2008

LONG TERM CARE SECTOR NURSING PLAN REPORT

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TABLE OF CONTENTS

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Report Summary

The purpose of the Long Term Care (LTC) Nursing Plan Report is to provide senior nurse leaders and their colleagues with a valuable source of information depicting the current state of nursing within their organizations. The indicators included in the 200 LTC Nursing Plan were derived from consultations with Directors of Care who expressed a need to have access to data that went beyond nursing human resources (i.e. FTEs and head counts) and include important areas such as nursing leadership infrastructure, access to advanced practice nursing roles, manager span of control and strategies to address the orientation and education needs of current and future nursing staff. It is hoped that this broader collection of information can better inform current and future strategies for nursing at the organizational, professional, and provincial levels.

Upon review of the 2008 LTC Nursing Plan submissions, three main areas emerged that would benefit from reflection and ongoing dialogue within the Long Term Care sector, as well as with nursing colleagues in the education, research and policy arenas:

1. Retention and Recruitment of Nurses (Registered Nurses and Registered Practical Nurses): The impending retirement of nurses at the point of care (e.g. percentage of nurses 55 years of age and older), coupled with the attrition rates for both Registered Nurses (RNs) and Registered Practical Nurses (RPNs), e.g. 10% and 11% respectively, may contribute to significant challenges in care delivery and resident care management within the Long Term Care Sector. As registered staff (RNs and RPNs) comprise a smaller percentage of the overall staffing compliment (e.g. ratio of registered staff to resident), any vacancy can have a significant impact on the overall care delivery and team functioning. A potential area of interest is the increasing presence of the "retired" nurses who are returning to the workplace. This new "cohort" of nurses may be a valuable resource for areas such as preceptoring new staff/ students, project work and short term staffing supports;
2. Leadership succession planning: Manager span of control within Long Term Care Sector is by far the most diverse in terms of areas of accountability (e.g. staffing , education, infection control and housekeeping). Of the 116

organizations include in this report, 31% reported they do not have a "nurse manager" role in place at the point of care. The absence of qualified internal and external candidates was cited as a main challenge to leadership succession planning for Long Term Care organizations; and

3. Access to Advanced Practice Nursing roles: Based on the 2009 MOHLTC Long Term Care Homes Staffing Survey Results, less than 3% of LTC homes have advanced practice nursing roles on staff (e.g. Clinical Nurse Specialists, Nurse Practitioners). Of the 116 LTC organizations that submitted Nursing Plans, 47% have access to an Educator and 14% have access to a Professional Practice Leader role. With the increasing complexity of resident care needs and the high proportion of unregulated care providers, access to advanced practice roles can be a valuable support and resource to Registered Nursing staff (RNs and RPNs) practicing within the LTC Sector.

This report contains the results of the initial analysis conducted. There may be further opportunities for ongoing data collection and analysis of any or all of these items in order to continue building a valuable source of information to assist with future planning and evidence based decision making.

Nursing leaders are encouraged to utilize the information contained in this report to initiate dialogue regarding the current and future opportunities and challenges for the nursing profession within your individual organization, and throughout our complex health care environment.

The 2008 report, *People caring for People: A report of the independent review of staffing and care standards for Long Term Care homes in Ontario*, included a recommendation for each LTC home and their stakeholders to determine an annual staffing plan and strategies for the provision of ongoing education and professional development opportunities for the regulated and unregulated staff providing resident care.

We hope you find the information contained here a useful resource for future planning within your Long Term Care organization and within the broader Long Term Care Sector.

How To Use And Read This Report

The information in this Report reflects *the 2008 Fiscal year*. The information included here describes a wide range of nursing human resource, service delivery and quality of work life issues. It is intended that this presentation of data will be useful in planning, communicating and forecasting nursing and the related infrastructure supports related to the delivery of resident care. To aid in this, the information included in this report provides a variety of perspectives regarding the state of nursing in Ontario LTC organizations. Nursing leaders are encouraged to discuss the report widely regarding the current and future opportunities and challenges being presented by our complex health care environment.

Unless otherwise indicated, the data for each item are reported as the *mean scores*. Beyond the presentation of the mean scores, when relevant, additional levels of analyses are provided to enhance the information available regarding a particular item. Please note: Specific to Section B of the LTC Nursing Plan, *where indicated*, the results are reflective of the 2008 MOHLTC Long Term Care Homes Staffing Survey Results. This information was provided by the Health Analytics Branch, MOHLTC. In order to reduce duplication of reporting, Long Term Care organizations were provided with the option of "skipping" this section of the Nursing Plan. A comparison of Section B results submitted in the Nursing Plans with the Staffing Survey results indicate that the "sample" Nursing Plan submissions (n = 116) are reflective of the LTC Staffing Survey results obtained by the MOHLTC (n= 546).

