Time to Care

Staffing and Workload in Alberta's Long-term Care Facilities

PARKLAND INSTITUTE | Rebecca Graff-McRae

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Rebecca Graff-McRae
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About the Author

Rebecca Graff-McRae is a research manager at Parkland Institute. She completed her undergraduate and doctoral studies at Queen's University Belfast (PhD Irish Politics, 2006). Her work, which interrogates the role of memory and commemoration in post-conflict transition, has evolved through a Faculty of Arts fellowship at Memorial University Newfoundland and a SSHRC postdoctoral research fellowship at the University of Alberta. She previously worked with the Equality Commission for Northern Ireland and Edmonton City Council. Her research at Parkland Institute focuses on health and social policy issues, including basic income, health care privatization, and working conditions in long-term care.

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Executive Summary

During the novel coronavirus pandemic which began in Canada in March 2020, the need for adequate staffing became a matter of life and death, as many seniors' care facilities that had previously "managed" with bare-minimum staffing levels were unable to provide even the most basic levels of care for their residents – with tragic consequences. The fundamental and painful lesson has been the way the virus exposed, exploited and exacerbated the long-standing fissures and flaws in the foundations of Canada's social safety net. Nowhere has this been more poignant than in long-term care (LTC).

By March 2021, Canada suffered 22,238 deaths due to COVID-19 – 67 per cent of these in long-term care. Long-term care staff accounted for 25,276 confirmed cases of the virus. In Alberta, 64 per cent of COVID-19 fatalities – more than 1,200 – were seniors in LTC.

Yet, even amidst this tragedy, the lesson has not been adequately learned: according to data from the Canadian Institute for Health Information released in March 2021, COVID-19 cases among residents of LTC and retirement homes increased by nearly two-thirds during the second pandemic wave compared with the first wave.

Inadequate staffing levels and poor working conditions for employees has been widely acknowledged as a significant factor in the ability of Canada's LTC facilities to respond to the pandemic and its concomitant public health restrictions.

However, concerns about adequate staffing and the ability of LTC staff to meet the care needs of residents have been raised over and over again for decades in Alberta and across the country. Increased staffing of direct-care workers results in fewer negative health outcomes for residents. Inadequate staffing levels are strongly correlated to burnout among health-care workers, higher likelihood of workplace injury, and result in high rates of staff turnover – all of which impact the quality of care they can provide residents.

Despite the crucial role staffing plays in providing quality care, provincial data on staffing is scarce. The Government of Alberta has not undertaken any study of staffing levels and working conditions in the LTC sector. To effect substantive change in seniors' care it is essential that front-line workers' voices be heard, and their experiences learned from.

To this end, in 2019 Parkland Institute researchers collaborated with the Canadian Union of Public Employees (CUPE-AB) to develop a survey of LTC staff in Alberta. The survey's objective was to hear from workers about their own experiences in LTC and what challenges they face in providing care. Workers were asked about their experience of injury, violence and

emotional distress in the workplace. We also asked workers about how these conditions impacted residents, and their own physical, mental and emotional well-being.

The survey was distributed via CUPE-AB to their membership in LTC facilities. Responses were received between October 2019 and the end of March 2020, during the early days of the pandemic in Alberta.

Fewer Staff Means Less Time to Care

One of the most important objectives of this survey was to determine how much time LTC workers have in their work day to do their jobs, whether that time is sufficient to do their job to the highest standard, and whether they feel lack of time impacts residents of the facility in which they work.

When asked, "If you had more time during your work day, what would you do?" workers spoke of time to complete necessary tasks which were too often left undone or deferred to the next shift. Most poignantly, many respondents expressed their desire for additional time to provide emotional and social connection for their residents, and to complete basic physical care tasks in an unhurried way that preserved residents' autonomy and dignity.

Nearly half of respondents – 43 per cent – did not have adequate time to complete required tasks consistently every day. Only 24 per cent stated they never had essential tasks outstanding at the end of a shift.

Consequently, staff are left with few options: leave important aspects of their job – including care tasks – undone, work through their breaks, or stay late to finish. Seventy per cent of respondents stayed beyond the end of their shift at least occasionally (occasionally, daily or once a week). Nearly one-quarter – 24 per cent – stayed late either daily or once per week. It is clear from these responses that staying beyond the end of their shift to ensure all essential tasks are done is the norm for many LTC workers.

Many respondents highlighted a concerning lack of time for cleaning. In the ongoing context of the COVID-19 pandemic, the lack of time to thoroughly perform cleaning tasks could have dangerous consequences as surfaces, linens and communal areas contribute to virus transmission if not properly sanitized.

Respondents did not have the luxury of time because so many were working short-handed. In total, 90 per cent of respondents reported their facility experiences short-staff at least occasionally. Almost half of the respondents – 44 per cent – reported they experienced short-staffing at least daily or weekly. Only one in 10 is never short-staffed. Pre-pandemic, this seems like an

incredibly low bar. In the wake of the pandemic, this low bar will have been even more difficult to surmount.

Understaffing Harms Residents

Inadequate staffing means basic care needs of residents – essential to their physical well-being and personal dignity – are frequently delayed or missed entirely.

Less than half of respondents felt the staff-to-resident ratio in their workplace was adequate to provide necessary care; 41 per cent felt it was seldom or never adequate to meet care needs.

About half of respondents felt pressures on staffing were creating conditions of actual harm to residents whose calls went unanswered for longer than was ideal, who were not helped to the toilet in time, and who were not turned sufficiently. Around 40 to 45 per cent of respondents identified actual harm to residents due to delayed assistance with meals and – alarmingly - injuries to residents as the result of inadequate staffing. Incomplete walking and bathing of residents was identified by approximately one-third of respondents.

Understaffing Harms Workers

Survey participants responded about their experience of various injuries and illnesses sustained while working in LTC. Around 30 per cent of respondents experienced some type of illness or injury on the worksite daily or weekly.

Survey participants reported experiencing a wide range of verbal, physical and sexual aggression from residents, residents' family members, and also other staff. Disturbingly, 82 per cent experienced verbal abuse from residents, 57 per cent experienced physical abuse, and 37 per cent experienced sexual harassment. Respondents were clear in linking additional staff to reduced incidence of violence among staff and residents. While 65 per cent of respondents believed more staff would prevent violent incidents, only four per cent did not believe more staff would prevent such incidents.

More than half (53 per cent) experienced mental distress or post-traumatic stress symptoms at work at least occasionally; 22 per cent experienced mental distress at least once a week or daily. A further 21 per cent had taken stress leave, and 54 per cent knew of at least one co-worker who had taken stress leave. The gap between the high number of staff experiencing distress and those who took leave from their job suggests this level of stress is normalized within their workplace.

This was the *status quo* pre-pandemic. The ripple effects of COVID-19 – ill and isolating staff, increased care needs for infected residents, increased duties around symptom checks, sanitizing and personal protective equipment – further reduced the number of hands available for an unimaginable workload, and the time available to provide care. As the pandemic enters its second year, LTC and other health-care workers, already vulnerable to mental health impacts of their work, are now experiencing post-traumatic stress disorder in response to the staggering death tolls in their workplaces.

Profit Status of Facilities Affects Work Conditions and Care Provided

Profit status and the owner-operator model of facilities was also a significant factor in our survey responses. The broad consensus in seniors' care research supports a correlation between profit status and quality of care. On average, for-profit facilities provide fewer hours of direct care per resident per day, and are more likely to have fewer staff per resident. Thus, residents in for-profit facilities are more at risk of adverse outcomes.

When asked whether their facility had adequate staffing to provide quality care for residents, a significant disparity could be seen across ownership/profit categories: 34 per cent of respondents based in for-profit facilities reported they never have adequate staff-to-resident ratios to meet resident needs, compared to just seven per cent for public facilities. Not-for-profit facilities fell in the middle, at 16 per cent.

In the pandemic context, this correlation between profit status and quality of care has contributed to more widespread outbreaks and greater fatalities in for-profit facilities: those with chain ownership, older building design, multiple residents to a room, and/or lower staffing levels are more likely to be run for-profit.

Our survey affirmed alarming issues that similar studies in other provinces have raised, and that workers and unions have been flagging for years in Alberta and across the country. Staffing levels in LTC are rarely adequate to meet the increasingly complex needs of older, more vulnerable residents, and staff are stretched to their limits trying to square an impossible circle.

Staff care about their residents. Staff want to provide individual, unrushed attention to their social and emotional needs as well as daily physical tasks. They want residents to be treated with dignity.

LTC staff value doing their job to the best of their ability, but the conditions under which they work – even before the coronavirus pandemic – often

made this impossible. Now the stakes are even higher. Workers, especially those delivering direct care, risk their health, their families' well-being, emotional distress and even their own lives to provide the bare minimum of care. The pandemic has exacerbated all the long-standing challenges entrenched in LTC, and added new ones, while simultaneously reducing the available staff to meet them.

Based on these research findings, Parkland Institute recommends that:

Staffing

- Alberta must increase staffing levels and consider staffing mix.
- Alberta Health needs to distribute the federally funded pandemic top-up pay to all LTC workers.
- LTC providers should offer equitable pay and benefits for health-care aides.
- LTC providers should create more opportunities for full-time positions.
- The proposed national staffing standards must be tied to funding and enforced through inspection and reporting.

Work-life Quality

- LTC providers should offer mental health supports for direct-care staff.
- LTC providers should ensure adequate staff on every shift to enable workers to take mandated breaks.
- Providers should empower direct-care staff to provide more input into resident care.
- Alberta Health should develop a relational care model to replace activity-based funding.
- Alberta must commit to building a resilient LTC workforce.

Quality of Care

- Remove the profit motive from care by phasing out for-profit ownership and delivery.
- Recognize that laundry, dietary, housekeeping, maintenance and therapy staff have essential roles in LTC – contributing to holistic care of the whole person and supporting a comfortable care environment.

Introduction

For 50 years, Canada and many other countries have generated inquiries, panels, task forces, commissioned reports, media reporting and clarion calls for action to reform conditions in nursing homes and create a higher standard of care.[1]

The fundamental lesson, in the middle of the novel coronavirus pandemic, is the way the virus exposed, exploited and exacerbated the long-standing fissures and flaws in the foundations of Canada's social safety net. Nowhere has this been more poignant – and more sadly redundant – than in long-term care (LTC).

While Canada's overall response to the pandemic during the initial wave was arguably more successful than some countries, for the residents and workers in long-term care it was catastrophic. At more than 80 per cent of all fatalities, Canada had by far the highest rate of COVID-19 deaths among long-term care facilities in the OECD during the first wave – more than double the average of these comparator countries.[2] This staggering gap between Canada's experience and that of other countries is largely attributable to Canada's older LTC population and lower staffing levels.[3] By March 2021, Canada suffered 22,238 deaths due to COVID-19 – 67 per cent of these in long-term care.[4] Long-term-care staff accounted for 25,276 confirmed cases of the virus.

As the landmark report by the Royal Society of Canada Working Group on Long-term Care bluntly observes, the problems are well-known and well-rehearsed and have been extensively studied and dithered about for decades.

> We have decades of evidence that languishes on shelves for many reasons, but at root the problem is a lack of political will to hear hard messages. … The … challenge is not that we lack evidence. We have a great deal of evidence that would contribute to major improvements, but this evidence has not been acted on. We have no shortage of data sources to cite.[5]

As the report notes, more than 100 reports and 150 media articles were written over the last 10 years alone, detailing the challenges faced by Canada's elder-care sector.[6] They invariably centre on reversing underfunding, under-resourcing, and urgent demands to place quality elder care higher up the list of political priorities. The vast volume of scholarly literature, journalistic reports, and advocate accounts conclusively demonstrate that long-term care is in danger, and these problems are periodically revisited by policy-makers

asking, 'Is there still a crisis in long-term care?" Reforms to-date are either short-term, piecemeal fixes to ensure the LTC system can continue to "just manage,"[7] or actually move the goalposts backwards, through increasing privatization and funding cuts.

> But this does not mean that Canada has sufficient data to manage a complex LTC sector … Canada requires data on its own nursing homes, on the residents, on the staff working in them and on the LTC sector broadly.[8]

The challenge for advocates and researchers, however, is that – despite this consensus – there is little systematic data to convey the urgency to legislators. We have mountains of data to support the assertion that there is a problem; what we lack is specific, focused data at the national and provincial levels clearly demonstrating the gaps.

