



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFIRMIÈRES
ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

Supporting Quality Nursing Care in the Long – Term Care Sector

Results of the 2005-2006
Long–Term Care Teleconference Series

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INTRODUCTION

The College of Nurses of Ontario (CNO) is the regulatory body for nursing in Ontario. CNO has over 144,000 members and is the largest group of regulated health professionals in Ontario. CNO regulates nursing to protect the public interest, sets requirements to enter the profession, establishes and enforces standards of nursing practice, and assures the quality of practice of the profession and the continuing competence of nurses. Nurses¹ are accountable to the standards of practice set by CNO. These standards establish the expectations of general nursing practice in any resident care setting.

Since Monique Smith's 2004 report *Commitment to Care: A Plan for Long-Term Care in Ontario*, CNO has seen initiatives in the long-term care (LTC) sector that have begun to address deficiencies in the system and that support quality care. The expanding role of nurse practitioners (NP) is a prime example. Despite these initiatives, CNO has learned of many on-going challenges in the sector.

CNO has heard directly from nurses and employers of nurses about these challenges. In 2005, CNO initiated a series of teleconferences to better understand the practice realities of nurses in the LTC sector. The input derived from these discussions has played a key role in informing CNO's understanding of processes and issues in the sector.

The purpose of this paper is to highlight the themes that CNO has derived from the LTC teleconference series. CNO acknowledges that new resources have been allocated to support resident care since 2001. However, findings from the teleconferences point to a persistent nursing resource deficit in the sector, and a strong message that nursing resources are insufficient to meet resident needs. They also reflect and support many of the findings from the Smith Report.

This paper profiles the themes identified through the teleconferences with other forms of evidence that describe the context of practice for nurses in LTC that together, point to the need for greater attention to resource and workplace factors that influence quality of care.

¹ In this paper, the term 'nurse' represents Registered Nurses, Registered Practical Nurses and Registered Nurses in the Extended Class

A NURSING PERSPECTIVE ON LONG – TERM CARE

In 2006, there were 7,047 registered nurses (RN) working in LTC facilities in Ontario, and 6,890 registered practical nurses (RPN).² Nurses comprise the largest body of regulated health professionals in the LTC sector.

The teleconference concept emerged from feedback received from LTC employer sessions held by CNO in September and October of 2004. These sessions were developed to provide an overview of CNO services and to consult with employers in the sector about some of the issues they were facing. From feedback and surveys from that outreach activity, CNO learned that there was a desire for focused dialogue regarding nursing leadership issues, challenges and strategies within the LTC sector.

CNO initiated a teleconference series in 2005 to better understand the experience of nurses, nurse leaders, administrators and employers in the LTC sector, with the following specific objectives:

- to exchange information with nurses/administrators in long-term care
- to answer their questions and concerns pertaining to regulatory issues and resources
- to establish a forum for dialogue and learning from their colleagues in the sector

These objectives are directly linked to CNO's broad strategic objective of better understanding the practice realities that nurses encounter in providing resident care.

METHODOLOGY

A total of eight teleconferences were held over a two-year period:

2005

Accountabilities of Nurse Leaders (March 29, 2005)
Working with Unregulated Care Providers (May 17, 2005)
RN and RPN Roles (September 14, 2005)
Standards in Practice (November 15, 2005)

2006

Delegation: What Is My Role? (March 28, 2006)
Innovations in Nursing Practice (May 16, 2006)
Supporting Learners in Long-Term Care (September 13, 2006)
Putting Research into Practice (November 21, 2006)

² Membership Statistics Report. College of Nurses of Ontario. 2006.

The sessions were approximately one hour in length and attracted an average of 100 facilities per session. The total number of nurses participating was greater than 100, as many facilities organized staff groups to maximize the knowledge transfer opportunity for the facility.

Each teleconference included an introduction by CNO staff to the topic and related standards/guidelines of practice, followed by commentary and discussion from and among participating facilities. CNO solicited questions from participants prior to the teleconferences to help shape the presentations and build on issues of concern. Participants were asked to complete evaluation forms following the sessions. These evaluations were helpful in identifying any changes to the format and organization of the sessions.