Missing Data

Although a total of 99 submissions were received, there is a wide variation in the amount of missing data within the various sections of the Nursing Plan template. The degree of missing data will be indicated through the report.

Introduction

The Nursing Plan was first implemented in 1999 as a result of recommendations generated from the Nursing Task Force Report: Good Nursing, Good Health: An investment for the 21st Century. The initial aim of the Nursing Plan was to collect meaningful data regarding the status of nursing services within each of the following sectors in Ontario: Hospital, Long Term Care (LTC), Community and Public Health. In order to ensure the indicators being collected were relevant to nursing leadership in each of these sectors, a series of consultations were undertaken with Chief Nursing Executives and others in Senior Nursing Leadership roles. The Long Term Care Sector Nursing Plan was first implemented in 2006.

This report contains the results of the data collected from the 2008 Long Term Care Nursing Plan. The LTC organizations included in this iteration of the Nursing Plans include representation from all 14 Local Health Integrated Networks (LHINs) in Ontario. The table below depicts the number of Nursing Plans submitted according to LHIN.

LHIN #	LHIN Region	# of LTC who submitted Nursing Plans	% of Nursing Plans submitted in total
1	Erie St. Clair	7	7.1%
2	South West	7	7.1%
3	Waterloo Wellington	5	5.1%
4	Hamilton Niagara Haldimand Brant	15	15.2%
5	Central West	1	1%
6	Mississauga Halton	3	3%
7	Toronto Central	13	13.1%
8	Central	4	4%
9	Central East	7	7.1%

LHIN #	LHIN Region	# of LTC who submitted Nursing Plans	% of Nursing Plans submitted in total
10	South East	7	7.1%
11	Champlain	12	12.1%
12	North Simcoe Muskoka	2	2%
13	North East	12	12.1%
14	North West	4	4%
	Total	**99**	**100%**

Description of Long Term Care Facilities

The Nursing Plan was distributed to all LTC facilities (n = 546) in March, 2009, with a request to submit nursing human resources information from the **2008 fiscal period**. In total **99** responses were received, three of which represented merged facilities, each representing 3, 4, and 10 sites resulting in a total of 116 organizations and 21% of all long term care facilities.

Data were also received directly from the Health Analytics Branch, Ministry of Health & Long Term Care. Specifically, the 2008 Staffing Survey Results (including facility data and human resource metrics) for **all 546 facilities**. Aspects of these data are summarized in Sections A and B of this Report.

Data Analysis

Data were analyzed using SPSS software (version 16.0). Initial descriptive statistics and frequency distributions were generated for each item. To enhance data quality, items with significant outliers were identified and requests for clarification were forwarded to the relevant organizations.

PROVINCIAL RESULTS

Section A: Facility Description and Nursing Leadership Structure

Resident Beds and Unit Capacity

This report represents a total of 16,698 resident beds. The mean number of beds per site was 169 (SD, 269.8, range 12 - 2612 beds). The mean number of care giving units within the facility was 33 (SD, 13.08), with sizes of up to 78 resident beds per unit (see Table 1).

Table 1: Resident beds and care giving units

Beds/beds per unit	N	Min	Max	Sum	Mean	Standard Deviation
Total resident beds	99	12.00	2612.00*	16698.00	168.66	269.78
Average number of beds per unit	96	1.00	78.00		32.63	13.08
* Inclusion of single Nursing Plans submitted for multiple sites						

From the Ministry of Health and Long-Term Care (MOHLTC) Data: Description of Facilities (N = 546)

Data describing the characteristics of the facilities in terms of beds, occupancy, operating capacity, actual resident days and mean Case Mix Index (CMI) data per facility were obtained from the 2008 database of the MOHLTC (see Table 2). The mean number of beds was smaller than the sample respondents' figures. A 20% overcapacity was reported in 2008.

- Number of licensed beds: 69,515

- Mean CMI: 98 (SD 16.13)

Table 2: MOHLTC Data – Description of Facilities						
Descriptor	**N**	**Min**	**Max**	**Sum**	**Mean**	**Standard Deviation**
Licensed Beds	546	12.00	943.00	69515.00	127.31	77.922
Occupied Beds	546	12.00	463.00	67690.00	123.97	68.23
Current Operating Capacity	546	.00	472.00	68402.00	125.27	69.46
Beds in Abeyance (BIA)	546	.00	38.00	179.00	.32	2.54
Over Capacity Beds	546	.00	64.00	109.00	.19	2.83
Actual Resident Days	546	1470.00	84351.00	12196019.00	22337.03	12388.35
CMI/Facility	546	1.00	132.82	53512.62	98.00	16.13