> One prime example is evidence on the right amount and type of staffing. This is, without any doubt whatsoever, one of the most critical components of quality in nursing homes.[9]

The crisis in long-term care hinges in many ways on staffing. During the novel coronavirus pandemic that began in Canada in March 2020, the need for adequate staffing became a matter of life and death, as many seniors' care facilities that had "managed" with the minimum staffing levels were unable to provide even the most basic levels of care for their residents – with tragic consequences.[10] [11] [12]

As Pat Armstrong and other leading experts in elder-care research have repeatedly reminded us, "The conditions of work are the conditions of care." The objective of this report is to generate a snapshot of working conditions in Alberta's long-term care sector, on the eve of the COVID-19 pandemic, to understand what challenges workers faced and why the virus outbreaks (as well as mitigation/containment measures) have been so devastating. This research will provide a crucial insight into the long-standing inadequacies that must be addressed if elder care is to emerge stronger after the pandemic to provide our seniors the quality of care they need and deserve and to ensure workers have the ability to meet those needs.

Why Staffing Levels and Mix Matter for Residents and Workers

Multiple studies have found that increased staffing of direct-care workers – registered nurses, licensed practical nurses and health-care aides – results in fewer negative health outcomes for residents, such as pressure ulcers, infections, incontinence, decline in activities of daily living (ADL), and the need for hospital transfers.[13]

Inadequate staffing levels are strongly correlated to burnout among health-care workers[14] and higher likelihood of workplace injury, and result in high rates of staff turnover – all of which impact the quality of care they are able to provide to residents.[15]

Adequate staffing is thus imperative for the health and well-being of residents and workers.

Long-term Care Staffing Across Canada

Long-term care has been in a deep staffing crisis in most provinces for more than a decade, but warnings from researchers, advocacy groups and workers are increasingly urgent.

> Research in all jurisdictions consistently shows that higher levels of all types of staffing lead to better resident outcomes. Most research studies specify the levels of staffing required to avoid specific adverse events or improve specific quality of care outcomes. Only three US studies address total nursing staff levels needed for quality care in residential facilities; the recommended range is between 3.9 and 4.8 paid hours per resident day.[16]

In recent years, research reports on the state of LTC staffing in Saskatchewan[17], Manitoba[18], Ontario[19] and Nova Scotia[20] detailed conditions of chronic understaffing and a workload antithetical to quality care. British Columbia's Seniors' Advocate released several reports since taking up her office, indicating inadequate staffing in the majority of facilities in the province.[21] In Newfoundland, care worker unions have attempted to raise the alarm on staffing issues in seniors' care.[22] All of this paints a picture of a severe, entrenched, structural staffing crisis in long-term care across Canada, and a sector that was near its breaking point prior to the 2020/21 pandemic.

The Long-term Care Landscape in Alberta

As the extensive evidence from other provinces demonstrates, the problems in long-term care are by no means unique to Alberta; but the specific political context and the funding and regulatory configuration here means those flaws and weaknesses have manifested in different ways and to different degrees.

It also means the decisions made around COVID-19 containment in Alberta occurred within a vastly different context than in Ontario or British Columbia; for example: a government ideologically hostile to publicly provided continuing care, actively engaged in confrontation with health-care unions, and reluctant to enforce public health measures. The results have been disastrous: as of Jan. 18, 2021, there were 1,007 active and 7,248 recovered cases at long-term care facilities and supportive/home living sites in Alberta.[23] By March 2021, of the total 1,914 deaths due to COVID-19 in the province, 1,215 (approximately 64 per cent) were in long-term care facilities or supportive/home living sites.[24] This figure has changed little since the pandemic began – decreasing only slightly during the second wave, when extensive community spread caused increased fatalities outside of and within LTC facilities. Despite the measures imposed and the repeated calls for action by everyone from staff to advocacy groups to the premier himself, why have two-thirds of COVID-19 deaths in Alberta persistently occurred among our seniors in residential care?

There were approximately 27,000 individuals in continuing care facilities in Alberta in March 2020, an increase of nearly 7,000 over 2016/2017.[25] Of these, 15,665 beds were in regulated long-term care facilities.[26] Around 80 per cent of residents were aged 75 or older and 59 per cent had a diagnosis of Alzheimer's or other dementia-related cognitive illness. Medical complexity and instability (measured with a CHESS score) is higher in Alberta LTC residents than among our provincial counterparts, which adds to the care needs of residents and the workload required to meet those needs.[27] Between 2011/12 and 2016/17, there was a significant increase in residents requiring extensive assistance with daily activities, such as dressing, personal hygiene, toileting, feeding and mobility.[28] Research undertaken in 2016 by the United Nurses of Alberta indicated Alberta had the highest per centage of clinically complex residents in long-term care among the Canadian provinces.[29]

Staffing, however, has not increased substantially in line with these increased needs. This means health-care aides, nurses and other direct-care staff are increasingly challenged to provide basic levels of care under more difficult conditions.

In Alberta, as in most other provinces, long-term care is delivered by a mix of public (provincial), and private (for-profit and not-for-profit) providers. LTC straddles an awkward space between health care and housing that has resulted in only the medical care of residents being covered by provincial funding. Residents and their families pay for the accommodation portion of their care, at varying rates depending on income and the type of facility where they reside.

Table 1: Long-term Care Beds and Facilities by Profit Status

Health Zone	AHS		Private for-profit		Not-for-profit	
	Facilities	Beds	Facilities	Beds	Facilities	Beds
South	12	243	3	288	2	35
Calgary	14	1,117	14	2,379	10	1,603
Central	23	1,058	2	133	8	474
Edmonton	8	1,048	14	1,694	14	2,118
North	23	780	4	226	1	30
Total	**80**	**4,246**	**37**	**4,720**	**35**	**4,260**

Source: Alberta Health Services Annual Report 2019-2020, 120.

Staffing Regulations and Quality of Care Metrics

Alberta stands out among the provinces as one of only two with legislated minimum staffing guidelines. However, this benchmark – 1.9 hours of direct care per resident day – is far below the widely cited 3.9-4.8 hours currently recommended, and less than one-third of the hours required to meet increasingly complex care needs and precautions during the pandemic.[30]

However, Alberta Health (via AHS) provides funding for 3.6 hours of paid care per resident day (hprd), plus an additional 0.4 hprd of allied health services such as physical or recreational therapy – seemingly a tacit acknowledgement of the minimum threshold for adequate care.[31] There is no systematic monitoring of whether this level of care is actually delivered. No independent studies have verified the actual delivery of care hours in Alberta long-term care facilities.

A 2014 report by the Auditor General found the level of monitoring mandated by AHS did not provide answers to the most fundamental questions about long-term care.

> For the families, long-term care is not an issue of organizing work and allocating resources. They have simple and direct questions. Will our parents be fed properly and at reasonable times? Will they be kept clean rather than left for long periods in their own wastes? Will they have people to talk to rather than being left alone for hours, drugged by sedatives? Will they receive prompt medical treatment whenever necessary?
>
> For the residents, long-term care may come down to an even simpler test: Am I reasonably happy here?[32]

The auditor general recommended AHS put measures in place to verify that long-term care facilities provide residents with an adequate number and level of staff every day and meet residents' basic needs.

In the midst of the coronavirus pandemic, more than six years after that report was released, a request by CBC to AHS was unable to fully answer if those recommendations had been met, or how.[33] Facilities are required to submit staffing data annually to AHS, which is then audited. Homes may also be subject to biennial audits to ensure they meet legislated care standards. This self-reporting has loopholes, and audits are few and far between.

Along with Nova Scotia and Ontario, Alberta is one of the few provinces where regulators can issue fines to long-term care providers for failure to meet standards of care, although only Ontario has ever done so, and rarely.[34]

In February 2021, the current auditor general for Alberta, Doug Wylie, announced his office would undertake an audit of the province's pandemic response in long-term care and determine what measures (if any) were taken to implement his predecessors' recommendations.[35]

The Relevance of Profit Status

The broad consensus in seniors' care research supports a correlation between profit status and quality of care.

McGregor et al.'s 2005 study of 167 LTC facilities in British Columbia (all of which received the same funding and were staffed by affiliates of the same union) found the number of hours per resident-day was higher in the not-for-profit facilities than in the for-profit facilities for both direct-care and support staff and for all facility levels of care. Not-for-profit status was associated with an estimated 0.34 more hours (approximately 20 minutes) per resident-day provided by direct-care staff and 0.23 more hours (nearly 15 minutes) per resident-day provided by support staff (primarily dietary and therapy aides). The authors concluded public funding "purchases significantly fewer direct-care and support staff hours per resident-day in for-profit long-term care facilities than in not-for-profit facilities."[36]

A report for Parkland Institute in 2016 found "public facilities are the only ones that on average over the three years examined spend most of their revenue on nursing staff." On average, private LTC facilities spent 11 per cent less on nursing staff than their public counterparts, which spent nearly 59 per cent. Not-for-profits were even lower, with at least 44 per cent of revenue spent on nursing staff.[37]

Earlier research demonstrated how facilities' investment in staffing related to money spent on direct care: "In 2009, not-for-profit operations expended $46.94 more on direct care for each resident every day than did for-profit facilities. In the LTC sector, over the entire decade under study, public and not-for-profit operators spent significantly more on direct care than did for-profit operators. In 2009, for instance, public facilities spent $71 more on direct care per resident per day than did forprofit facilities."[38]

In British Columbia, the Office of the Seniors' Advocate reported that for-profit care homes failed to provide several hundred thousand care hours for which they received government funding. Public and not-for-profit homes significantly overdelivered in terms of hours of care.[39]

In the pandemic context, this correlation between profit status and quality of care contributed to more widespread outbreaks and greater fatalities in for-profit facilities; those with chain ownership, older building design, multiple residents to a room, and/or lower staffing levels are more likely to be for-profit.

> While many of the factors contributing to the tragedy in long-term care facilities are the result of underfunding, privatization is making the situation worse. In most provinces, the effects of the COVID-19 pandemic are more serious in for-profit long-term care facilities than in public or not-for-profit facilities. …
>
> Many not-for-profit and publicly owned long-term care homes are also being hit hard by the COVID-19 pandemic. But the data from Manitoba, Ontario, and Quebec show that for-profit ownership exacerbates the consequences of the pandemic.[40]

According to a meta-analysis (a study of available studies) by McGregor and Harrington, the "evidence clearly shows that ownership matters when it comes to staffing, and staffing matters when it comes to managing outbreaks of COVID-19 in LTC facilities."[41]

With all this evidence, why then have provincial governments been so resistant to phasing out for-profit care? In Alberta, "The provincial government continues to fund for-profit long-term care facilities despite the fact that they provide an inferior level of care compared to publicly run facilities".[42]

In fact, the 2019 Ernst & Young report explicitly recommended the province (AHS) sell off publicly owned and delivered LTC facilities under the CareWest and CapitalCare umbrellas, alongside increasing fees for residents.[43] As researcher Alison McIntosh points out, "Alberta has substantial private and non-profit participation in designated supportive living (DSL) and long-term care (LTC). Reducing public provisioning of DSL and LTC has proven negative impacts on working and living conditions at these sites. … Instead, Alberta should expand its publicly owned and operated DSL and LTC facilities to ensure better work and care conditions for all patients."[44] An initiative pushed through ahead of the Continuing Care Review (currently underway at the time of writing) encouraged large LTC chains to invest in taking over delivery of care in "surplus" publicly owned facilities: "The Alberta government says it will create "hundreds" of continuing care spaces through a new bidding process for non-profits and private businesses. … Spokeswoman Tara Jago said any spaces contracted through the bidding process will receive operating funding through AHS but no capital funding for renovation or construction."[45]

The chain ownership and delivery of for-profit LTC also has consequences for the distribution of funding – and wealth:

As of 2013, in Alberta "the private LTC sector is limited to just 13 companies, with nearly half owned by two major, multi-national corporations: Revera and Extendicare."[46]

Large, multinational corporations, as well as small- and medium-sized companies, are currently paid to operate long-term care homes by the same government that operates its own facilities through Alberta Health Services (AHS). These corporations profit from the delivery of health care to seniors, which inevitably means the diversion of public funds from front-line service delivery to the personal bank accounts of corporate shareholders.[47]

During the coronavirus pandemic, several large for-profit chains claimed benefits via the federal Canada Emergency Wage Subsidy (CEWS) program, which was intended to assist employers in maintaining workers' salaries amid the public health restrictions. Yet several LTC corporations – including two of the largest in Canada, Extendicare and Chartwell – collected CEWS benefits while paying out record dividends to their shareholders.[48] Meanwhile, their facilities were among the hardest hit by the COVID-19 virus.[49]

All of this illustrates that conditions in Alberta's long-term care sector were already far from ideal: medically complex residents, a mixed delivery model privileging for-profit and chain ownership, and little accountability or transparency on staffing levels.

The Survey

In collaboration with CUPE Alberta, researchers from Parkland Institute developed a survey to ask long-term care workers specific questions about their jobs and whether their working conditions supported their ability to provide care. These questions (full question template attached as Appendix 3), focused on staffing levels, overtime and time required to complete essential tasks. Workers were asked about their experience of injury, violence and emotional distress in the workplace. We also asked workers about how these conditions impacted residents, and their own physical, mental and emotional well-being.

