BC NURSES' UNION

Standing up for health care

BCNU REPORT TO BC's SELECT STANDING COMMITTEE ON HEALTH

December 2014

INTRODUCTION

The BC Nurses' Union represents over 40,000 registered nurses, licensed practical nurses, registered psychiatric nurses and other health care professionals across BC.

BCNU believes all British Columbians deserve access to high quality health care services and trained health workers when they need it and no matter where they live.

The reality of living in rural and remote areas is that there are fewer health care services and people may not be getting the care they need, partly due to difficulties in recruiting and retaining nurses.

Nurses who work in rural emergency departments are committed to providing quality, safe patient care, but cutbacks and staffing shortages mean some rural emergency rooms are one sick call away from closing. With very low levels of nursing staff in a rural facility, there are difficult decisions that must be made to move staff from in-patient rooms or from residential care to help with medical emergencies, particularly if several occur at the same time. Teamwork and collaboration is paramount, a hallmark of rural care. But the realities of short staffing put tremendous pressure on nurses and other care providers as they attempt to provide safe patient care.

A key factor for all emergency services is the ability to triage and stabilize patients with medical emergencies, twenty-four hours a day, seven days a week. A notable characteristic of emergency care is the importance of access to care within one hour (also known as the Golden Hour' or time from illness/ injury to treatment).

"Time to treatment" is a critical factor affecting patient outcomes in emergency care. Factors such as weather and road conditions, terrain or geography may have a significant impact on morbidity and mortality.

The solutions have been outlined in the evidence of countless stakeholder documents and government reports on improving health care in BC:

Investing in community health care is the most cost effective long term strategy for a sustainable health care system.

A broad conversation on how community care will be delivered is crucial and in order for it to be meaningful and truly patient centred, the conversations must take place at the community level. The patient voice must be heard but so does the voice of nurses who are delivering the care. A nursing approach to care strongly aligns with the philosophy behind patient centred care, much more so than the traditional medical model. We must make use of that nursing expertise.

Select Standing Committee Question #1:

How can we improve health and health care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health care professionals in rural British Columbia?

OVERVIEW

In order to deliver health care services in rural areas, an adequate number of nurses is essential, yet the nurse to population ratio is wider than in urban areas. That is, there are fewer nurses trying to deliver care.

Health facilities in rural areas face challenges recruiting and retaining all health care professionals, yet the same level of resources is not allocated to nurses compared to other providers, particularly physicians.

There are many personal and family issues that influence a decision to relocate to a rural area, such as employment for spouses or education for children. In addition, there are unique challenges for nurses, related to lack of supports in practice. Rural nurses must be creative, flexible and confident in their ability to work independently.

Many rural sites are staffed by one RN who may have limited support from other regulated nurses working in the facility. Some sites have physician services Monday to Friday during the day but in others, physicians are not available on site and are either on call or available by phone.

"We have to triage which patient the doctors are called into the ER for. They only come in for major emergencies, and the RN handles the rest themselves with the assistance of a doctor by phone"

► *BCNU survey of rural nurses 2013*

Due to the difficulty recruiting and retaining nurses, expensive agency nurses are often used to cover unfilled shifts or vacancies. Even when new nurse graduates are hired, they may not remain due to lack of supports or access to full time hours.

Nurses will neither relocate to, nor remain in areas that have a high cost of living (accommodation, groceries, etc.) if they can only access casual work.

". . . unless the RN has a significant other who is also working, it may become difficult to sustain employment here because it may not be consistent, so the casuals don't always stay long term."

► *BCNU survey of rural nurses 2013*

SOLUTIONS

PROVIDE INCENTIVES TO NURSES

Offer incentives to recruit nurses to rural areas, similar to those provided to doctors. Incentives make it easier for nurses to make the decision to locate to rural and remote areas, by compensating for the lack of family and career supports and general amenities available in urban centers.

For example:

> Provide retention bonuses for staying at rural work sites.