The teleconferences yielded a rich set of information on nursing practice environments. CNO undertook a qualitative approach to interpreting the results by using verbatim transcripts and content analysis. CNO undertook a qualitative analysis of teleconference transcripts to identify underlying themes in the commentary.

The following table describes these themes:

Theme	Description
Isolated Sector	There is a sense of isolation in the LTC sector, both in terms of the attention paid by health system policy makers, and from nurses working in isolation from their peers
Lack of Resources	The sense of isolation is compounded by a funding model that does not support adequate numbers of nurses nor an appropriate staff mix. The demands of the workplace contrast with the limited availability of resources to support quality care.
Accountability	The demands of the workplace have also created pressures on individual accountability. Medication administration and management of support staff are a few of the areas where nurses expressed concern about their role and accountability, and that of unregulated staff.
Collaboration	Amidst the challenges facing the sector, there is a desire to collaborate and develop strategies to provide quality care.

DISCUSSION OF THEMES

CNO undertook a survey of participants to validate the themes that emerged from the aforementioned teleconference sessions. The results of the survey confirmed what CNO had heard during the open discussions. The themes and supporting evidence are described below.

1. Isolated Sector

According to nurse leaders in the LTC sector, there is a sense of isolation of nurses working in the sector, both in terms of the attention paid by health policy makers and by nurses working in isolation from their peers. CNO heard from nurses who felt there was little external recognition of the challenges they face in providing quality care. Unfortunately, these sentiments were directed across the board and included CNO, the provincial government and their unions. There were feelings of disappointment that these groups weren't doing enough to highlight the challenges and struggles nurses were going through in the LTC sector.

Participants also expressed the view that the LTC sector is far different than it was five years ago with regards to resident acuity and complexity. These issues are felt to pose a barrier in recruiting and retaining nurses into the sector, and are reflected in the following commentary:

“Compared to even 10 years ago, the complexity of residents has increased - G tube feeds, catheters, oxygen, and the concept of palliative care and pain control are added dimensions to an increasing and more incapacitated population. Also the knowledge and public awareness of the possibilities for care increase the expectations on the staff and delivery of care...”

“Most of our residents have complex medical problems and approximately 80 % of these residents have dementia. This directly impacts number of meds/ resident. We have worked with physician and family to review, change, or reduce meds but it remains difficult to give meds in timely manner...”

“There is also a strong sense of LTC being a second class sector managed by second rate nurses...”

“Lack of recognition and sense of isolation could be attributed to poor funding for LTC setting and the sometimes inappropriate use of non-registered staff. Clarification of the role of the RN/RPN in this setting would be beneficial...”

The trend towards increasing acuity in the level of service was documented in a 2001 study commissioned by the Ontario Long-term Care Association, and the Ontario

Association of Not-for Profit Homes for Senior's.³ This trend is compounded by the increasing prevalence of dementia in the LTC population. The Smith report cites Ministry of Health and Long-Term Care (MOHLTC) data showing that 64% of residents admitted to a LTC facility have some form of dementia or suffer from cognitive impairment.⁴

Furthermore, the Canadian Coalition for Seniors Mental Health released a guideline for the assessment and treatment of mental health issues in LTC homes in May 2006.⁵ The guidelines include a series of recommendations related to organizational and system issues, including that organizations have written protocols for staff mix in support of residents with behavioural problems.

2. Lack of Resources

Teleconference participants expressed the view that the provincial funding model does not support adequate numbers of nurses, and that the demands of the workplace contrast with the limited availability of resources to support quality care. It is felt that human and financial resources have not kept pace with residents' needs, and it is perceived that there is little external recognition of the challenges to providing quality care. Participant views echo the conclusions of the Smith Report that funding and staff shortages negatively impact quality of care.

Participants also held strong views about the role of unregulated personal support workers (PSW) in the sector. Unregulated PSWs are thought to be performing care that is outside the bounds of the training they receive, leading to increased risk of harm for residents. Participants expressed frustration that unregulated PSWs are increasingly providing care for complex residents without a corresponding increase in nursing resources to supervise and monitor the care they provide.

3. Accountability

Findings from our qualitative analysis demonstrate that the demands of the workplace have created additional pressures on nurses' individual accountability, specifically with the supervision requirement of unregulated staff and with the dispensing of residents' medication.