The survey was distributed via CUPE-AB to their membership in long-term care facilities via local chapters. Participation was entirely voluntary and anonymous, and respondents were able to complete the survey online (using the Qualtrics platform) or in hardcopy. Responses were received between October 2019 and the end of March 2020. It was decided by the researchers, in consultation with CUPE-AB, to close the survey early due to the detrimental impacts of the COVID-19 pandemic in long-term care, including hampering workers' ability to undertake additional paperwork when already stretched to their limits, and also potentially skewing the results as staffing levels reacted to illness outbreaks and government- and employer-imposed restrictions (in particular, the single-site working policy enacted mid-April 2020). We received 370 surveys: 166 paper surveys and 204 online responses.

Many questions in the survey were structured around a Likert-style scale, giving respondents a range of options to indicate the degree of their experience. Several questions in our survey offered an opportunity for respondents to provide additional information in short-answer format. The responses to these open-ended questions allow us to foreground LTC workers' unique experiences in their own words, to trace patterns and common ground, and to identify perspectives and concerns we may have missed as researchers.

Our analysis of the survey responses posited four thematic questions as cornerstones: Demographics: who responded? Staffing: where are the gaps? Impact: how do staffing levels affect residents and workers? Equity: are some impacts felt more deeply than others (by others)?

Some responses have been condensed or combined for the purposes of this summary, for brevity or to convey the most relevant results. Due to rounding, responses may not total 100 per cent.

Who are the LTC Workers? Respondent Demographics

As the survey was distributed through CUPE-Alberta locals, all respondents were members of the union at the time of participation. Due to the nature of the survey and the distribution method, all participants were self-selected.

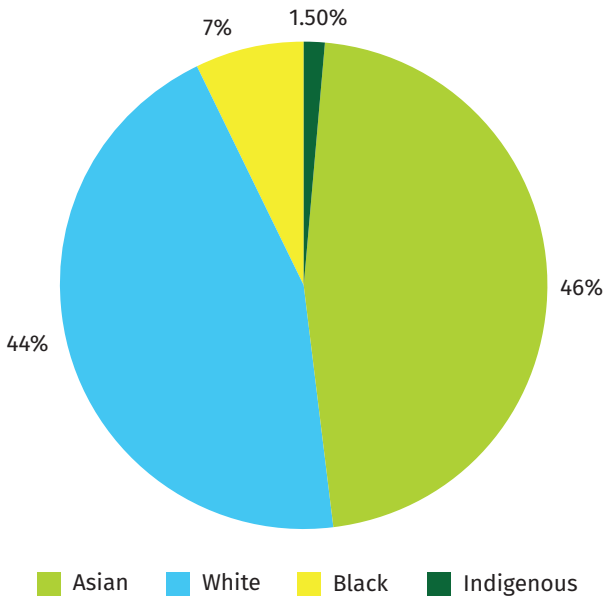
Gender, Language and Ethnicity

The overwhelming majority of our survey respondents identified as female: 93 per cent. This is consistent with data on LTC workers in Canada's comparator countries.[50]

Approximately six in 10 respondents (61 per cent) spoke English primarily at home, while 27 per cent spoke Tagalog. Nineteen other languages were represented. Eighty-four per cent were Canadian citizens.

A slight majority of respondents (46 per cent) identified as of Asian ethnicity; while 44 per cent identified themselves as white. Black and Indigenous respondents comprised seven per cent and 1.5 per cent, respectively.

Chart 1: Respondents by Racial Identification

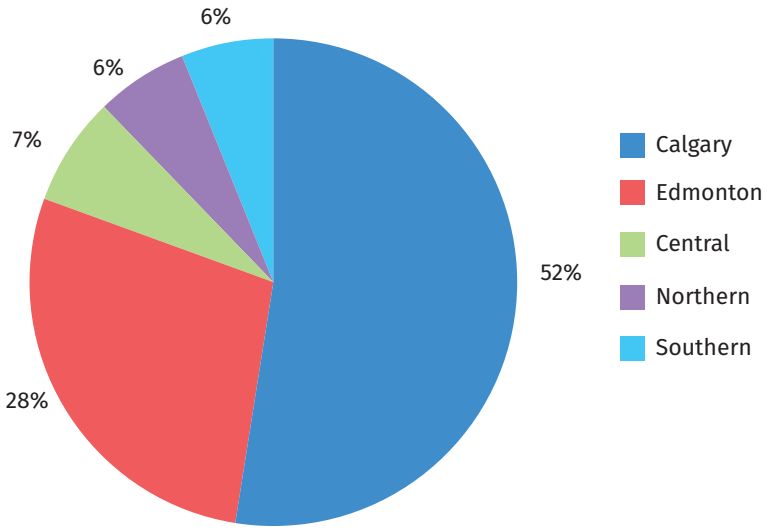


These demographics are generally in line with recent studies of long-term care workers in Canadian prairie provinces.[51]

Location

Our respondents were concentrated heavily in the Calgary Health Zone, and to a lesser extent, the Edmonton Zone.

Chart 2: Respondents by Alberta Health Zone



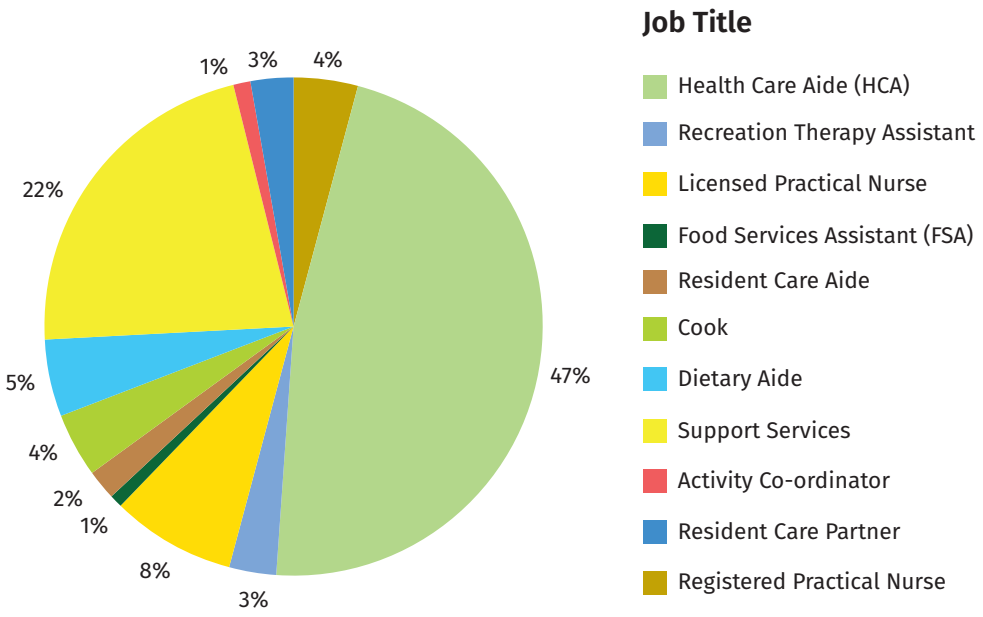
While the responses to our survey approximately equate to the urban/rural distribution of Alberta's population (around 81 per cent of Albertans live in urban areas), the results of our survey may skew toward working conditions in the province's two largest cities and under-represent the experiences of workers in small town, rural or remote locations. Research comparing urban facilities with those in rural or remote areas is sorely lacking across Canada, and policy approaches to seniors' care would be enhanced by a focus on the experiences and needs of these areas.

Survey Respondents by Job Title

Respondents performed a diverse range of roles in long-term care.

The largest proportion of our respondents – nearly half – were health-care aides. These unregulated care workers[52], called personal support workers or personal-care aides in some provinces, provide up to 90 per cent of the direct care in long-term care settings.[53]

Chart 3: Respondents by Job Title



While there have been a handful of thorough studies conducted in the last 10 years focused specifically on health-care aides in prairie provinces, as one leading researcher notes,

> At present in Canada, we can offer only a partial and unsatisfying response to the question, 'Who is looking after Mom and Dad?' We have an even sparser picture of care aide working conditions, health indicators, and work-life quality indicators – all areas that influence the quality of care.[54]

To understand the full picture of how care is delivered to seniors in LTC facilities, we need to know who is providing that care, under what conditions, and with what constraints. How can direct-care workers be better supported so they in turn can better support the residents under their care?

As researcher Carol Estabrooks notes, "Care aides are both a neglected and socioeconomically disadvantaged workforce, as well as a critical source of emotional and social support for residents."[55]

Studies of the health-care aide (or personal support worker) workforce in Canada show clearly they are not being supported under the *status quo*, and the physical and emotional burdens of the pandemic have only heightened workers' risk of exhaustion and burnout.

> While the majority are highly satisfied with their jobs, they work in a resource-constrained environment, with more than 70 per cent of care aides reporting moderate to high risk for emotional exhaustion – and that's before the pandemic.[56]

Estabrooks and her collaborators found this strain on the caregiver workforce has been relatively stable between 2009 and 2020 – but that "stability" is deceptive. It masks the reality of more than a decade of unchanging conditions for workers who were just able to manage despite the emotional and physical pressures placed on them. And it means these workers had little breathing room to absorb the additional emotional costs of the pandemic. Health-care aides, in Alberta as across Canada, are "an at-risk group caring for an even more at-risk resident group—a perfect storm for crisis, as the world has observed."[57]

In addition to the increased strain on direct-care workers, the challenges brought to the fore during the pandemic highlight that support services, cleaning and maintenance, and food services must be more widely recognized as essential elements in the provision of quality care for residents. Armstrong & Cohen note that all work in LTC contributes to the provision of care.[58] Yet their work experiences have not been widely explored in long-term care, and their role is frequently downplayed. These positions are also often first on the chopping block for layoffs and out-sourcing.[59]

Where are the Gaps? Staffing and Workload

Time

One of the most important objectives of this survey was to determine how much time LTC workers have in their work day to do their jobs, whether that time is sufficient to do their job to the highest standard, and whether they feel lack of time impacts residents.

Time – rather, lack of time – emerged over and over again as a significant concern for respondents.

When asked, "If you had more time during your work day, what would you do?" [Appendix 1, Question 11], many respondents provided an exhaustive account of additional tasks that could be accomplished. A majority of respondents stated additional time would simply enable them to complete the necessary tasks assigned to their role. This suggests the norm for many staff is a workload that cannot be accomplished in one shift with one set of hands.

In this open-ended question, nearly one-quarter (23 per cent) of survey participants indicated unprompted that there could not be "more time," as there was always more work to be done. Ten respondents (five per cent) would use their time to help coworkers finish their duties, while several

others would prepare work ahead of the next shift – to pay that extra time forward to the workers coming in after them.

The restrictions on visitors imposed during the COVID-19 pandemic exposed the extent to which staff relied on residents' loved ones to perform essential care tasks. In its survey of family experiences of LTC conditions during the pandemic, the Health Quality Council of Alberta heard that

> They [family of residents] attributed declines in care quality to insufficient staffing levels that the pandemic exacerbated, staff that were overwhelmed by pandemic-related tasks, and their inability to visit as they normally did to supplement the care provided by staff, for example, at mealtimes.[60]

The situation had become normalized; a 2013 Parkland study noted that

> In Alberta LTC, friends and family of elders have been obliged to either pay for additional services, or to provide these services themselves, in order to ensure that their loved ones receive a very basic standard of care. Inadequate care throughout the LTC system has resulted in rampant offloading onto the friends and family of elders. This situation also raises concerns about elders who may lack such personal support networks.[61]

A survey conducted by the B.C. Seniors' Advocate found that, before the pandemic, 55 per cent of families were visiting long-term care and assisted living residents for an hour or more several times per week and even daily, and performing essential care for residents, such as personal care, grooming, assistance with feeding and mobilization.[62]

According to Campanella and Stunden Bower, "the costs of offloading are not borne solely by those with intimate involvement in the elder care system. Rather, caregivers' families, their employers, and even society at large bear the related costs."[63]

With access to residents severely limited (or cut off entirely), these tasks were reallocated to already overloaded health-care aides, or left undone. After the Canadian Armed Forces intervened in Ontario and Quebec facilities, many soldiers were tasked with this care work — feeding, cleaning and walking residents.[64]

Workload

How often do you have adequate time to perform required tasks?

Daily – 57% At least once a week – 9.5% Occasionally – 25%
Never – 8% N/A – < 1%

Nearly half of respondents – 43 per cent – *do not* have adequate time to complete required tasks consistently every day. One-quarter only occasionally have adequate time to complete their required tasks during their shift.

How often do you have necessary tasks undone at the end of shift?