Nursing Leadership

Virtually all (**98%**) of the respondents indicated that they had an individual designated as the senior nursing leader who was responsible for the nursing services provided in the facility. The titles of the senior nurse leader varied, and the most predominant titles were Director of Care/Resident Care or Manager (see Table 3). Thirty-five percent reported that the **senior nursing leaders and nurse managers** had a Baccalaureate of Science in Nursing (BScN) degree (SD 39.3%, *range, 0-100%).*

About two-thirds (64.6%) of senior nursing leaders reported to an administrator, or the Chief Executive Officer (CEO) (26.3%). Other reporting relationships were described, e.g., Vice-President, Board of Directors, Chief Administrative Officer (CAO) of the Municipality, Director (Corporate, LTC, Patient/Resident Services, Seniors' Services), Manager, and Consultant (from a management company).

Table 3: Titles of nurses in the senior leadership position

Title	N
Director of Care/Director of Resident Care	78
Manager	11
Other roles specified: Executive Director of Resident Services, Vice-Presdient Clinical and Resident Services and Chief Nursing Officer (CNO), CNO, Administrator, Administrator of Resident Care, Administrator/Director of Care (DOC), Assistant Director of Care (ADOC), Director of Nursing (DON), Assistant Manager, Unit Coordinator.	

From the MOHLTC Data (N=546 LTC Facilities): Nursing Administration Data

For the fiscal year, 2008, the number of nursing administrative roles coded as Director of Care (DOC), Assistant DOC/Manager, or Clinical Manager for all 546 FTC Facilities is represented in Table 4.

Table 4: Senior Nursing Leaders (MOHLTC Data – all facilities)

Roles coded as...	N*	Min	Max	Sum	Mean	Standard Deviation
DOC	510	0	3	543	1.06	.340
ADOC/Manager	238	0	6	325	1.37	.840
Clinical Manager	35	0	3	37	1.04	.422

**total n >546 owing to multiple codes in various facilities*

The Nursing Plan requested information as to whether the senior nursing leaders' roles also included other organizational responsibilities. Infection control and education were responsibilities held by approximately one third and three quarters, respectively, while the responsibilities for finance and payroll were assumed by about one-third. Additional accountabilities were varied (see Table 5).

Table 5: Responsibilities within the role of the senior nursing leader

Responsibility within the senior nursing leader's role	**N**	**%**
Infection control	61	62.9
Education	70	72.2
Finance	37	37.8
Payroll	31	32.3
Other Responsibilities within the role: Human Resources (contracts, performance appraisal, recruitment/retention, attendance management); Quality and Risk; Special Nursing Care Programs (skin, restraints, behaviour management); Compliance; Vacation Relief (for the Administrator); Resident Billings; Medical Records, Privacy Officer; Pandemic Planning; Corporate Reports; RAI-MDS Co-ordinating; Accreditation Leader; Supply Ordering; Staff Development.		

Other Nursing Roles That Support Clinical Care

Respondents were requested to provide a response (yes/no) as to whether specified 'other' nursing roles, supporting nursing care, were working in the LTC facility. Table 6 details the frequency of 'yes' responses. Most prevalent among the 'other' notations were coordinators for RAI-MDS, infection control nurses and nurses in management and coordination roles.

Table 6: Other supportive nursing roles in the LTC Facility		
Other supportive nursing role	**N**	**%**
Educator	46	47.2
ADOC	38	39.2
Care Co-ordinator	31	31.6
Professional Practice Leader	14	14.4
Other supportive roles: RAI-MDS Co-ordinator; Infection Control; Managers (coordinators, clinical leader [Registered Practical Nurse (RPN)], charge nurse); Informatics Specialist; DOC/N, Occupational Health Nurse, 'Retired' Co-ordinator, Best Practices RPN; Professional Practice Leader, Clinical Practice Nurse.		

From the MOHLTC Data Set: Advanced Practice Roles (coded for all LTC facilities)

Roles coded and reported as Clinical Nurse Specialist (CNS)/Nurse Clinician and Nurse Practitioner (NP) by the few, individual LTC facilities (per 'N reporting' column) are represented in Table 7.