While nurses are accountable to their residents, to CNO and to their employer, unregulated staff is accountable to their employer. They are not accountable to an external body and there is no regulatory mechanism to set standards or monitor quality of service. CNO was repeatedly told that the ability of registered nursing staff

³ Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long-term Care Facilities and selected Comparators. PriceWaterhouseCoopers, 2001.

⁴ Commitment to Care: a Plan for Long-term Care in Ontario. Ontario Ministry of Health and Long-term Care, 2004.

⁵ National Guidelines for Seniors Mental Health. Canadian Coalition for Seniors Mental Health. 2006

to adequately supervise unregulated staff in LTC facilities is a major issue, primarily related to staff mix.

A secondary but related issue raised by some participants is that nurses are not adequately prepared to manage unregulated PSWs. In most LTC settings, PSWs are supervised by nurses. Despite the existence of CNO's guideline on "Working with Unregulated Care Providers," teleconference participants acknowledged that PSWs are frequently working with limited oversight from supervising nurses. Further, the supervising nurse may not have seen the resident, nor be aware of particular circumstances regarding the provision of care to the resident.

The following comments on PSW roles are representative of those received in the teleconference series and in the validation survey.

"The ratio of RN to unregulated care provider (UCP) is often quite high making it difficult to address issues that arise in a timely and efficient manner..."

"UCPs require a great deal of attention as they have a lack of accountability that is inherent to the role. If this group could somehow be regulated, perhaps things could change for the better. This group, in our home anyway, is paid very well but can be very irresponsible..."

"UCPs can provide excellent basic care in the form of comfort measures, and emotional support. However, when asked to perform duties beyond their scope of practice, it leaves the organization open for multiple sets of problems in care delivery..."

Recently, there have been national and local incidences of nurse errors in medication administration that have resulted in negative resident outcomes. Nurses, because they administer the drugs directly to residents, are the last links in the safe medication administration chain. Complicating matters is the increased acuity of the residents they serve in LTC facilities and the decrease in the resources available to nurses to ensure safe practice. Nurses need to become cognizant of their practice's vulnerability and vigilant about protecting their practice. As one nurse stated:

"One area of concern that I have found is that nurses, especially new grads, do not realize the importance of following CNO standards for medication delivery...I am observing registered staff at both levels with terrible practices in medication delivery."

Or as another nurse stated:

"From my perspective of medication administration it is apparent there was and is a (nursing) lack of professional development, knowledge deficit regarding CNO's Standards of Practice for medication administration and professional accountability."

4. Collaboration

Amidst the challenges facing the sector, there is a desire to collaborate and develop strategies to provide quality care in LTC settings. These include measures to increase the accountability of unregulated providers, methods for increasing communication between managers and staff, and the provision of continuing competence opportunities for staff.

Collaboration has consistently been found to be significant in obtaining desired resident outcomes. Nurse-physician collaboration has a positive effect on nurses' caregiving decisions,⁶ while decreasing the risk of negative outcomes such as resident deaths.⁷ Collaboration is especially important as the complexity of the resident-care situation increases.

Leadership and management are key attributes that facilitate quality care.⁸ The impact of these skills on resident outcomes was documented by Anderson (2003) in an analysis of long-term care facilities. Communication openness and relationship oriented leadership were related to decreased incidence of aggressive behaviour, restraint use, and fractures.⁹ Strong nursing leadership contributes to positive resident outcomes by developing staff expertise and stability.¹⁰ Results of a study of nursing homes identified that the longer the director's tenure, the lower the prevalence of restraint use and complications of immobility.¹¹ In short, the ability of nurse leaders to collaborate and develop strategies with staff providing care has been directly linked to positive resident outcomes in LTC.

LITERATURE REVIEW

There is a body of research that links increased levels of nursing care with higher quality outcomes. The Ministry's evaluation of NP roles supports the further expansion of NPs in the LTC sector.¹² The 2004 evaluation indicates that NPs make a valuable

⁶ Krairiksh, M., & Anthony, M.K. (2001). Benefits and outcomes of staff nurses' participation in decision making. *Journal of Nursing Administration*, 31(1), 16-23

⁷ Shortell, S.M., Zimmerman, J.E., Rousseau, D.M., Gillies, R.R., Wagner, D.P., Draper, E.A., et al. (1994). The performance of intensive care units: Does good management make a difference? *Medical Care*, 32(5), 508-525.