Every day – 10% At least once a week – 16% Occasionally – 50%
Never – 24%

The flip side of the question regarding adequate time: Approximately three-quarters of respondents had necessary tasks left undone at least occasionally; 26 per cent had tasks undone at least daily or once per week. Only 24 per cent – less than one-quarter – stated they never had essential tasks outstanding at the end of a shift.

Consequently, staff are left with few options: leave important aspects of their job – including care tasks – undone, or stay late to finish. Seventy per cent of respondents stayed beyond the end of their shift at least occasionally (occasionally, daily or once a week). Nearly one-quarter – 24 per cent – stayed late either daily or once per week. It is clear from these responses that staying beyond the end of their shift to ensure all essential tasks are done is the norm for many LTC workers.

Do you ever have to stay late to finish necessary tasks?

Daily – 10% At least once a week – 15% Occasionally – 45%
Never – 30%

As Baines and Armstrong note, staying late or working additional unpaid time to provide care is a highly gendered dynamic: women were much more likely to stay late due to social and moral pressures. "Unpaid care work is saturated with gendered assumptions on the part of the state, management and workers that women will sacrifice to ensure the wellbeing of others." In interviews with personal support workers or health-care aides, women reported that

They often put in extra unpaid hours to complete their regular workload, in the words of one worker, 'because we care'. Another noted that she and her colleagues worked unpaid hours and knew that it made them tired and stressed but explained that, 'Because we care about people, we are our own worst enemy.'[65]

With more time, I could …

Finish up required tasks instead of designating to the next nurse.

Finish necessary tasks so that I don't have to endorse to the next shift.

Help people who are behind; help others to finish their jobs.

I hate leaving one person on [after my shift ends] to clean up and do the dishes.

Many respondents highlighted a concerning lack of time for cleaning. While the legislated standards for continuing care accommodation require "that the operator provides a clean and comfortable environment,"[66] there are no quantitative measures to assess adequate cleanliness. In its 2017 quality assessment survey of long-term care facilities, the Health Quality Council of Alberta asked residents' family members a number of questions regarding the environment of the long-term care facility. Most of the respondents felt their loved one's facility was not cleaned frequently or thoroughly enough and smells were not adequately managed.[67] Among our respondents who reported working short-staffed (daily, once a week, or occasionally), a significant proportion were employed in housekeeping or food preparation (10 per cent and nine per cent respectively).

If I had more time I could …

More thoroughly clean rather than [just] what was necessary

Clean walls

Do extra cleaning

Do personal laundry, clean up linen room or patient room

In the ongoing context of the COVID-19 pandemic, the lack of time to thoroughly perform cleaning tasks and inventory or refill supplies could have dangerous consequences as surfaces, linens and communal areas contribute to virus transmission if not properly sanitized. Additional cleaning also included residents' personal items and spaces, which were not maintained on a daily basis. In the 2017 HQCA survey, many family members said their residents' laundry often needed to be laundered at home and resident rooms were not regularly cleaned.[68] This work was frequently downloaded to family members by default.

In the Extendicare Parkside (Saskatchewan) facility outbreak, COVID-19 positive residents were moved to unoccupied rooms (because of four-person rooms), and negative residents were moved to occupy those rooms. Staff raised concerns about the sanitization of spaces that had housed positive residents:

According to a staff member interviewed by CBC:

> Making matters worse was that during room changes, "there wasn't additional housekeeping staff on to make sure that the rooms were completely scrubbed down," according to the male employee.
>
> "Beds were wiped down, bed rails were wiped down," he said. "But those curtains, which are notorious for harboring bacteria and viruses, wouldn't have been cleaned."[69]

Other respondents hinted at the "extra, extra tasks" that often remained when the essential work had been completed – work that would normally require staying late, delegating to other staff, or leaving undone entirely.

In a survey of their membership working in seniors' care conducted between 2005 and 2006, CUPE Alberta found that recent changes to the sector significantly impacted staff working conditions in a number of ways:

- 75 per cent perceived an increased workload of both regular duties and new duties
- 78 per cent reported an increase in work-related stress
- 68 per cent reported increased health and safety concerns due to workload demands[70]

Fourteen years later, our survey found these concerns were not alleviated for long-term care workers – in fact, they had been persistent and, in some cases, more widespread.

In the 2006 CUPE-AB survey, "respondents reported that they were working additional overtime (35%) or overtime hours were needed but there was no budget (43%). Twenty three per cent (23%) reported that they worked extra hours without pay in order to keep up with work that needs to be done."[71] By 2020, that number had increased substantially: 41 per cent of our respondents who worked beyond their shift said they did not receive overtime pay for working late.

How often does your facility work short staffed?

Daily – 18% Once/week – 25% Occasionally – 45% Never – 10%
N/A – 2%

In total, 90 per cent of respondents reported their facility is short-staffed at least occasionally. Forty-four per cent reported short-staffing at least daily or weekly. Only one in 10 is never short-staffed. Pre-pandemic, this seems like an incredibly low bar. In the wake of the pandemic, this low bar is even more difficult to surmount.

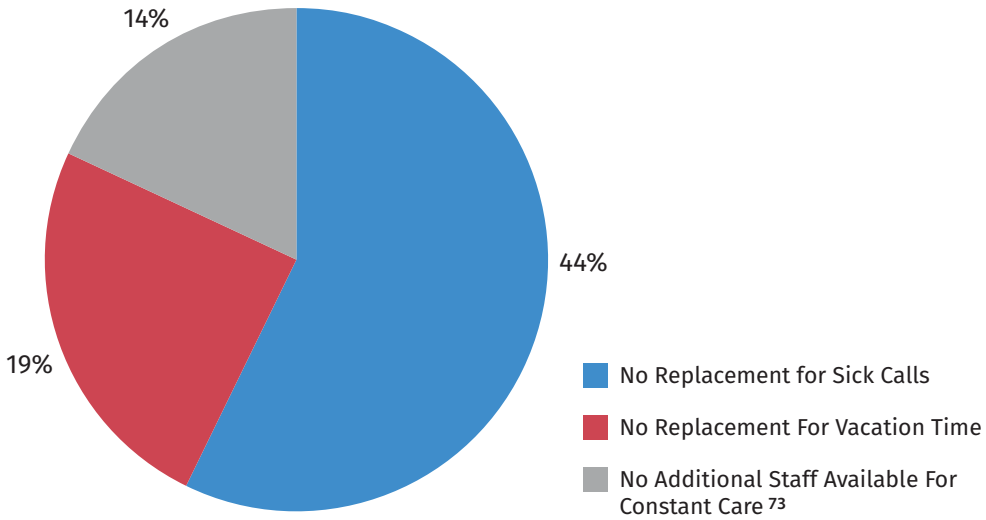
How often do you do tasks that are out of scope of your role?

Daily – 20% Once/week –8% Occasionally – 46% Never – 24%

This means that three in four respondents at least occasionally have to work out of scope of their job description and role. Within the survey data, there was a significant degree of correlation between those who said they work out of scope and those who reported working short-staffed. The largest group of respondents who worked short daily, once/week or occasionally were health-care aides (36 per cent). Support services made up 18 per cent of those who worked short. Cooks and dietary aides also reported working short (nine per cent).

When facilities are short-staffed, respondents were asked to provide the main reason. For 44 per cent, the shortage was due to replacements unavailable for sick calls. Given that this was asked prior to the pandemic, we can only surmise that facilities will have even more difficulty filling in for sick staff members or those who have been forced to isolate due to COVID-19 exposure.[72] Reports from Ontario indicate many facilities hit by outbreaks have relied heavily on recruiting agencies to provide temporary staffing cover, while in Alberta, chief medical officer Dr. Deena Hinshaw offered exemptions to the single-site policy to permit short-staffed facilities to bring in workers from other sites. In both situations, to prevent complete staffing collapse, staff were inter-mingling in multiple sites during outbreaks.

Chart 4: Reasons for Working Short-Staffed



With no cover for vacation or sick time, LTC workers are at increased risk of working until burnout, coming to work sick, or working double shifts to cover for those absent. These conditions reinforce each other, creating an environment in which bare-minimum staffing is perceived as the norm, and staff are under implicit pressure to avoid taking sick days, personal days or holidays. Not only does this exacerbate the risk for worker exhaustion and burnout, but also increases the likelihood of staff working while ill. The COVID-19 pandemic has underscored the life-or-death implications of bringing illness into LTC facilities; however, staff working while ill always has potential for deadly consequences during localized viral outbreaks.

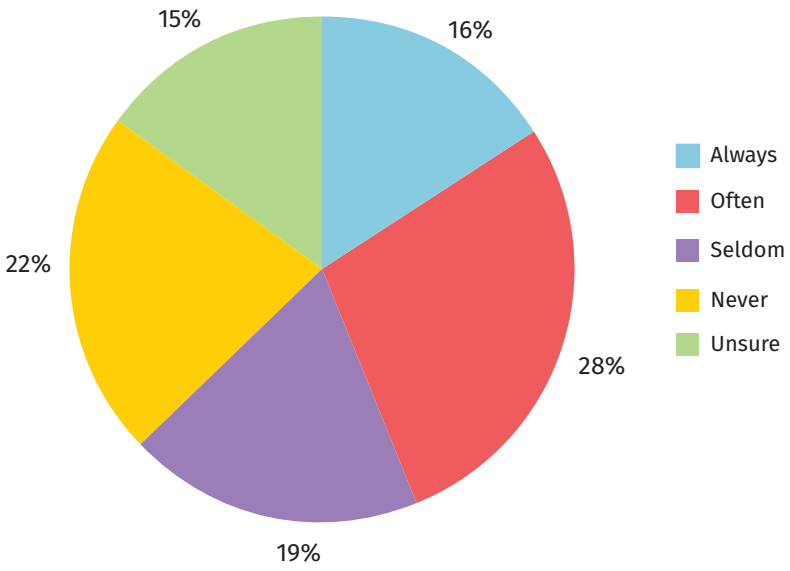
Impacts: The Effects of Short-Staffing on Residents and Workers

Impacts on Residents

Inadequate staffing means basic care needs of residents – essential to their physical well-being and personal dignity – are frequently delayed or missed entirely.

Less than half of the respondents felt the staff-to-resident ratio in their workplace was adequate to provide necessary care; 41 per cent felt it was seldom or never adequate to meet care needs, while 15 per cent were unsure.

Chart 5: Are Staff-to-Resident Ratios Adequate to Meet Resident Needs?



The wording of the question deliberately leaves the definition of "adequate" and "necessary care" to the discretion of the respondents. This is not to rely on vagueness, but because this language is centred in the regulatory and legislative coding of seniors' care. From the open-ended questions on time, staff generated a picture of "necessary care" as a relationship that allows for a resident's physical, emotional and social needs to be met in a timely and dignified manner. While the exact ratio of staff to residents, or the precise number of hours of care survey participants deem "adequate" is not asked, it is clear that for the majority of respondents the level of "adequate" care was simply not realized under their current working conditions.

Importantly, though, the per centage of respondents who were "unsure" was quite significant – 16 per cent, or approximately one in six. Potential explanations for this are speculative; however, the number may reflect the perceptions of staff who do not work in a direct-care role and perhaps feel less qualified to comment on levels of care. On a more abstract level, it may be indicative of a dissonance between levels of care that are "adequate" in a regulatory sense, but that feel morally or ethically inadequate. Ultimately, the most painful lesson of the coronavirus pandemic has been a national awareness of the "inadequacy" of a care system that Canadians had collectively considered sufficient.

For staff who responded to our survey, the pressures they faced before the pandemic already posed substantial, detrimental consequences for residents.

Survey participants were asked to identify "the potential or actual hazards to residents from your work site's workload/staffing situation." For approximately half of respondents, pressures on staffing were creating conditions of actual harm to residents whose calls went unanswered for longer than was ideal, who were not helped to the toilet in time, and who were not turned sufficiently. Around 40 to 45 per cent of respondents identified actual harm to residents due to delayed assistance with meals and – alarmingly – injuries to residents as the result of inadequate staffing. Incomplete walking and bathing of residents was identified by approximately one-third of respondents.

Table 2: Perception of Harms Caused by Understaffing

Harm to Residents	% Perceived as Actually Occurring	% Perceived as Potentially Occurring
Delayed Answering of Call Lights	58	26
Delayed Assistance with Toileting	52	30
Delayed or Insufficient Turning of Residents	50	28
Delayed Assistance with Meals	45	31
Resident Injury	41	36
Walking Residents Incomplete	38	32
Bathing Residents Incomplete	32	33

The workers' perceptions of actual or potential harms residents may face as a consequence of under-staffing are confirmed by a recent study conducted under the Translating Research in Elder Care (TREC) project, which examined work-life quality experienced by health-care aides in Canada. While 43 per cent of our respondents reported working short-staffed either daily or once a week, Song et al. (2020) found one-half of health-care aides worked short-staffed either daily or weekly.[74] One possible explanation for the difference in results is that our survey included only unionized workers, who have a procedure for raising concerns around staffing and other issues. We also included all CUPE-affiliated job categories within the care facilities, not just health-care aides; from this we might presume that care aides are more likely to work short-staffed than staff in other roles. This is broadly confirmed by the responses to our survey: the vast majority, 62 per cent, of those who worked short – daily, once a week, or occasionally – were direct care staff in HCA, LPN, RN or recreational therapy roles.