Table 7: Advanced Practice Roles by classification, per MOHLTC Data Set					
Roles coded for MOHLTC as...	**N**	**Head count mean**	**Standard Deviation**	**Total hours mean**	**Standard Deviation**
CNS/Nurse Clinician: Full-Time	15	.79	.56	1350.2	807.85
CNS/Nurse Clinician: Part-Time	16	1.0	.35	698.8	711.71
CNS/Nurse Clinician: *Purchased Services	3	.00	.00	582.66	480.13

Table 7: Advanced Practice Roles by classification, per MOHLTC Data Set					
Roles coded for MOHLTC as...	**N**	**Head count mean**	**Standard Deviation**	**Total hours mean**	**Standard Deviation**
CNS/Nurse Clinician: Casual	34	.82	.51	975.92	797.53
NP: Full-Time	11	.71	.36	876.7	575.51
NP: Part-Time	7	1	-	609.42	201.92
NP: Purchased Services	3	00	00	1200.3	762.39
NP: Casual	1	.4	-	192.00	-

**Purchased Services, external to the organization, not LTC facility staff.*

Section B: Nursing Human Resources

Table 8 presents the MOHLTC data (mean numbers of staff and mean total hours) for roles coded in the various care giver categories, by the number of facilities coding staff in the respective roles.

From the MOHLTC data on roles coded for care giver categories

Table 8: Care giver HR data (all LTC Facilities)					
Roles coded as...	**N (reporting for each category)**	**Mean Head count**	**Standard Deviation**	**Mean Total hours**	**Standard Deviation**
Registered Nurse (RN): Full-Time	511	4.3	3.6	6640.02	4042.06
RN: Part-Time	523	5.8	4.03	4732.92	2967.80
RN: *Purchased Services	124	00	00	831	1051

Table 8: Care giver HR data (all LTC Facilities)					
Roles coded as...	**N (reporting for each category)**	**Mean Head count**	**Standard Deviation**	**Mean Total hours**	**Standard Deviation**
RN: Casual	240	3.8	2.99	1554.43	1480.09
Registered Practical Nurse (RPN): Full-Time	510	7.4	6.2	11181.36	9274.06
RPN: Part-Time	513	8.1	7.18	6995.9	8601.91
RPN: *Purchased Services	127	00	00	1546.98	2154.63
RPN: Casual	202	5.59	5.3	3073.49	4362.09
Nursing Attendant: Full-Time	147	14.3	14.29	22411.44	22258.93
Nursing Attendant: Part-Time	155	17.12	18.68	17929.67	21063.50
Nursing Attendant: *Purchased Services	4	00	00	872.75	1039.89
Nursing Attendant: Casual	45	7.4	8.3	3595.1	4564.47
Personal Support Worker (PSW): Full-Time	479	25.75	18.26	39664.6	31809.88
PSW: Part-Time	500	35.7	22.64	34073.7	21743.21
PSW: *Purchased Services	133	00	00	1053.38	3356.09
PSW: Casual	201	14.3	12.6	8360.40	11850.34
** Purchased Services, not on LTC facility staff*					

Characteristics of Registered Nurses (RNs) and Registered Practical Nurses(RPNs)

From the respondents' data, the average age of Registered Nurses (RNs) was about 8 years higher than the Registered Practical Nurse (RPNs). The Unregulated Care Provider (UCP) average age was closer to that of the RPN. About one-third of the RNs were reported to be over the age of 55 years however the late-career staff of RPNs and UCPs were about the same at about 17% (see Table 9). The mean percent of RNs with a BScN degree was 9%.

Table 9: RN, RPN and UCP Characteristics

RN, RPN, UCP Characteristics	Average percent	Std Deviation	Range in %s
Average age: RNs	49.31	4.80	30-60%
Percent of RNs >55 years	33.27%	21.01	0-100%
Percent of RNs with BScN degree	9.4	3.16	0-50%
Average age: RPNs	41.7	5.36	28-58%
Percent of RPNs >55 years	17.3%	14.94	0-71.4%
Average age: UCPs	42.9	6.00	20-53%
Percent of UCPs >55 years	17.5%	14.09	0-82.5%

Job Share Positions

Only 20 LTC facilities **(20.4%)** reported that they have job share positions; positions where 2 part time staff members share one FTE 'line' in the schedule.

Nursing Students and New Graduates

LTC facilities provide valuable clinical practice settings for students in baccalaureate nursing and practical nursing programs. Various questions were posed about the

presence and numbers of students (groups of students, and preceptored practicum students), as well as issues pertaining to student volumes, organizational needs, and other concerns.

Seventy-five (valid percent, 80.6%) of the responding facilities reported that students were placed in their units and programs. The volume of students among responding facilities is represented in Table 10.