> Regularly review relocation packages to ensure they are sufficient to attract nurses.

> Provide housing/accommodation incentives.

> In tight housing markets, look for creative and cost effective solutions (i.e. using a cruise ship to house resource sector workers in Kitimat).

> Increase funding for rural training.

> Regularize hours to make the positions more attractive and 'family friendly'.

NURSES' SCOPE OF PRACTICE

Nurses should be supported to work to full scope of practice in rural areas. This would increase job satisfaction, which assists in recruitment and retention and provides better care for patients.

LPNs require access to post-basic education to prepare them for expanded roles, for example peri-natal, peri-operative, rural practice. In addition, it is critical that the LPN Regulation under the Health Professions Act (HPA) is confirmed with no further delay so that there is a standard approach to practice. RNs could contribute more by providing full chronic disease management or having the RN Health Professions Act Regulation altered to allow RNs to discharge patients.

DEVELOP REGIONAL FLOAT POOLS FOR NURSES

> Replace and reduce the need for expensive agency nurses by creating special health authority float/resource pools where nurses are guaranteed full time hours and are compensated adequately for the life disruption that increased travel away from a home base will create.

> Explore creative scheduling and "community exchanges" of interested nurses to provide effective care while acknowledging and supporting nurses' life circumstances.

TRAINING AND EDUCATION

Obtaining and maintaining skills sets and competencies directly impact the quality of care that is provided by nurses in rural emergency facilities.

"There are many instances when critically ill patients are waiting for transport, but they are staying with us for hours, so we need to have additional skill sets in order to manage them appropriately. To me it is a safety issue, and I owe it to my patients and I to get specialized training."

▶ *BCNU survey of rural nurses 2013*

> Provide and fund training for RN First Call certification.

> Ensure supports are in place to keep nurses' obstetrical skills current, for example by providing periodic placements in busier obstetric centres.

> Provide regular in-services and supports for nurses to keep current in Advanced Cardiac Life Support, neonatal resuscitation and other skills required for rural and largely independent practice.

> Expand the delivery of the rural nursing curriculum and offer it as an elective in all Schools of Nursing. The rural curriculum was created and is offered at UNBC and is only now being offered at the College of the Rockies.

> Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas.

> Provide scholarships, bursaries or other education subsidies with reasonable agreements for return of service in rural or remote areas to increase recruitment.

PERSONAL AND PROFESSIONAL SUPPORT

> Where feasible, use Telehealth to provide additional support to rural health workers.

> Develop and support career development programs.

> Adopt public recognition measures such as rural health days, awards and titles at local,

> National and international levels to lift the positive profile of working in rural areas.

Select Standing Committee Question #2:

How can we create a cost effective system of primary and community care built around interdisciplinary teams?

THE EVIDENCE ON THIS IS CLEAR: IN MOST CIRCUMSTANCES, COMMUNITY HEALTH CARE COSTS SIGNIFICANTLY LESS THAN ACUTE CARE.

If people are given adequate home support and home nursing care with follow up the expensive cycle of hospital to home and back can be halted. More importantly, care provided in the community prevents a downward health spiral for citizens in need of support. However, in many small communities, adequate supports are not in place.

"In Kaslo, like other small communities with few services, we see patients sent home from the hospital too early. They often return to the emergency room needing care. Sometimes it's due to unforeseen complications, other times patients just need help teaching help on issues like wound or catheter care. Unfortunately these issues were not properly done, due to high work load issues at other hospitals. Other times early discharge and lack of community care are contributing factors and patients are ill enough to need readmission to an acute care facility This leads to a further overburdened system."

▶ *BCNU RN Jessie Renzie*

'Setting Priorities for the BC Health System' (February 2014, Page 39) confirms community care should be a priority. "Reducing hospitalization and the need for residential care by preventing or slowing down the onset of frailty by targeted secondary prevention, with a particular focus on better managing the development from low to moderate to complex chronic conditions linked to aging/ increased frailty."