⁸ McGilton, Katherine, Dr. Barbara Power, Barbara McKenzie-Green, Veronique Boscart & Maryanne Brown (2007). "Leadership in Long-Term Care". *PowerPoint Lecture presented at the College of Nurses of Ontario on April 18, 2007. Study funded by the Collaborative Research Program: Rehabilitation and LTC and the College of Nurses of Ontario.*

⁹ Anderson RA, Issel LM, McDaniel RR Jr. Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. *Nurs Res* 2003;52(1):12-21.⁹

¹⁰ Houser, J. (2003). A model for evaluating the context of nursing care delivery. *Journal of Nursing Administration*, 33(1), 39-47.

¹¹ Anderson, R.A., Issel, L.M., & McDaniel, R.R. (2003).

¹² Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario, Ministry of Health and Long-term Care, 2005.

contribution to resident care in LTC facilities, and that their contributions are also valued by physicians in the sector.

The findings from a 2004 Institute of Medicine report, *Patient Safety: Transforming the Work Environment of Nurses*, relates higher levels of RN hours per patient day and lower RN turnover rates with improved patient survival rates, improved functional status, earlier discharge, fewer pressure ulcers, decreased urinary tract infections and reduced use of antibiotics.¹³

The IOM report also cited a study of quality of care in 34 randomly selected LTC facilities with different categories of nursing care providers. Results indicated that in the facilities that had more practical nurses compared with nursing assistants, the residents were out of bed more, were more active during the day and demonstrated higher levels of self care. When these findings were compared with those of studies that utilized separate quality indicators such as weight loss, pressure ulcers, incontinence and loss in levels of physical activity, the researchers concluded that staffing type is an effective predictor of high-quality care processes.

A second large scale review, entitled *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* was done in two phases under the auspices of the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services. These reports provide a comprehensive assessment of staffing-related issues in LTC and the policy context for addressing them. The core of this work demonstrated consistent associations between staffing levels (dose and/or mix) and quality of care based on outcome measures relevant to resident safety, including incidence of pressure ulcers, skin trauma and weight loss. The data collected had a significant association until a certain staffing threshold was reached. Beyond this threshold, there were no further detectable benefits. This study also found a strong relationship between staff retention and positive resident outcomes related to resident safety.¹⁴

CNO acknowledges the limitations of the above research as it relates to Ontario's LTC environment. The findings take on a particular meaning, however, when held up against the consistent comments and views from nurses in the teleconference series.

Coroners' Reports

Coroners' reports offer another perspective on resource issues in the LTC sector. For the past fifteen years, a committee of the Chief Coroner's office, the Geriatric and Long-term Care Review Committee, has produced annual recommendations for resident care based on a review of coroners' reports gathered from across the province. Each year, the Committee brings forth recommendations based on analyses of case files forwarded by regional coroners' offices. The following is a sample of recommendations from the 2004

¹³ Institute of Medicine, Committee on the Work Environment for Nurses and Patient Safety. (2004). Page, A. (Ed.). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC.: National Academies Press.

¹⁴ Centers for Medicare & Medicaid Services. (2000, 2001). Report to Congress: *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes – Phase 1 and 2 Final Reports*.

and 2005 reports highlighting resident care issues that the Committee views as representative of care within the sector.

. . . changes in an elderly patient's clinical condition including behavioural changes may indicate the presence of a potentially serious medical illness¹⁵

. . . health care professionals should be reminded of the importance of accurately assessing the skin integrity of residents of long-term care facilities.¹⁶

. . . health care professionals caring for elderly demented patients should receive ongoing training in the specialized care needs of these residents.¹⁷

Since these recommendations pertain to nursing and are within the scope of nursing practice, they provide further evidence of the need for adequate allocation of nursing staff in a long-term care facility.