In the TREC study, care aides reported frequently having to rush or skip essential care tasks in their most recent shifts, which was a significant theme among our survey responses. For the care aides who participated in the TREC study, walking residents and talking with them were the most frequently missed elements of care. Basic hygiene tasks, such as mouth care, toileting and bathing, were also left undone between 10-15 per cent of the time, while even feeding was missed six per cent of the time.[75]

Many of our survey respondents felt the pressures of workload and lack of time for them also put pressure on residents to rush their daily activities.

With more time, I could …

Provide a resident focus rather than task focus; proper resident care on their time, instead of waking them …

Spend more time with residents, so they do not feel rushed.

That basic physical care rarely left time for the personal care that most of us take for granted: being assisted to the toilet when we need to go, or help with shaving, nail and hair care. Many respondents expressed a desire to make time for these tasks.

Staff under time pressures also felt the social and emotional needs of their residents were sacrificed to complete basic physical care.

With more time, I could …

Not have to rush and have enough time to spend with residents.

Spend more time with the residents talking or doing activities they enjoy. I wouldn't have to rush in and out all the time.

Socialize with residents while doing care.

Spend more with residents, read with residents, bring them a fresh or hot drink.

Rushing to complete basic tasks also had safety implications for residents. Several respondents commented that any additional time in their shift would be used to "look after the residents who are fallers" or "watch residents who are in the hallway." Worryingly, this suggests higher-risk residents might not be adequately supervised when staff are short-handed.

When staffing shortages and care needs increased exponentially during the COVID-19 pandemic, the amount of time available for these most essential of human needs would have decreased dramatically – resulting in some cases in the disturbing accounts of neglect related by the Canadian Forces report.[76] At the same time, due to public health restrictions, family caregivers were unable to pitch in as they normally would, resulting in a higher workload for care workers. Staff would also have had increased demand to provide updates to family members expecting regular contact with their loved ones, and new, potentially unfamiliar, tasks like managing technology for residents.

For some workers, the prospect of "more" or "extra" time was unfathomable: several respondents bluntly stated that they just never have more time.

> *[I] never have more time – always overloaded with work.*
>
> *So many things to do, we're always rushing to finish.*
>
> *[I] don't have more time.*
>
> *No time at all times.*
>
> *[There's] not enough time because lack of staff due to pandemic.**

* This survey was received by the researchers in early March 2020, at the very beginning of the COVID-19 pandemic in Alberta.

These recent studies, the Armed Forces' observations, and our survey results reaffirm the paramount importance of staffing for provision of care. As articulated by Pat Armstrong and Donna Baines,

> Promoting care as a relationship requires adequate staff and an appropriate staff mix.
>
> Over and over again in Canada especially we heard "there are not enough hands". In Sweden we saw almost one staff member for each resident compared to one staff member for five residents in Canada. Staff had more time to respond, to take residents to the toilet and to help them eat, more time to chat and to sing. As a result, levels of violence and of drug use were significantly lower, providing just two indicators of how staffing levels influence workers and residents.[78]

For many of our respondents, the lack of time to accomplish more than the essentials was expressed in a desire to "do better" – to provide better quality work rather than a breathless rush:

> With more time, I could …
>
> *Learn more about my job and how to do it better – using the relaxed atmosphere for leisure (usually [I am] rushing to keep up).*
>
> *Do my work better than rushing.*
>
> *Actually take my time and go above and beyond.*

Impacts on Workers

Burnout, Workplace Injury and Incidents of Violence

Care workers are under incredible stress, exacerbated by the conditions of working and the behaviours of residents and interactions with other staff. Inadequate staffing means an increased risk of harm to staff and residents.

Survey participants responded about their experience of various injury and illnesses sustained while working in long-term care. Around 30 per cent of respondents experienced some type of illness or injury on the worksite daily or weekly.

More than half (53 per cent) experienced mental distress or post-traumatic stress symptoms at work at least occasionally; 22 per cent experienced mental distress at least once a week or daily.

These mental and emotional effects impacted respondents' ability to continue working, and their colleagues: 21 per cent had taken stress leave, and 54 per cent knew of at least one co-worker who had taken stress leave. It is also telling that there is a significant disparity between respondents who experienced symptoms of mental distress or PTSD (53 per cent) and those who took stress leave (21 per cent). This gap suggests many workers experiencing high amounts of work-related stress felt unable to take leave from their job, or that stress is normalized within their workplace.

A report from the Ontario Health Coalition, released mere weeks before the onset of the pandemic in Canada, cited burnout and compassion fatigue as significant problems among personal support workers "who have to cope with grief as residents die; high expectations from families, management and government; stressful workloads and inadequate (or non-existent) emotional support."[79]

This was the status quo pre-pandemic. The ripple effects of COVID-19 – ill and isolating staff, increased care needs for infected residents, increased duties around symptom checks, sanitizing and personal protective equipment – further reduced the number of hands available for an unimaginable workload. The pandemic "has demanded extraordinary physical and mental effort from healthcare workers."[80] In an interview with CBC's Dr. Brian Goldman, a personal support worker from Ontario described the pressure she felt to continue to work, even when she experienced COVID-19 symptoms: "We were already working short. … We are losing PSWs because they are getting too exhausted, and they are burnt out."[81] In their study of health-care workers in Ontario during the pandemic, Brophy et al. (2021) affirmed this:

> [Health-care workers] reported that the risk of contracting COVID-19 and infecting family members has created intense anxiety. This, in conjunction with understaffing and an increased workload, has resulted in exhaustion and burnout. HCWs feel abandoned by their governments, which failed to prepare for an inevitable epidemic, despite recommendations. The knowledge that they are at increased risk of infection due to lack of protection has resulted in anger, frustration, fear, and a sense of violation that may have long-lasting implications.[82]

As the pandemic enters its second year, LTC and other health-care workers, already vulnerable to mental health impacts of their work, are experiencing post-traumatic stress disorder in response to the staggering death tolls in

their workplaces.[83] A recent study by Italian researchers "found the available findings highlight the presence of trauma-related stress, with a prevalence ranging from 7.4 to 35%, particularly among women, nurses, frontline workers, and in workers who experienced physical symptoms. Future studies should clarify the long-term effects of the COVID-19 pandemic on the mental health of healthcare workers, with particular focus on posttraumatic stress disorder."[84]

Prior to the pandemic, many of our survey respondents noted they worked non-stop throughout their shift and frequently missed breaks. The stress of rushing was reflected in the desire of many respondents to use their hypothetical "extra time" for basic self-care.

With more time, I could …

Take all my breaks and give quality time to residents.

Use my break – now I sacrifice my break in order to catch up with my workload.

Have less stress and burnout, put more time into my work, create new projects, and make things easier.

Take better care of myself.

Rest.

One respondent simply answered: *Tired*.

Inequity, Harassment and Discrimination

As the coronavirus pandemic has unfolded, it has exposed deeply entrenched systems of inequality; but while there is new awareness, these inequalities have also been exacerbated by both the virus and the economic, political and public health impacts. For already marginalized or equity-seeking communities, this has given the lie to the adage that "we're all in this together."

"COVID-19 has unveiled historical inequities and elevated race-based differences. As a result, anti-Black racism has become more visible."[85]

Long-term care, as a professional sector, is a workforce primarily of women – a significant proportion of whom are of racialized backgrounds. As lower-wage earners, often with additional unpaid caring responsibilities,

LTC workers are at the intersection of multiple axes of inequity. One-third (33 per cent) of female respondents in our survey took on unpaid caregiving in addition to their paid employment, along with 29 per cent of male respondents.[86] These pressures have increased unevenly on women and single parents as schools and child-care facilities closed under pandemic health restrictions, and as limits on social gatherings isolated caregivers from additional supports.

Of respondents from racialized or immigrant backgrounds, 52 per cent had experienced harassment or discrimination they felt was due to their race, ethnicity or nationality. Only 31 per cent of these respondents said they had never experienced racial or ethnic abuse.

Respondents experienced a wide array of violence in their line of work. In addition to challenging behaviours from residents, staff also experienced abusive behaviours from residents' relatives. Staff also identified abuse from other staff and management.

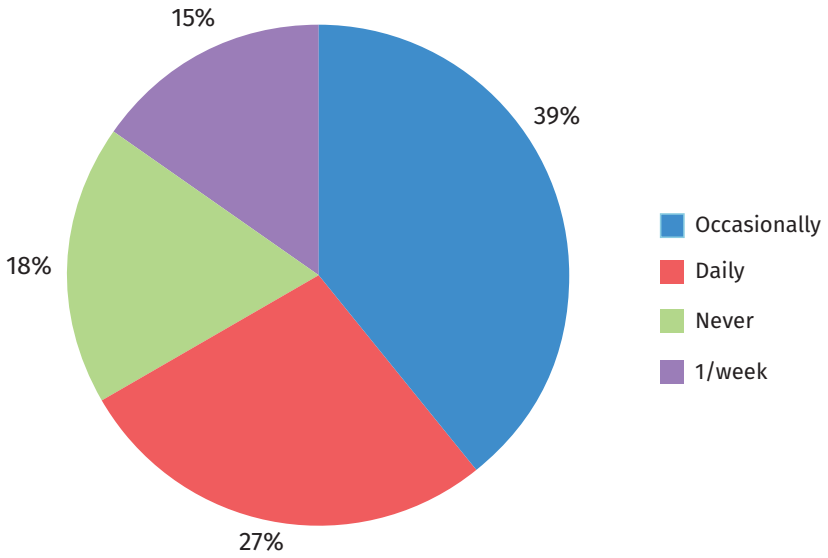
Table 3: Experience of Abusive Behaviours among LTC Staff

Bullying or verbal abuse from residents	82%	Verbal abuse from residents' relatives	52%
Physical abuse from residents	57%	Physical abuse from residents' relatives	25%
Sexual harassment from residents	37%	Sexual harassment from residents' relatives	11%
Witnessed violence towards residents	19%	Verbal abuse from other staff	56%
Verbal abuse from management	35%	Sexual harassment from other staff	5%

(Question 22: Combined responses – daily, weekly, or occasionally)

Chart 6: Experience of Verbal Abuse from Residents

Q: At your current employer, how often have you experienced verbal abuse, aggression or bullying from residents?



Reporting: few respondents chose to answer this question, and even fewer indicated they had made a formal complaint. Staff expressed fear of repercussions and normalizing abuse as just "part of the job." Those who did indicated they had reported incidents to their supervisors, but their concerns were dismissed or no action was taken.

In the past year, how many incidents of physical, non-physical, and sexual violence have you formally reported to your employer?

Almost every day I reported it to my supervisor, especially aggressive resident.

Yes, depends on who you trust

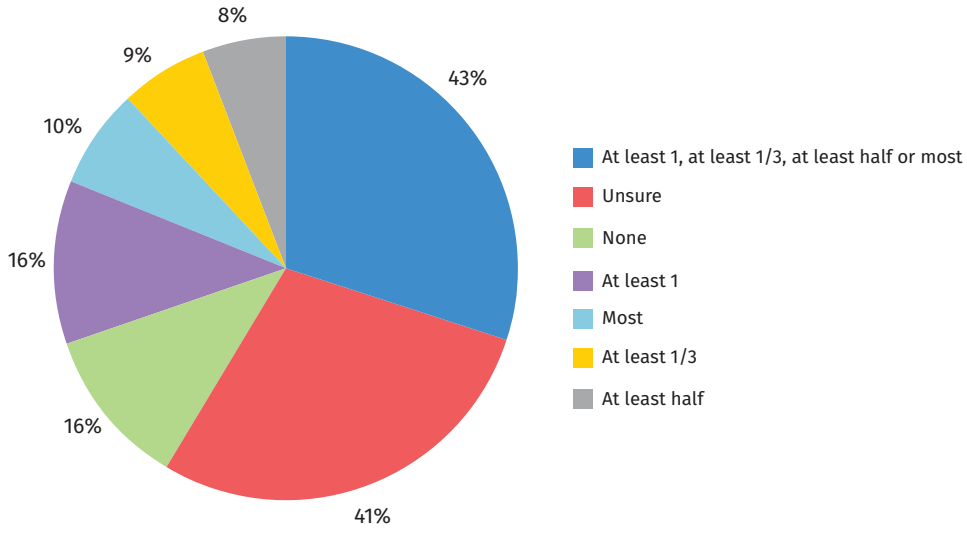
Zero, they have chosen to ignore me on most points I address

I didn't - there is no point to do that; we deal with dementia

While there was a great deal of uncertainty about how many of the above incidents occurred while the respondent's unit was understaffed, an almost equal percentage – 43 per cent – reported that one or more happened during staff shortages.[87] Only 16 per cent reported none of the distressing or violent incidents occurred during times of short-staffing.[88]

Chart 7: How Many Incidents of Violence Occurred When Unit Was Understaffed?