Table 10: Numbers of students

Student numbers	N	Min	Max	Sum	Mean	Standard Deviation
Total number: Nursing Students (BScN)	90	.00	158.00	819.00	9.10	24.25
Total number: Practical Nursing Students	91	.00	200.00	1033.00	11.35	25.94
Total number : Consolidation/Practicum Nursing Students (BScN)	85	.00	19.00	93.00	1.09	3.17964

Based on the total number of consolidation placements provided (e.g. 93), this would equate to *approximately 5.3 Nursing FTEs of "in kind" direct preceptor* support across the 116 organizations represented in this report. This calculation is based on the following assumptions: 6 week consolidation placement, requiring varying degree of preceptor direct support (minimum of 112 hours/placement) X 93 placements / 1950 hours.

Student Issues

- **80.6%** would like **more nursing students**; 2% would prefer **fewer** students;

- 54% reported affirmatively that they require more staff to function as **preceptors;**
- 16 organizations (16.3%) felt that they were **too far** from nursing schools;
- 37 (38.1%) reported that they **did not receive requests** for student nurse placements; and
- 36 organizations (65.6%) answered affirmatively that they needed more **formal preceptor programs**.
- Other comments offered about students included:
    - Would like more bilingual students;
    - Need to encourage students to complete their practicum in the north;
    - Would like to attract more RN students;
    - Have PSW students; no problem placing PSW students; and
    - Difficulty recruiting RPN preceptors [college has ½ day program].

New Graduates

New graduate numbers and full time role classification were requested and the majority of organizations provided data (see Table 11).

- **32% of RN new graduates were hired into full time positions;**
- **37% of RPN new graduates were hired into full time positions.**

Table 11: RN and RPN New Graduate Hires

New Graduates	N	Min	Max	Sum	Mean	Standard Deviation
RN new graduates hired	95	.00	10.00	31.00	.32	1.16
RN new graduates: hired into permanent full time positions	94	.00	2.00	10.00	.10	.40
RPN new graduates hired	95	.00	12.00	148.00	1.55	2.09
RPN new graduates: hired into permanent full time positions	93	.00	4.00	35.00	.37	.79

Section C: Utilization

Budgeted and Worked Hours, Agency, Casual and Overtime

Table 12 represents the budgeted and worked hours among those facilities that responded to the Nursing Plan survey.

Table 12: Nursing budgeted, worked, agency and casual hours.

	N	Min	Max	Sum	Mean	Standard Deviation
Total Budgeted RN Hours	90	272.00	713440.00	2061345.07	22903.83	75003.25
Total Worked RN Hours	90	232.00	713440.00	2028983.53	22544.26	75017.02
Total Budgeted RPN Hours	88	.00	480480.00	2496715.16	28371.76	52323.25
Total Worked RPN Hours	86	.00	480480.00	2426055.22	28209.94	53147.44
Casual Hours: RN	85	.00	176800.00	231107.02	2718.90	19132.44
Casual Hours: RPN	85	.00	303680.00	403918.65	4751.98	32878.79
Casual Hours: UCP	81	.00	30751.00	245824.87	3034.87	5361.32

Regulated Staff- to- Resident Ratios and Hours of Care/Resident Day

Respondents were requested to indicate the ratio of regulated staff (RN or RPN directly involved in care delivery) to residents on the day shift and the night shift. An explanation was provided with the question: for every one (1) regulated staff, there are 'X' # of residents at your facility on the day shift (provide the 'X' number for your response) and on the night shift. The ratio was, on average 1 to 29 residents on day shift, and 1 to 39 residents on the night shift, with a maximum number of residents of 96 and 155 on days and nights respectively (see Table 13).

The average hours of care per resident per day was reported as 3.6 (SD 4.87). Although this is consistent with the recommendation included in the report *People caring for People: A report of the independent review of staffing and care standards for Long Term Care homes in Ontario* (2008), the current method of reporting of resident care hours, includes all resident care provided and does not provide a distinction between the hours of care provided by registered staff (e.g. nurses) versus unregulated care providers.

Table 13: Regulated staff to resident ratios

Shift	N	Min	Max	Mean	Standard Deviation
Day Shift	87	.04	96.00	29.17	14.14
Night Shift	87	.03	155.00	39.19	26.93
Hours of Care per Resident per Day	76	.51	4.69	3.62	4.87

Reasons for Overtime

From a list of five common reasons for overtime, respondents were requested to stipulate their rank order. Table 14 depicts the placement of the ranked responses. Replacement of staff was the key priority in terms of the number of respondents who ranked the issue as their 'number one'. Following this were workload, filling vacancies, coverage for education, and bringing on additional staff for infection control. Respondents entered 'other' reasons and the predominant reasons were for RAI-MDS activities and coverage for vacations and lieu days.