Of particular relevancy to CNO's findings, the 2006 report comments on the management of residents with cognitive impairments, recommending that the MOHLTC rapidly increase resources and capacity of the health system to effectively manage this resident population, and develop and implement a strategy to address system deficiencies identified by the Canadian Coalition for Seniors' Mental Health.¹⁸

Ontario Auditor's Report

A further comment on nursing resources comes from the 2004 Ontario Auditor's report. The report provided an update following the 2002 Auditor's recommendations to the MOHLTC regarding LTC facilities, including that the ministry track progress in ensuring that funding provided to facilities is sufficient for the level of care required by residents. While the 2004 report acknowledges progress in assessing staffing patterns, a common tool (Minimum Data Set) that would aid in the assessment has not been widely implemented in the long-term care sector.

Assessment of Health Human Resource Needs

A 2001 PriceWaterhouseCoopers report remarked on the weakness of the current resource assessment instrument.

The eight (assessment) areas do not fully reflect the resident's medical or health status, required treatments, procedures and medication, nor do they adequately

¹⁵ Fifteenth Annual Report of the Geriatric and Long-term Care Review Committee. Office of the Chief Coroner of Ontario, 2005, p. 10.

¹⁶ Fourteenth Annual Report of the Geriatric and Long-term Care Review Committee. Office of the Chief Coroner of Ontario, 2004, p. 9.

¹⁷ Ibid p. 9.

¹⁸ Sixteenth Annual Report of the Geriatric and Long-term Care Review Committee. Office of the Chief Coroner of Ontario, 2006.

*reflect special need areas such as rehabilitation/restorative care, mental health care, or palliative care.*¹⁹

This view was echoed by O'Brien-Pallas et al in their 2003 analysis of Ontario's nursing workforce:

*Critics say that utilization of this flawed (assessment) system discourages facilities from engaging in accurate long-range planning that can ensure adequate nursing resources for residents. As a result, there has been casualization of nursing personnel.*²⁰

Improving the assessment of resident needs is a key element in identifying the appropriate staff mix for LTC facilities and is consistent with a broader health human resources planning framework.

Relationship between Quality of Care and Work Environments

The issues described above underlie some of the commentary that nurses provided in the teleconferences, related to quality of care and their work environments. These views are underscored by an established body of research that links the quality of the working environment to the quality of care. The research was summarized in a report by the Canadian Nursing Advisory Committee in 2002, along with their recommendations for change. Furthermore, a progress report written in 2004, found key barriers in place to restrict effective implementation. One of the key barriers is summarized as follows:

*The findings of this study suggest that improving nurses' quality of work is viewed as distinct from improving the quality of care that nurses play a large role in providing. The implementation of improvements to the quality of work life for RNs, LPNs and RPNs would be facilitated by viewing nursing supply as an essential input to health care provision and health care reform rather than as a cost to the system or a budget item.*²¹

CNO Outreach Initiative

CNO has undertaken a new outreach initiative designed to support effective leadership and management in the long-term care sector, part of a broader strategy that has established outreach consultants in six practice sectors. They include:

- Acute care – adult;
- Community/public health;
- Long-term care/rehabilitation/complex continuing care;

¹⁹ PriceWaterhouseCoopers, Op Cit. p. 4.

²⁰ O'Brien-Pallas. Stepping to Success and Sustainability: An Analysis of Ontario's Nursing Workforce. 2003. p. 71

²¹ Maslove, L. and C. Fooks. Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses: A Progress Report on Implementing the Final Report of the Canadian Nursing Advisory Committee Final Report. Canadian Policy Research Network, 2004. p. 21.

- Mental health/correctional services;
- Palliative care
- Pediatrics – continuum of care;

Through this initiative, CNO provides regulatory expertise to the LTC sector and engages nurses in interactive forums for ongoing dialogue about practice setting realities. The Long-Term Care/Rehabilitation/Complex Continuing Care Advisory group includes nurses from all roles and categories across the province working in the LTC sector. This group shares information on trends and issues in their practice sectors that may facilitate or hinder their ability to practice according to the nursing standards. This feedback allows CNO to integrate this knowledge into ongoing resource development.

Nursing leaders, along with staff nurses and students, are a key target audience of the outreach strategy. One of the major components of the new model focuses on ways in which CNO engages with nurse leaders in the development of processes to support systems and work environments that assist nurses to apply practice standards in the work setting. A leadership advisory committee has been implemented to facilitate this work.