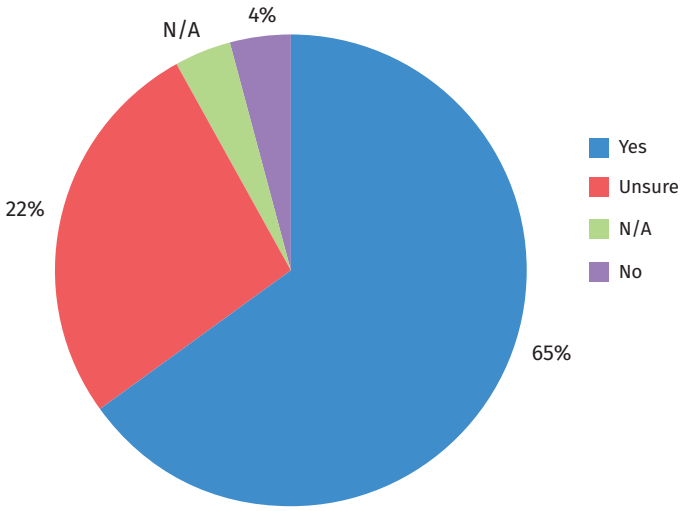
Q: How many incidents of violence occurred when your unit was understaffed?



Yet, despite this uncertainty, respondents were clear in linking additional staff to reduced incidence of violence among staff and residents. While 65 per cent believe more staff would prevent violent incidents, only four per cent did not believe more staff would prevent such incidents. One in five respondents, however, were uncertain – again possibly reflecting the experiences of staff who do not provide direct care. But this uncertainty may indicate a broader lack of understanding of the root causes of violent responsive behaviours in residents and how they may be mitigated or prevented.

Chart 8: Would Additional Staff Help Prevent Violence?

Q: Do you feel additional staff would help prevent violence?



In the recent study by Song et al. (2020), staff were asked specifically about incidents of violence occurring in the previous five shifts worked. The results of this research are comparable to our survey responses, and consistent with our respondents' experiences. Taken together, this data illustrates that long-term care workers routinely experience a work environment that is psychologically and physically harmful. In Song et al.'s study: "The majority of respondents experienced significant rates of dementia-related verbal, physical, or sexual behaviours from residents on a routine basis."[89]

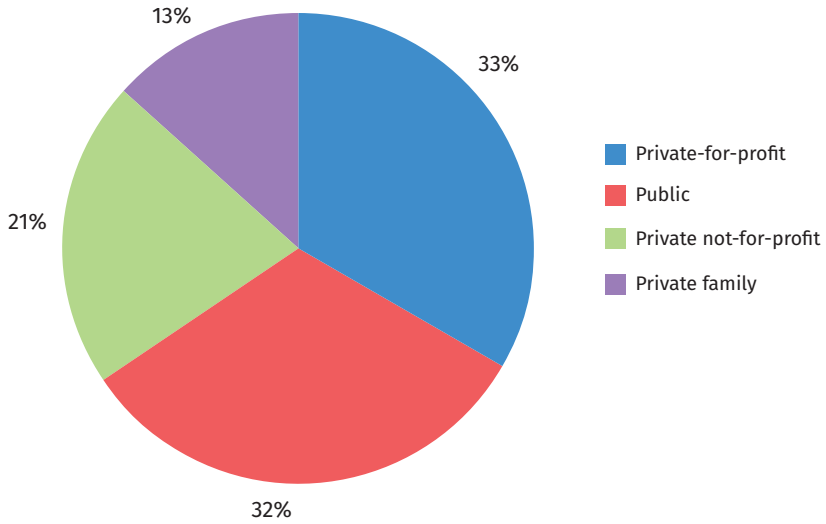
The relationship between staffing and harm becomes cyclical, as workers who experience trauma through injury, illness, burnout or abuse are more likely to require a period of leave – and are more likely to leave the sector altogether. As outlined by the Ontario report into LTC Staffing (the 2020 Gillese Inquiry),

> The current level of care cannot consistently support a high quality of life or care for all residents. Staff are frustrated because they cannot provide the care needed by residents and are often rushed. This can also lead to a higher prevalence of workplace incidents and injuries, and create unmanageable workloads for staff, which leads to burnout and high turnover.[90]

This places direct strain on the facilities where they worked, and systemic strain on the long-term care sector to replace experienced staff with new trainees.

Profit Status, Working Conditions, and Quality of Care

Chart 9: Respondents by Profit Status of Worksite



Proportions of part-time positions were higher in public (53 per cent) and for-profit (54 per cent) facilities. Meanwhile, 62 per cent in private family-owned facilities were working full-time, and 57 per cent of full-time positions were distributed among the non-profit organizations.[91] Public and for-profit facilities relied almost equally on part-time staff, suggesting this issue is pervasive across the LTC sector.

Table 4: Employment Status of Respondents by Profit Status of Facility

Facility type vs employment status	Full time	Part time
For profit	46%	54%
Non-profit	57%	43%
Private family	62%	38%
Public	47%	53%

Profit Status and Employee Compensation

Wages for LTC staff vary widely across the province and across owner/operator categories – even among unionized employees, as in our survey population. According to provincial data, health-care aides employed in AHS facilities earned $24.95 hourly in February 2020 (just prior to the pandemic onset). Licensed practical nurses earned $34.36 hourly, and housekeeping earned $21.23 per hour. Covenant Health and CapitalCare and CareWest facilities, as AHS subsidiaries, paid very close to the AHS set wage. However, there was significant disparity in hourly pay in private not-for-profit and private for-profit facilities, with some paying health-care aides up to three dollars per hour less. Facilities in the Extendicare chain paid 70 cents less per hour for HCAs, and more than one dollar per hour less for housekeeping staff. Licensed practical nurses, however, were paid nearly a dollar an hour more than AHS rates. Revera facilities paid on average two dollars less per hour for HCAs, housekeeping and LPNs compared to the AHS rate.[92]

Examining compensation for time worked over and above scheduled shifts, there was considerable disparity between different owner/operator categories:

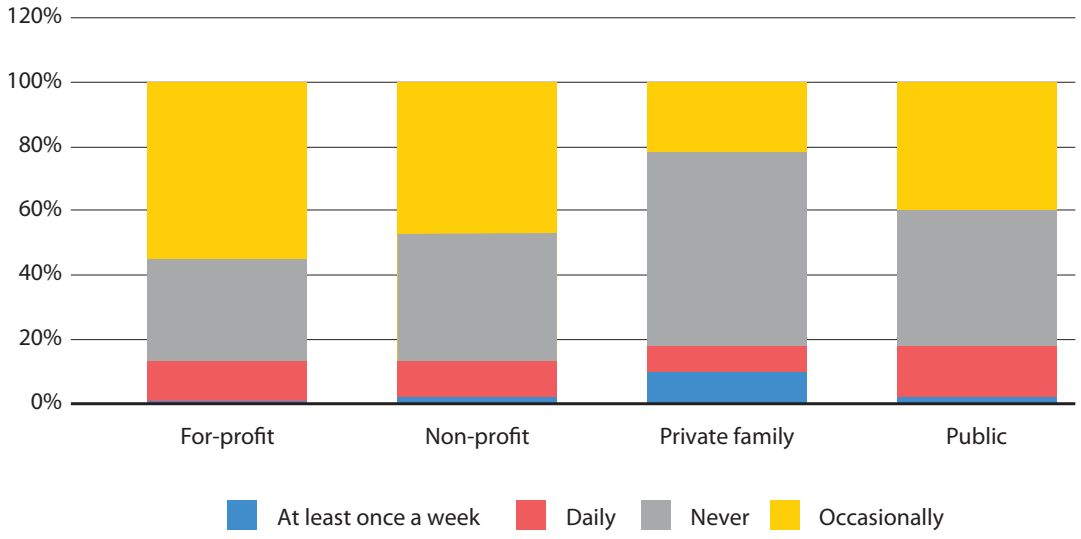
61 per cent of private family facility respondents said they never receive overtime pay

33 per cent of for-profit facilities respondents said they never receive overtime pay

41 per cent of non-profit facilities respondents said they never receive overtime pay

44 per cent of public facilities respondents said they never receive overtime pay

Chart 10: Overtime Pay for Hours Worked Over and Above Contracted Hours, % by Facility Type



Given the previous questions, we know staff are often working short, compensating for co-workers who called in sick and weren't replaced on shift; and many reported frequently having to stay late after their shift ended. This data shows they are obligated to stay and not be properly compensated or leave having tasks undone – it is the staff who must go the extra mile. Between one-third and two-thirds of respondents were not compensated for that additional work.

Often, this additional time falls into loopholes in employees' collective agreements. If the additional time is not explicitly authorized as official overtime, it is not compensated. If 15 or 20 minutes after each shift does not put an employee over a specified per-shift, weekly, or bi-weekly threshold – which is plausible with part-time or casual contracts – the time is also not compensated.[93]

Profit Status and Respondents' Perception of Staffing Levels

Long-term care facilities have generally faced additional challenges in staffing overnight shifts, which already have lower staffing than day shifts. These overnight staffing levels presume a lower level of care needs for residents but do not take into account safety measures such as the need for an evacuation (as seen recently with fires requiring evacuation at LTC facilities in Quebec and Prince Edward Island).[94]

- 28 per cent of for-profit facility worksite respondents reported they have adequate staff for overnight shifts
- 46 per cent of non-profit facility worksite respondents reported they have adequate staff for overnight shifts
- 42 per cent of private facility family worksite respondents reported they have adequate staff for overnight shifts
- 32 per cent of public facility worksite respondents reported they have adequate staff for overnight shifts

However, when asked whether they felt their facility operated with an adequate ratio of staff to residents to provide quality care, the results showed a distinct difference across ownership categories/profit status.

Table 5: Facility Type Versus Staff to Resident Ratios (adequate to provide quality care and meet residents' needs)

Facility Type by Profit Status	Always	Often	Seldom	Never	Unsure	TOTALS*
For-profit	15%	19%	20%	34%	13%	101%
Non-profit	11%	38%	13%	16%	22%	100%
Private family	9%	26%	21%	29%	15%	100%
Public	20%	37%	20%	7%	15%	99%

* Note that per centages may not total 100 due to rounding.

This difference between types of facility is quite stark:

- 34 per cent of respondents based in for-profit facilities reported they NEVER have adequate staff:resident ratios to provide quality care, and meet patient/resident needs – compared to just seven per cent for public facilities
- 38 per cent of respondents for non-profit facilities reported they OFTEN have adequate staff:resident ratios to provide quality care, and meet patient/resident needs
- 29 per cent of respondents for private family facilities reported they NEVER have adequate staff:resident ratios to provide quality care, and meet patient/resident needs
- In for-profit facilities, 34 per cent replied Always or Often; and 54 per cent replied Seldom or Never
- In public facilities, 57 per cent replied Always or Often; and 27 per cent replied Seldom or Never. In private not-for-profit facilities, 49 per cent replied Always or Often; and 29 per cent replied Seldom or Never.

Equity: Are some Impacts Felt More Deeply than Others (by Others)?

Precarity

The precarity associated with many long-term care roles has long been a concern within Alberta and throughout the sector nationwide. To piece together full-time hours, many part-time workers take on shifts at multiple facilities. This situation is particularly prevalent among health-care aides (or personal support workers), who provide the vast majority of direct resident care. Not only does this increase the stress on workers, who are often left with insufficient benefits – or none at all – the lack of job security also contributes to frequent staff turnover and a consequent disruption to the care relationship.

During the COVID-19 pandemic, this precarity – movement of staff between multiple work sites, insufficient paid sick days and inadequate replacement of sick workers – became active factors in virus transmission. More fundamentally, long-term care workers were asked to risk their health, their lives and the well-being of their families while being denied employment security and an adequate living wage.

