Recommendation 9

Pilot Regional Volunteer Coordinator Role

Develop regional volunteer coordinator roles to support groups of nursing homes to recruit, support and manage volunteers. Such roles should be appropriately resourced in order to develop volunteer recruitment campaigns, volunteer recognition/validation initiatives, mechanisms to match the right volunteers to the right homes, etc.

It is recommended that this approach role be piloted in two to three diverse communities with an appropriate evaluation before developing a province-wide roll out.

Recommendation 10

Establish Provincial Nursing Home Quality Monitoring System

Leverage the nursing home quality monitoring systems developed, tested and implemented in other Canadian jurisdictions such as Alberta and Ontario. Tools used in the evaluation of the 3.5 hour pilot can be adapted for provincial use. Using these systems, benchmarks on quality performance can be established as part of public reporting and sector quality improvement initiatives.

Nursing homes should also have an annual quality improvement plan based on quality results. Mechanisms need to be developed to make user-friendly versions of these quality plans available to the broader public.

Cultural Change

Four recommendations are made to address the culture of the nursing home industry in the province. These recommendations are believed to support the overall human resource and staffing challenges and create a robust and forward moving industry.

The role of the RN is critical to nursing homes as a highly-skilled and regulated leadership position. Efforts are required to attract qualified RNs to undertake a career path in the nursing home sector. Additionally, resident care requires a holistic approach with staff recognizing the need to work collaboratively and in synergy. In this regard, it is important that all staff in the nursing homes internalize their contribution not only to resident care but also provide ongoing restoration and rehabilitation supports to the residents. The nursing homes in the pilot initiative demonstrated a number of different promising practices that should be considered for wide spread sharing and potential adoption across nursing homes.

Lastly, the 3.5 hour pilot concluded that much needs to be done to dispel the myth that increasing staffing levels alone will improve resident quality of care and quality of life in nursing homes.

Recommendation 11

Establish a Recruitment Strategy for Attracting RNs to the Nursing Home Sector

Establish a strategy to attract and retain RNs to the nursing home sector by considering the following suggestions:

- Consider programs such as the successful New Graduate RN program in Ontario which provides longer practical experience and additional training on the job; this provides longer time to increase graduates' skills and confidence.
- Incentive to increase RN recruitment to nursing homes in general.

- Implement this type of strategy for a time limited period.
- A pilot initiative should be implemented before expanding the program/approaches.

These approaches signal the importance of RNs to the nursing home sector and the need for specialized knowledge and skill to work in the sector.

Recommendation 12

Change Culture to Ensure Rehabilitation/Restoration is Part of Everyone's Responsibility

There needs to be a philosophical/cultural change to ensure all staff, family and volunteers view rehabilitation/restoration as part of everyone's responsibility. The care plan for each resident needs to highlight how all team members can participate in supporting rehabilitation including range of motion exercises, walking programs, upper body mobility, transferring/weight bearing, etc.

Recommendation 13

Acknowledge and Disseminate Promising Practices¹ in the Nursing Home Sector

Acknowledge the positive contributions the pilot sites have made to resident care and highlight the promising practices. Distribute knowledge of these promising practices to the broader nursing home sector. The promising practices identified in the evaluation include (in no particular order):

- Resident centred care philosophy exemplified residents' choice, preferences and day-to-day considerations in care planning and delivery - Central Carleton and at Shannex operated nursing homes.
- A comprehensive strategy of community involvement that included significant volunteers, engagement of families, physicians, pharmacists, pastoral services

across faith groups, student placements and community events – Central Carleton

- Client case management that involves both RNs and LPNs in leadership capacity – Shannex operated nursing homes.
- Consistent resident endorsement on food services including strong involvement of dietician in planning menus/meals and resident specific nutritional needs – Le Foyer-Notre-Dame-de-Lourdes and Central Carleton.
- Strong focus on hydration – hydration rounds and stationary hydration stations – Shannex operated nursing homes.
- Well established least restraint set of practices with a specific care plan for each resident – Central Carleton.
- Pressure ulcer prevention by getting people out of bed more than once a day – Central Carleton.
- Optimal use of the LPN-Rehab role – integrated with wound care, educational role to develop capacity of other staff, review of all equipment and products – Central Carleton
- Protection of rehab role at the Shannex operated Thomas Hall nursing home and Le Foyer-Notre-Dame-de-Lourdes.
- Continuity of caregiver models at all the homes – Maisonee model at Le Foyer-Notre-Dame-de-Lourdes that addresses the physical layout of the building; buddy system at the other homes lends itself to this model; buddying system – Central Carleton and Shannex operated nursing homes.

Recommendation 14

Strategic Communication Campaign – Dispel the Myth that More Staff Alone is the Solution

Develop a long term, strategic communication campaign for the province on dispelling the myth that investment in staffing alone is a solution to improving quality of care and quality of life of residents.

Communicate widely the diversity and complexity of factors that influence/impact on resident quality of care and quality of life. All stakeholders need to agree that nursing home care needs a comprehensive approach and should not be centred solely on hours of care. The stakeholders should include residents, family members, staff, leadership, physicians, unions, consumer groups, media, associations, government/policy decision makers and researchers.

It is also important that champions/opinion leaders who share this perspective are engaged from multiple stakeholder groups to help disseminate the messages from the communication plan.

The pilot evaluation findings demonstrate that many factors have and can impact on resident care. Hours of care is important but is not the only solution to improving quality care. This is validated in the literature by researchers and other jurisdictional reports¹.

Conclusion

The 3.5 hour of care pilot (project) evaluation in New Brunswick involved five nursing homes and the collection of quantitative and qualitative data from multiple sources providing rigour in the analyses and conclusions drawn.

The evaluation study has produced a significant amount of information and specific findings on resident care needs, levels of care. There are many factors that support or hinder the optimal impact of additional investments in staffing and lessons in how to best deploy such investments.

Fourteen recommendations have been made in the areas of hours of care based on residents' needs, nursing homes' human resources, supports and investments and culture change. These recommendations need to be considered as a package in order to produce the maximum benefit for residents, staff and nursing homes.

The most important key messages that were generated from this pilot evaluation of staffing investments is that a comprehensive approach needs to be used to approach quality of care and quality of life of residents in nursing homes. There is a continuous need to ensure all stakeholders work within this framework and avoid the myopic attention to hours of care as the sole answer to residents' quality of life in nursing homes.

¹ Muller & Savik, 2010; Sharkey 2008; Harrington et al, 2012.