The new outreach program employs a variety of methods to link CNO resources to the realities of practice settings, including face-to-face learning sessions so that learning is more consultative, and increased use of telecommunications, including web-based learning which is available around the clock.

As part of the outreach philosophy, CNO has initiated discussions with the MOHLTC's compliance and inspection division to identify areas of intersection between the ministry's compliance standards and CNO's standards of practice.

IMPLICATIONS

CNO proposes continued exploration and development in the following areas to improve quality of care within the LTC sector.

Nurse Practitioner Role

The recent initiative by the MOHLTC to create twenty pilot sites for the testing and evaluation of Nurse Practitioners in LTC facilities in Ontario was developed as a result of the recommendations from the Nursing Task Force report *Good Nursing, Good Health: An Investment for the 21st Century*.²²

Indeed, numerous studies have identified additional support for the value added with the Nurse Practitioner role in the LTC setting. The evaluation suggests that Nurse Practitioners, via their extended practice role and in collaboration with a family physician in a shared care and teaching model, positively impact aspects of residents' care and health. Indeed, the Smith report recommends that the MOHLTC fund the addition of

²² Report of the Nursing Task Force. *Good Nursing, Good Health: An Investment for the 21st Century*. Toronto. 1999.

more nurse practitioners in the LTC sector.²³ The report noted that the 17 NPs hired in a MOHLTC pilot program were converted to full-time positions in 2003.

NP utilization is an important complement to the health and safety of residents in LTC facilities and is consistent with the province's broader NP strategy.

Unregulated Staff in LTC Facilities

CNO has previously commented on the increasing role of unregulated care workers in the provision of nursing work. CNO's work with the LTC sector lends support to the need to strengthen legislative and regulatory frameworks that LTC facilities operate in, to clearly delineate the roles of unregulated health care workers from regulated staff and mechanisms for appropriate supervision and delegation of controlled acts, when appropriate.

Staff Mix Assessment Models

The provincial Auditor's report recommended that the MOHLTC track progress in ensuring that funding provided to LTC facilities is sufficient for the level of care required by residents. Evidence supports the relationship between nursing staff mix and quality of care. What is not clear is the particular mix that is required in each facility. Feedback from the teleconference series indicated the support for continued exploration of implementation of the MDS across all LTC facilities.

Information and Communications Strategy

One of the strongest recurring themes in the teleconference series was the need for improved access to information and technology. Communication among nurses and other members of the health care team is emerging as the single most important factor affecting quality of care. Specifically, the teleconferences supported the identification of the need for LTC facilities to have access to technology that will allow nursing staff to link with real time information, best practices and on-line learning tools to support professional development, reflection and collective problem solving.

During the SARS outbreak one of the biggest challenges identified by the SARS Commission was that health professionals and organizations were not well supported with either information or proper communications.²⁴ Nurses identified their inability to get timely and reliable information and direction. Unfortunately, these same sentiments were echoed from nurses in the LTC teleconference series. That sense of isolation nurses felt working in the LTC sector compounded by their lack of resources can result in negative health outcomes for residents.

²³ Commitment to Care. op cit , p. 22

²⁴ Campbell, The Honourable Mr. Justice Archie, (2006). "SARS Commission: Spring of Fear Volume 1". Toronto. Access via <http://www.sarscommission.ca/report/v1-pdf/Volume1.pdf>

CONCLUSION

CNO initiated the LTC Teleconference Series to provide a forum for nurses, nurse leaders, administrators and employers to share ideas and knowledge. These sessions also assisted CNO in becoming more familiar with the realities of the LTC practice setting. The views expressed in the teleconferences to date provide a powerful narrative in support of a resident-centered care model that incorporates nursing knowledge of physical, social and emotional care.

CNO will continue to monitor issues within the LTC sector and be responsive to its regulatory mandate of protecting the public interest. The Outreach Program with its advisory groups representing different practice sectors, including LTC, will put CNO in a better position to assist nurses with their issues and advance CNO's mission in protecting the public's right to quality nursing services by providing leadership to the nursing profession.

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