The risks associated with multiple work sites was recognized early on in the pandemic, with several of the hardest hit provinces instituting a "single site" policy that required part-time workers to choose one facility to work at for the duration of the public health emergency. There were, however, many unintended consequences of this policy, which was applied unevenly across provinces and across the seniors' care sector. The first was that workers would need part-time contracts to be supplemented – either by additional hours or a monetary top-up – to compensate for the loss of income they experienced. While the federal government dedicated targeted funds for LTC staff as a wage top-up, in Alberta this relief money was used as a political football by the Ministry of Health.[95] As the pandemic worsened and case numbers in Alberta soared, several facilities with active and extensive COVID-19 outbreaks were issued exemptions by the chief medical officer of health to address staffing shortages. With so many staff ill or isolating, such facilities were unable to meet minimum staffing requirements or provide even the most basic care (as seen in Ontario, Quebec and Manitoba facilities).[96] There was also significant resistance to authorizing AHS to assume administration of private facilities where outbreaks were out of control.

Yet, while the intention of the exemptions was harm prevention, permitting staff to move between multiple worksites with active outbreaks likely contributed significantly to wider spread of the virus. The policy also had several loopholes: staff were not restricted from working in LTC as well as

another, unrelated job – retail or hospitality, for example – and staff were not restricted from working in lodges or unregulated assisted living facilities. Attempts to mitigate the precarious nature of care roles in LTC imposed a significant burden on staff while at the same time continuing to endanger residents during the pandemic.

Precarity and Double-Jobbing: Respondents by Employment Status

Our survey found that 78 per cent of respondents were employed at a single LTC site, while 22 per cent were employed in various roles at multiple sites.

Respondents related an almost equal split between full-time and part-time employment at their primary work site: 44 per cent were employed full time and 45 per cent part time. A further 10 per cent of respondents were employed on a casual or temporary basis.

For those employed at more than one facility, employment status at the secondary worksite was overwhelmingly part time – 32 per cent and casual – 43 per cent. Only six per cent were employed full time at their secondary worksite.

More than one in five – 22 per cent – had other additional jobs outside of LTC, and 34 per cent had unpaid caring responsibilities for a child or relative.

In contrast to Alberta (and other hard-hit provinces such as Ontario and Manitoba), British Columbia's LTC workers' wages were quickly brought up to the highest unionized pay grade, full-time hours. This meant workers did not have to choose between sustainable wage and adhering to public health measures.

In our survey, the issue of employment precarity cut across all facility types, regardless of profit status.

Equity and Marginalized Workers

During the COVID-19 pandemic, precarious work status has cut both ways: for many workers, it meant unexpected layoffs, reduced hours, or inability to work desired hours due to child care or remote schooling challenges. For others, it has manifested in a greatly increased workload, with life-or-death implications. For long-term care staff, it has inflicted the worst of both scenarios: the single-site restriction limiting hours, the need to pick up casual shifts in unregulated seniors' care (such as retirement homes, which were not covered by the rule) or in front-line service jobs; while within long-term care facilities, staff have had to do so much more with less. The much-lauded pandemic wage top-up offered by the federal government has instead become a means to subsidize low-paying private facilities. While the

Kenney government has elected to access only a small fraction of available federal funds for front-line workers[97], the announcement of a one-time $1,200 Critical Worker Benefit has only served to underscore a division between those workers deemed essential and those who are left without access to financial supports. Precarity is structural, and has been exacerbated by political choices – more starkly around paid sick leave policies.

For direct-care LTC staff, who are more likely to be racialized women, this financial insecurity is compounded by inequities in social determinants of health that make their communities more likely to experience higher rates of COVID-19 infection and fatalities.[98] Members of visible minority communities are more likely to work in occupations with a higher risk of exposure to COVID-19 – particularly health-care workers, but also the cleaning staff, food services, and laundry workers who serve health facilities. These communities are also more likely to experience greater economic impacts of the public health restrictions.[99]

It has been difficult to piece together the structural, systemic nature of these challenges, as LTC workers' experiences have been only patchily reported. Health researcher Naomi Lightman notes

> the current health crisis has highlighted these existing [equity] issues as COVID-19 ravages long-term care sites but few are seeking to hear directly from women in these roles, who are facing consequences to their overall health and financial security.[100]

The circumstances of LTC workers – and other front-line workers in congregate care settings – during the pandemic has exposed how little society values care work. Despite weekly applause events hailing health-care "heroes," the daily risks and sacrifices undertaken by care workers for meagre pay has not been fully acknowledged:

> the early elevated rates of pandemic amongst this workforce, particularly low wage, insecure and non-unionized workers, forces us to see the critical mistake of devaluing certain types of highly feminized labour connected to care. Government austerity programs and for-profit care provision have both placed workers in vulnerable positions. This is clearer than ever in the time of a dangerous pandemic putting pressure on workers who cannot afford time away from work to protect themselves and are also working with medically susceptible populations without adequate personal protective equipment.[101]

The first health-care worker to die of COVID-19 in Alberta, a LTC worker named Joe Corral, was not officially named in the chief medical officer's daily

pandemic briefings. His friend, co-worker and housemate, who discovered his body, took Corral's story to the local media:

> Corral is being remembered by friends as a hero, dedicating himself to his care of the residents with dementia at the facility, not asking for a break from work or stopping out of fear of the spreading virus.
>
> Even since we had COVID-19 in our unit, he never stopped working. He committed his life to take care of the residents until he was COVID positive. He gave more than 100 per cent of his commitment to the residents," said his friend Ephraim Tiangha over the phone Monday.
>
> "Even during COVID-19 outbreak, they need his care and he did not give up on them. And that is why he is a hero."[102]

Five other health-care workers have since died of the virus in Alberta.

An outbreak in Ontario was sparked by two long-term care PSWs who had been staying at an Ottawa homeless shelter.[103] Their wages were not enough to pay their rent and their essential bills. In this intersection of congregate settings – the shelter and the care facility – the conditions of precarity were doubly reinforced. Long-term care workers "are disproportionately migrant and racialized women, some of whom hold precarious immigration statuses. In the COVID-19 context, some care workers have experienced abrupt layoffs (in part explaining Canada's "she-cession"), while others have seen an intensification of work, often working multiple jobs in multiple locations. In addition, supportive workers who help keep these institutions running, such as cleaners or people in food preparation, are also disproportionately racialized women working in jobs with low pay and low autonomy."[104]

Care as Relationship

Throughout our research, one theme was especially prominent: there is not enough time in care to care. Care as relationship also relies on continuity, which is disrupted by temporary staff and high-turnover of direct-care workers. The overwhelming majority of our respondents expressed a desire to *care for* their residents that was simply not possible under the constraints of their work. Many of their responses centered on concern for their residents, explicitly equating time with care, and care with relationship.

> If I had more time I could …
>
> *Spend more quality time with residents to give them proper care.*
>
> *Spend more time with residents, ensuring all their needs are met.*
>
> *More interaction with residents.*
>
> *Provide adequate care – not haphazardly.*
>
> *Give residents the best care.*

Additional, unhurried time for residents also had the potential to identify concerns and address unmet needs, preventing problems from growing unchecked.

> *Spend more quality time with each resident like assessing them more, being proactive, and refer them to get adequate help.*

This conception of time as care was most frequently expressed as time to simply sit and talk with residents – a fundamental level of engagement as human beings. In a comparative study of elder care in Canada, Germany, Norway, Sweden, the United Kingdom and the United States, researchers Pat Armstrong and Donna Baines found the facilities that provided the highest quality care were those that prioritized care as a relationship between staff and resident. In order to re-imagine long-term care, "it is necessary to begin by understanding that care relationships are central to treating residents, staff and families with dignity and respect."[105]

If I had more time I could …

Stay with residents and talk with them

Take more time to talk with residents outside the programs I run

If there is a resident awake I always talk to them

Have a chat with residents; socialize with residents; do an activity with residents

Let patients see I care

Armstrong and Baines' work concluded that, "Promoting care as a relationship requires time, which is not the same as staffing levels"[106] – though they acknowledge the critical importance of staffing levels and mix. Time is itself a component of care: when we spend quality time with family or friends, we are offering a gift of time. The responses to our survey suggest that for many long-term care workers, time is one thing they are not able to give sufficiently.

Conclusion: The Conditions of Work are the Conditions of Care

Our survey affirmed alarming issues that similar studies in other provinces have raised, and that workers and unions have been flagging for years in Alberta and across the country. Staffing levels in long-term care are rarely adequate to meet the increasingly complex needs of older, more vulnerable residents, and staff are stretched to their limits trying to square an impossible circle.

Staff care about their residents. Staff want to provide *care* for their residents, including individual, unrushed attention to their social and emotional needs as well as daily physical tasks. They want their residents to be treated with dignity. Workers, especially those delivering direct care, risk burnout, injury, mental exhaustion and emotional distress to provide the bare minimum of care.

They value doing their job to the very best of their ability, but the conditions under which they work – even before the coronavirus pandemic – often make this impossible. Now the stakes are even higher: workers' health, their families' well-being, and even their own lives. The pandemic has greatly exacerbated all the long-standing challenges entrenched in long-term care, and added new ones, while simultaneously reducing the available staff to meet them.

Profit status plays a role in short-staffing to some extent, but staffing is a concern across public, not-for-profit, and for-profit facilities.

The highly gendered and racialized nature of the LTC workforce points to the need for an intersectional analysis of the similarly inequitable impacts of the pandemic, public health containment measures and financial relief programs.[107]

Going forward, policymakers will need to take into account the post-COVID-19 context (or, unfortunately, the ongoing context) as well as acknowledge the long-standing deficiencies in seniors' care that have been compounded by various incoherent changes and under-resourcing.

Alberta's response to the COVID-19 pandemic has been a litany of both categories, fuelled by ideology rather than evidence. Early on in the pandemic, Premier Kenney claimed the Alberta government would "build a wall of defence" around our most vulnerable[108], but policy measures for long-term care were either one step behind the virus, offering too little too late, or directly contradicted best practice and best available evidence from other jurisdictions. Many of these measures fell short of, or went directly against, what our respondents said they needed.

By Dec. 22, 809 LTC and retirement facilities were experiencing outbreaks of COVID-19. One hundred and fifty-one of those were in Alberta, the third highest after Ontario and Quebec. In British Columbia, outbreaks in long-term care were one-third of Alberta's numbers.[109]

Rather than moving toward more public delivery of seniors' care, as the evidence supports, increased privatization looms. Alberta Health launched a review of the continuing care sector. From the highly flawed, ideologically skewed survey circulated in January 2021, the outcomes appear to be mainly predetermined – increased contracting out, sales of publicly owned LTC facilities, and hikes to accommodation fees for seniors are all options "on the table."

Accountability and repercussions for privately-owned facilities during the pandemic may also be closed down rather than actively pursued for residents and their families. Private seniors' care groups have actively lobbied the Alberta government for legislation to shield LTC owners from wrongful death lawsuits similar to Ontario's Bill 218.[110]

While the promise of national long-term care standards, as announced in the 2020 federal Throne Speech, offers the tantalizing potential to remake seniors' care in light of the tragic lessons learned this year, this may prove too optimistic. Potential clashes of provincial and federal jurisdiction, politicking between (mainly conservative-led) provinces and Ottawa, or attempts to opt out of national standards entirely, may result in a watered-down compromise that will only leave Alberta seniors in a more vulnerable place.

Recommendations

The RSC report on long-term care determined conclusively the very first step that must underpin Canada's response to the long-term care crisis must be a strategy to address staffing. Reports and policy documents from the most experienced elder care researchers echoed this. Our survey of long-term care workers confirmed that staff – especially but not only health-care aides – feel they do not have the time or resources to provide the care their residents need and deserve.

Their experiences are, unfortunately, not unique. Their responses give voice to the silences and omissions in long-term care policy across Canada, where those raising the same concerns have been ignored again and again. The problems are known, and the staff who answered our call identified them clearly. The solutions are known and achievable with investment, political will and an explicit drive to centre caring in policy making and decision-making. To this end, we offer the following recommendations:

Staffing

- Alberta must increase staffing levels and consider staffing mix.
- Alberta Health needs to distribute the federally funded pandemic top-up pay to all LTC workers.
- LTC providers should offer equitable pay and benefits for health care aides.
- LTC providers should create more opportunities for full-time positions.
- The proposed national staffing standards must be tied to funding and enforced through inspection and reporting.

Work-life Quality

- LTC providers should offer mental health supports for direct-care staff.
- LTC providers should ensure adequate staff on every shift to enable workers to take mandated breaks.
- Providers should empower direct-care staff to provide more input into resident care.
- Alberta Health should develop a relational care model to replace activity-based funding.
- Alberta must commit to building a resilient LTC workforce.

Quality of Care

- Remove the profit motive from care by phasing out for-profit ownership and delivery.
- Recognize that laundry, dietary, housekeeping, maintenance and therapy staff have essential roles in LTC – contributing to holistic care of the whole person and supporting a comfortable care environment.