Table 14: Reasons for overtime (as ranked by respondents)

Issue	#1 Rank	#2 Rank	#3 Rank	#4 Rank	#5 Rank
Replacement, sick/leaves	**79**	12	3	0	1
Workload	10	20	**26**	17	18
Vacancies	6	**39**	**20**	7	17

Table 14: Reasons for overtime (as ranked by respondents)					
Issue	**#1 Rank**	**#2 Rank**	**#3 Rank**	**#4 Rank**	**#5 Rank**
Infection Control (outbreaks/isolation)	3	7	**21**	27	**28**
Education/Orientation	2	11	17	**33**	23
Other Comments:	RAI-MDS work, vacation relief, lieu day coverage				

Sick Time and Turnover Rates

Documented sick time hours for nursing staff, as reported by the respondent facilities is found in Table 15.

- The overall sick time hours for RNs equates to 31 FTEs
- The overall sick time hours for RPNs equates to 50 FTEs

The turnover rate was provided as a percentage. Respondents were asked to calculate the rate by adding both the full time and part time terminations (RN or RPN) divided by the total number in that category. Terminations were defined as actual exits from the organization, not unit terminations for internal transfer purposes. Turnover rates were somewhat higher for RPNs and UCPs than RNs.

- RN turnover rate: 9.5% , *range 0-52%*
- RPN turnover rate 10.5%%, *range 0-50%*
- UCP turnover rate: 11%, *range 0-46%*

Table 15: Sick Time and Turnover Rates						
Sick time / Turnover Rates	**N**	**Min**	**Max**	**Sum**	**Mean**	**Standard Deviation**
Total RN sick hours	91	.00	8296.00	60029.48	659.66	1232.23
Total RPN sick hours	91	.00	16400.00	97363.89	1069.93	1908.58

Table 15: Sick Time and Turnover Rates						
Sick time / Turnover Rates	**N**	**Min**	**Max**	**Sum**	**Mean**	**Standard Deviation**
Turnover rate: RN (percentage)	93	.00	52.00	883.84	9.50	12.57
Turnover rate: RPN (percentage)	91	.00	50.00		10.55	12.28
Turnover rate: UCP (percentage)	88	.00	46.15		11.03	9.46

Reasons for Turnover

A list was provided for staff to identify (yes/no) if the item on the list represented a reason for turnover at their LTC facility. Table 16 is a summary of the number (and %) of respondents who chose the particular item listed. Retirement, relocation, and job advancement at another organization were the top reasons. Other comments were solicited for additional reasons. Family, moving to the acute care sector, multiple jobs, and better wages/benefits elsewhere were the predominant entries. Some organizations (20, 21.7%) noted that they did not know the reasons for turnover.

Table 16: Reasons for nursing turnover	
Reason for Turnover	**Yes (%)**
Do not know	20 (21.7)
Relocating out of district	41 (54.9)
Job advancement elsewhere	60 (66.7)
Returning to school	33 (36.3)
Work Stress	20 (22.2)
Retirement	43 (46.7)
Termination	27 (29.3)

Table 16: Reasons for nursing turnover	
Reason for Turnover	**Yes (%)**
Death	7 (7/6\0
Other specified: family, move to hospital setting/role, multiple jobs, not available (for shifts), better wages/benefits elsewhere, maternity, resignation.	

Retired staff Returning to Work

LTC facilities were asked if retired nursing staff (Registered Nurses and Registered Practical Nurses) were returning to the workplace. Forty-two percent (n = 42, valid percent, **44.2%**) of the facilities responded affirmatively. Options were provided for respondents to identify the roles, paid and unpaid, usually assumed by the returning, retired nurses. Table 17 provides the data and identifies that returning to direct care is most usual for returning retirees, with others assuming project work, volunteer roles, or providing education support.

Table 17: Roles assumed by retired nurses returning to the workplace	
Roles for Returning Retirees	**Yes (%)**
Direct Care	72.2
Project Work	9.1
Volunteer Role	6.8
Educator/Mentor/Preceptor	19
Other roles: casual, charge nurse, discharge planning, assistant to the coordinator, orientation, quality assurance, RAI-MDS Co-ordinator.	

Section D: Education and Orientation

Owing to the rapid changes in acuity and new equipment/technology, continuing nursing education is needed to address organizational accountability for safe, high quality care. This section details the hours for nursing education and orientation (see Table 18). In-service hours, i.e. time when an on duty staff member may attend a teaching session or rounds, is not included, given that most organizations do not capture these hours. Education hours for UCPs are also included in Table 18. It was understood that orientation hours may vary, unit to unit, however, respondents were asked to provide the average minimum number of hours for categories of 'new' nursing staff. Wide variations were observed.