Appendix: Survey Question Template

Study Title: Workload and Staffing Realities in Alberta's Long-Term Care Facilities

Research Investigators: Alison McIntosh & Rebecca Graff-McRae
Parkland Institute

Background

The Canadian Union of Public Employees – Alberta (CUPE-AB) is conducting a research project about workload and staffing issues in Alberta's long-term care facilities in partnership with the Parkland Institute. You are being contacted because CUPE identified that you work in the long-term care sector in Alberta, including **long-term care homes, lodges, assisted living, hospice, retirement homes, continuing care, complex care, daily assisted living, and senior care facilities**. All eligible workers will receive recruitment materials for the survey. The results of this study will be used to produce a report, posters, and presentations for CUPE-AB leadership and membership outlining the realities of working in the long-term care sector in Alberta.

Purpose

The purpose of this project is to understand what work is like in the long-term care sector in Alberta. Similar studies in other parts of Canada indicate that workers in long-term care often work short staffed, and have workloads that are increasing over time. In Alberta, changing demographics, budgetary constraints, and few new long-term care beds suggest similar realities for long-term care workers in Alberta. This project attempts to give voice to front line workers in long-term care. Results of this research may be used to advocate for improved work conditions in the long-term care sector.

Study Procedures

You are being asked to complete a survey that should take around 15 minutes to complete.

The survey asks if you:

Work in more than one job, and how many of these jobs are in long-term care

Have enough time to do your job, work short, or work out of scope

Experience overwork or burnout

Work nights, and what differs between day and night shifts, if applicable

Experience violence or harassment at work, and impacts that has on your work, if applicable Demographic information including: (general) location, ethnicity, immigration/citizenship (in general terms), educational background & current job title, and gender.

You can do the survey online through the Qualtrics link provided (works on desktop or mobile), or on paper (print the version from your email, request from CUPE-AB chapter chair or the researcher listed above). You can return paper copies directly to the researcher (mailing address above), or to your CUPE chapter chair. The survey is anonymous, meaning that the researcher will never know who participated, and who did not. If you complete the survey on paper, your participation may be inferred based on how you return the survey.

Benefits

There are no direct benefits to participation. Your responses will provide valuable information to the researchers, and your Union about your experiences of working in long-term care. CUPE may use this information to benefit you in collective bargaining, and by policymakers to fund improvements to the long-term care sector that will benefit workers like you.

Risk

Some of the questions in the survey touch on sensitive topics like harassment, workplace violence, and discrimination. All questions are optional – you do not have to answer any questions that make you feel uncomfortable.

Voluntary Participation

Participation in this survey is completely voluntary, and will not impact your relationship with CUPE, or with the Parkland Institute. The survey is anonymous – it does not ask for any identifiable information about you. Therefore, responses cannot be withdrawn after you submit them. The last question in the survey asks you to confirm that you wish to submit your responses. You can opt out without any consequences – you can choose not to answer particular questions, or not to complete the survey at all.

Confidentiality & Anonymity

The results of the survey will be used in: a report by the Parkland Institute written for CUPE, presentations to CUPE leadership and membership, posters for CUPE sites, and social media posts for CUPE members. It is also possible that the results of the survey will be used by CUPE during collective bargaining with long-term care employers, and in advocacy work with policymakers. The Parkland Institute researcher will manually remove any incidentally or indirectly identifiable information (e.g. if a participant volunteers identifiable information about their workplace, or specific situation) from the raw data prior to analysis. The clean data will be retained indefinitely by the Parkland Institute, and shared with CUPE, who may also retain the data indefinitely. The anonymous data will be retained on password protected computers.

Parkland may use the data we get from this study for online posts, in future research, or to do the same study again sometime in the future subject to Research Ethics Board approval.

Further Information

The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have questions about your rights or how research should be conducted, you can call (780) 492-2615.

Consent Statement

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form (if completing online, you can request a separate copy of the consent materials from the researcher noted above).

- ◯ I agree to participate in the survey (1)
- ◯ I do not wish to participate in the survey (2)

Skip To: End of Survey If Consent Statement I have read this form and the research study has been explained to me. I have... = I do not wish to participate in the survey

Q5 What is your job title (including professional designation if applicable)? You may list more than one:

_____

Q6 For the following questions, please respond with your primary work site in mind.

Q7 How often do you have adequate time to do required tasks (e.g. morning routines, mandatory duties)?

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)
- ◯ N/A (5)

Q8 At the end of a typical shift, are there necessary tasks you have to leave undone?

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)
- ◯ N/A (5)

Q9 Do you ever need to stay late/work overtime to finish necessary tasks?

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)
- ◯ N/A (5)

Q10 When you work overtime, do you receive overtime pay?

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)
- ◯ N/A (I do not work overtime) (5)

Q11 What would you do at work if you had more time?

_____

End of Block: Workload

Start of Block: Burnout

Q12 How often do you 'work short'? (i.e. without all the staff necessary to run your facility)

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)
- ◯ N/A (5)

Q13 How often do you do tasks that are 'out of scope' for your job?

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)
- ◯ N/A (5)

Q14 If the number of staff scheduled is less than the usual number on the shift, what is the usual reason for the difference? (select all that apply).

- ◯ no replacement for sick call (1)
- ◯ no replacement for vacation (2)
- ◯ unit staff assigned to constant care (3)
- ◯ no additional staff available for constant care (4)
- ◯ other reason (please specify) (5) _____
- ◯ N/A (6)

Q15 Are your staff:patient ratios adequate to provide quality care, and meet patient/resident needs?

- ◯ Always (1)
- ◯ Often (2)
- ◯ Seldom (3)
- ◯ Never (4)
- ◯ Unsure (5)

Q16 In a typical shift, how much time do you spend on the following tasks (in hours):

- ◯ Direct patient care: (1) _____
- ◯ Caring for emotional/social needs of patients/residents: (2) _____
- ◯ Food preparation/serving: (3) _____
- ◯ Housekeeping/maintenance: (4) _____
- ◯ Paperwork and administrative tasks: (5) _____
- ◯ Other (please specify task[s], then indicate number of hours): (6) _____

End of Block: Burnout

Start of Block: Overnights

Q17 Do you work overnight shifts?

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)
- ◯ N/A (there is no overnight shift at my work site) (5)

Skip To: Q20 If Do you work overnight shifts? = Never
Skip To: Q20 If Do you work overnight shifts? = N/A (there is no overnight shift at my work site)

Q18 Does your primary worksite typically have adequate staff for overnight shifts?

- ◯ Yes (1)
- ◯ No (2)
- ◯ Unsure (3)

Q19 At your primary worksite, do you ever have to work overnight shifts alone?

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)

Q20 Has your primary worksite made significant changes to staff schedules, shifts, or hours in the past year?

- ◯ Yes (please specify) (1) _____
- ◯ No (please specify) (2) _____
- ◯ Unsure (please specify) (3) _____

Q21 At your current employer, how often have you experienced the following as a result of your job:

	Daily (1)	At least once a week (2)	Occasionally (3)	Never (4)
Sprains or strains (1)	○	○	○	○
Back pain/injury (2)	○	○	○	○
Flu or other infectious illnesses (3)	○	○	○	○
Needle pricks (4)	○	○	○	○
Injury caused by violence from a patient (5)	○	○	○	○
Mental distress/PTSD (6)	○	○	○	○
Burns/cuts/scrapes (7)	○	○	○	○
Other (please specify) (8)	○	○	○	○

Q22 At your current employer, how often have you experienced the following:

	Daily (1)	At least once a week (2)	Occasionally (3)	Never (4)
Physical abuse from patients (1)	○	○	○	○
Verbal abuse/bullying/aggression from patients (2)	○	○	○	○
Sexual harassment from patients (3)	○	○	○	○
Physical abuse from patients' relatives (4)	○	○	○	○
Verbal abuse/bullying/aggression from patients' relatives (5)	○	○	○	○
Sexual harassment from patients' relatives (6)	○	○	○	○
Verbal abuse/bullying/aggression from other staff (7)	○	○	○	○
Sexual harassment from other staff (8)	○	○	○	○
Verbal abuse/bullying/aggression from management (9)	○	○	○	○
Sexual harassment from management (10)	○	○	○	○
Violence towards patients (11)	○	○	○	○

Q23 In the past year, how many incidents of physical, non-physical, or sexual violence have you formally reported to your employer?

_____

Q24 How many of the incidents of violence occurred when your unit was understaffed, short-shifted or co-workers not replaced?

- ◯ Most of them (1)
- ◯ At least half of them (2)
- ◯ At least a third of them (3)
- ◯ At least one of them (4)
- ◯ None of them (5)
- ◯ N/A or unsure (6)

Q25 Do you believe that additional staffing would help to prevent violence?

- ◯ Yes (1)
- ◯ No (2)
- ◯ Unsure (3)
- ◯ N/A (4)

Q26 In your opinion, what were the potential or actual hazards to patients/residents from your work site's workload/staffing situation?

	Potential (1)	Actual (2)	Never (4)
Assistance with toileting delayed (1)	◯	◯	◯
Assistance with meals delayed (2)	◯	◯	◯
Insufficient turning of patients (3)	◯	◯	◯
Delays in answering call lights (4)	◯	◯	◯
Patient injury occurred (5)	◯	◯	◯
Bathing patients left incomplete (6)	◯	◯	◯
Ambulating patients not complete (7)	◯	◯	◯
Other (please specify): (8)	◯	◯	◯

Q27 In your time working in long-term care in Alberta (current or previous employer), have you taken stress leave?

- ◯ Yes
- ◯ No

Q28 At your current employer, have any of your coworkers gone on stress leave?

- ◯ Yes, one co-worker (1)
- ◯ Yes, more than one co-worker (2)
- ◯ No (3)
- ◯ N/A or Unsure (4)

End of Block: Workplace satisfaction and safety

Start of Block: Demographics

Q29 The following questions help us understand how we can help workers from different backgrounds and identities:

Q30 Where in Alberta do you work? (if you work in more than one area, select all that apply):

- ◯ Edmonton area (1)
- ◯ Calgary area (2)
- ◯ Northern Alberta (3)
- ◯ Central Alberta (4)
- ◯ Southern Alberta (5)

Q31 Is the community where you work... (if more than one community, select all that apply):

- ◯ Edmonton (1)
- ◯ Calgary (2)
- ◯ A community with over 50,000 people (e.g. Red Deer, Lethbridge, Medicine Hat, Grande Prairie) (3)
- ◯ A community with 25,000 to 49,999 people (e.g. Cochrane, Spruce Grove) (4)
- ◯ A community with 5,000 to 24,999 people (e.g Cold Lake, Camrose) (5)
- ◯ A community with less than 5,000 people (6)

Q32 In what kind(s) of facility(ies) do you work? (select all that apply)

- ◯ Public (1)
- ◯ Non-profit (2)
- ◯ For-profit (3)
- ◯ Private family (4)

Q33 How long have you been working in long-term care? (in years)

_____

Q34 What is your educational experience?

- ◯ Some high school (1)
- ◯ High school/GED (2)
- ◯ Some post-secondary (no diploma/degree) (3)
- ◯ Professional diploma/degree (4)
- ◯ Other (please specify) (5) _____

Q35 How many long-term care worksites do you work at?

_____

Q36 What is your employment status at your primary worksite?

- ◯ Full-time (1)
- ◯ Part-time (2)
- ◯ Casual (3)
- ◯ Temporary full-time (4)
- ◯ Other (please specify) (5)

Q37 If applicable, what is your employment status at your secondary work site:

- ◯ Full-time (1)
- ◯ Part-time (2)
- ◯ Casual (3)
- ◯ Temporary full-time (4)
- ◯ Other (please explain) (5) _____

Q38 Do you have other jobs outside of long-term care?

- ◯ Yes (if so, how many?) (1) _____
- ◯ No (2)

Q39 Do you do also have unpaid care responsibilities (e.g. caring for a relative or child)?

- ◯ Yes (1)
- ◯ No (2)

Q40 What is your age?

_____

Q41 What is your gender?

_____

Q42 What is your home language?

_____

Q43 What is your ethnicity?

_____

Q44 Please answer this final question only if you identify as indigenous, racialized, recent immigrant, or visible minority. In general, how often do you experience harassment or abuse that you believe is related to your race or ethnicity?

- ◯ Daily (1)
- ◯ At least once a week (2)
- ◯ Occasionally (3)
- ◯ Never (4)
- ◯ N/A (5)

Q45 If applicable, what is your immigration status?

- ◯ Canadian citizen (1)
- ◯ Permanent resident (2)
- ◯ Work or work-study visa (3)
- ◯ Other (please specify) (4) _____

End of Block: Demographics

Start of Block: Final page

Q46 Is there anything important to your work that we missed?

_____

Q47 Thank you for completing this survey. Please press 'submit' to confirm your responses.

- ◯ Submit (1)
- ◯ Do NOT submit response (2)

End notes

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