- Minimum RN orientation: 7.24 days
- Minimum RPN orientation: 6.9 days
- Minimum UCP orientation: 5.6 days

Table18: Hours allocated for RN, RPN, and UCP education and orientation

Education/Orientation	N	Min	Max	Sum	Mean	Standard Deviation
Total hours: Nursing staff education*	63	.00	40000.00	76162.75	1208.93	4999.99
Paid education hours: RN*	81	.00	2031.00	13774.74	170.05	320.30
Paid education hours: RPN*	81	.00	3039.00	17901.55	221.00	460.36
Number of paid education hours: UCP	75	.00	6760.00	30455.35	406.07	883.57
Approximate minimum number of orientation days for one new staff: RN	93	3.00	21.00	674.00	7.24	4.03

Table18: Hours allocated for RN, RPN, and UCP education and orientation						
Education/Orientation	**N**	**Min**	**Max**	**Sum**	**Mean**	**Standard Deviation**
Approximate minimum number of orientation days for one new staff: RPN	92	3.00	17.00	635.00	6.90	3.55
Approximate minimum number of hours for one new staff: UCP	92	2.00	17.00	514.50	5.59	2.82

**does not include in-service education hours*

Section E: Manager Span of Control

LTC facilities were asked if they had Nurse Managers, operationally defined as one who is directly accountable for operations at the point of care (or unit level), and to whom clinical staff directly report (may also be described as a "front-line manager"). Approximately 70% of those responding reported that this position was in place (see Table 19). The titles of individuals employed in the nurse manager role varied (see Table 19). The most frequently reported title was Manager and Charge Nurse.

Table 19: Percentage of LTC facilities reporting the presence of Nurse Managers			
Nurse Manager role?		**Frequency**	**Percent**
	Yes	67	67.7
	No	30	30.3
	Total	97	98.0
Titles of Nurse Managers: Nurse Manager, Charge Nurse, Head Nurse, Facility Manager, Unit Director, Unit Manager, RN supervisor, Co-ordinator, Resident Care Coordinator, Director of Nursing (DON), 'RN on Duty', Assistant DON/DOC, Shift Supervisor, Nurse designate, RPN, Director of Resident Care (DORC), Assistant DORC.			

The nurse middle manager specifications, in terms of average age, numbers of sites, units and direct reports are contained in Table 20. According to the respondents who provided data, the findings include:

- The **average age** of the nurse manager was **47.4 years** (SD 8.86);
- The percent of nurses managers who were BScN degree prepared was **30%** (SD, 33.67, *range 0-100%*);
- The **average number of beds/residents for which a nurse manager was responsible** was 94 (*range 0-282 residents);*
- The percent of managers who are **not nurses** was 9%;
- A large majority (79%) of managers report to administrators who are nurses;
- The average number of **units per manager** was 3.2 (SD, 1.85, *range 0-8 units*);
- Only 2 respondents noted that managers have responsibilities at more than one site (applicable to merged organizations); and
- The number of **direct reports per manager** ranged from a **minimum mean of** 27 (*range 0-150)* to a **maximum mean of 44** (*range 0-266).*

Table 20: Manager span of control

	N	Min	Max	Sum	Mean	Standard Deviation
Average age of nurse managers	58	5.00	64.00	2747.55	47.37	8.86691
Managers who are degree (BScN) prepared (%)	63	.00	100.00	1895.90	30.09	33.67
Average # beds for which a nurse manager is responsible	68	.00	282.00	6384.92	93.89	53.11
% of RNs and RPNs who report to a manager who is a nurse	70	.00	100.00	6515.00	93.07	22.47
Number of managers who have RNs	79	.00	100.00	330.00	4.17	12.40

Table 20: Manager span of control						
	N	**Min**	**Max**	**Sum**	**Mean**	**Standard Deviation**
and RPNs as direct reports						
Of that total number of managers in the above question, indicate the number of managers who are not nurses.	73	.00	7.00	29.00	.39	1.26
% of nurse managers who report to a nurse functioning in an administrative capacity (i.e. Director level position)	72	.00	100.00	5675.00	78.81	39.50
Average number of units per manager at your facility	69	.00	8.00	224.17	3.24	1.85
Lowest number of direct reports per manager	64	.00	150.00	1750.00	27.34	37.99
Highest number of direct reports per manager	64	0	266	2831	44.23	55.17

On-call and Off-hours Organization/Unit Supervision

On-call (off-site) nurse manager responsibilities for after hours and weekends is expected in 45% of responding organizations. In 70.5% of the responding organizations, there are on-site individuals (managers, coordinators, supervisors) for after hours and weekends (see Table 21).

Table 21: Manager off site (on call), and on site coverage			
Manager, on call, and on site supervision	**N**	**Frequency, 'yes'**	**Percent**
Managers expected to be on call (after hours/weekends)	82	37	45

Table 21: Manager off site (on call), and on site coverage			
Manager, on call, and on site supervision	**N**	**Frequency, 'yes'**	**Percent**
On-site supervisors for after hours and weekends	88	62	70.5

Recruitment Challenges (Middle Manager Roles)

Leadership roles in management and administration have been cited as a challenge over the past several years (Ballard, 1995; McGilton et al, 2007). To scan for information and explanation, questions were asked about the challenges related to recruitment of candidates for manager positions in Long Term Care. From a list of recruitment challenges, the respondents were asked to indicate any, as applicable, in their organization. Space was left for the respondent to indicate other comments. Table 22 details the responses. While all options were important to the majority of the respondents, the predominant challenges were few external and internal applicants, followed by attributes of the role (duties and scope of the role) were not consistent with the individuals applying. Other comments are also reported relate primarily to:

- Wages, benefits better elsewhere;
- Qualifications of applicants – language, calibre of the applicant (skills and experience);
- Distance;
- Aging population of the RNs – not interested in management; and
- Role demands in LTC – specific to LTC complexities, demands that manager include 'hands-on' duties [may not be suitable for applicants desiring office role].

Table 22: Recruitment challenges (Middle Manager Roles)			
Recruitment challenge	**N responding**	**Yes**	**%**
Few External Applicants	80	58	72.5
Role Attributes	80	39	48.8
Few Internal Successors	80	53	66.3
Other recruitment challenges: wages, benefits, competition with others, language requirements, spouses' employment opportunities, aging RN population (who are not interested in management role), experience/calibre of applicant, and nuances of LTC management roles.			

Section F: Issues and Other Comments

From a list of current nursing issues, respondents were asked to rank, in order of priority (1 being most important and 5 being least important), those most critically important at this time. Table 23 details the ranking. The variability among the spread of the data was relatively even. Recruitment and retention, along with workload, patient acuity/complexity, and the aging workforce were ranked more frequently at the higher levels, followed by technology complexity. Space was allocated for the respondent to add other key issues.

Table 23: Ranked critical issues in nursing					
Critical Issue	**#1**	**#2**	**#3**	**#4**	**#5**
Recruitment /Retention	**39**	20	**21**	11	7
Aging Workforce	**29**	20	**21**	11	17
Patient Acuity/Complexity	**21**	**23**	**24**	18	12
Retention/Turnover	8	17	19	**27**	**26**
Technology/Complexity	7	16	16	**27**	**32**

Table 23: Ranked critical issues in nursing
Other specified issues: Funding limited in meeting the needs of residents, overload/workload, attendance management, education/training/clinical support, language needs among staff ['many do not have English as a first language, this deficit can have critical impact on nursing care and high risk factors'], LTC 'value' in terms of being seen as a desirable work setting, MOHLTC changes and expectations coupled with RAI-MDS, skill level of new graduates lower than in prior years.

The Mid-career and Late Career Nurse

While emphasis has been generated toward the new graduate, attention is also required for the mid (age 35-55 years) and late career (>55 years) nurses. To scan the LTC sector, respondents were asked if any initiatives for these cohorts of nurses had been initiated and the number and percent replying in the affirmative are noted as follows:

- **Mid-career Nurse Initiatives**: initiatives in place, **15.6%,(** n = 15/96)
- **Late Career Nurse Initiatives**: initiatives in place, **48%,** (n = 48/94)

Other Additional Comments Relative to the Nursing Plan Survey

Space was left for the respondent to add any comments that, in their opinion, were relevant to the Nursing Plan. The comments are summarized as follows:

- RAI-MDS activities: ministry pressure; taking nurses away from the bedside with overabundance of documentation; *'significant challenges have presented themselves with the phase 5 of MDS/RAI[sic]...staff need to shift from Alberta classification to RAI'; 'financial repercussions as a result of changes in CMI classifications...RPNs unused to primary type role with added responsibility of MDS/RAI[sic] requirements and are considering employment in other than the LTC sector';*
- **Support needed: Late Career/Mid Career –** short time to use Late Career funding; applied but was not accepted; *'sustainability of the late career funding will assist us with our aging workforce. Funding for mid career nurses would be extremely useful'***;**

- **Documentation of nursing resource data:** data hard to produce, very time consuming; hard to do in a small setting;
- **Patient mix:** acuity and complexity increases;
- **Challenges: fiscal** restraints, recruitment/retention to **northern and remote** areas; access issues in northern areas (access to network, support, training); would like adequate funding to '*increase the ratio of full time to part time staff'; and*
- **Image of LTC setting/sector:** need to enhance positive image, *"there is still a negative stigma in society about LTC and this stigma in turn damages recruitment efforts"*.