The Select Standing Committee on Health Interim Report 2012 concluded: "The current levels of long term, community and home-based care are not sufficient to meet the needs of our population today. This capacity needs to be enhanced in order to cope with rising demand."

SOLUTIONS

COMMUNITY NURSING PROVIDES REAL SOLUTIONS

The job of the community nurse and the public health nurse is about creating healthy families and healthy communities. Prevention plays a large part, the promotion of which will result in the reduction of health care costs in the long term.

NURSE PRACTITIONERS

In the Premier's Letter of Mandate, the Minister of Health is asked to: "#8: Increase the scope of practice for Nurse Practitioners in BC by working with the College of Physicians and Surgeons and other credentialing organizations".

Scope of Practise: https://www.crnbc.ca/Standards/Lists/StandardResources/688ScopeforNPs.pdf

Educating and funding health authorities to support more Nurse Practitioners providing primary care would be a significant boost to under-served areas, both rural and urban.

REGISTERED MIDWIVES

Increasing the number of Registered Midwives in rural areas would be a great asset to rural areas. Creating collaborative practice between Midwives and nurses working in rural areas would address concerns that nurses have related to keeping their obstetric skills current. However, simply increasing the number of midwives is not sufficient; they must have admitting privileges at hospitals. Government should address the barriers to this occurring.

COMMUNITY HEALTH CENTRES

Health authorities should consider all models of care but in the context of true collaborative teams. Teams do not need to be led by physicians but as long as the current funding formulas are in place, this is unlikely to change. Funding the development of Community Health Centres (CHC's), rather than allocating funds to Divisions of Family Practise to attempt a watered down form of providing inter-disciplinary care will create true transformation.

The B.C. Ministry of Health's 'February 2014 Service Plan' highlights "a provincial system of primary and community care built around inter-professional teams" as a priority objective.

British Columbia's CHC's have been around in some form or another since at least 1969. They are currently the only multi-interdisciplinary team model we have that operates under one roof and unlike other provinces, there are very few of them. This team approach includes dietitians, nurses, counselors, pharmacists and many others who work together to provide the comprehensive care that a solitary doctor simply cannot provide alone.

Utilizing a case-management approach, CHC's integrate high-quality primary clinical care services with health promotion programs,

illness prevention programs and community development initiatives, in keeping with the World Health Organization's definition and vision for primary health care.

As part of this integrated, comprehensive primary health care approach, CHCs support communities and residents to achieve health by addressing "social determinants of health" — factors such as income levels, access to shelter/housing, education, language/geographical barriers and other factors that are known to have a direct impact on health outcomes for individuals, families and communities. In doing so, CHCs partner actively with other local agencies within the health sector and across sectors such as education, housing and justice to address the bigger picture of health.

BC Federation of Community Health Centres: http://www.bcfchc.ca/

Unfortunately, rather than expanding CHCs in BC we have seen dismantling of or erosion of existing Community Health Centres. If the government is truly committed to patient-centred care in the community, funds must be allocated to support true Community Health Centres.

ACUTE CARE

Nurse First Call and Remote Nursing Practice Certification will help reduce the dependence on doctors for overnight emergency care.

RN FIRST CALL: occurs in small acute care hospitals, diagnostic and treatment centres and other settings where there is physician or nurse practitioner service available in the community. These registered nurses provide primary care as set out in decision support tools.

Registered nurses who complete CRNBC certification in RN First Call:

> Diagnose and treat minor acute illness (including administering, compounding or dispensing Schedule I medications without an order) as set out in CRNBC-approved Decision Support Tools (DSTs).

https://www.crnbc.ca/Standards/CertifiedPractice/RNfirstcall/Pages/Default.aspx

REMOTE NURSING CERTIFIED

Remote Nursing Certified Practise occurs in communities where there is no resident physician or nurse practitioner, but where physicians or nurse practitioners visit the community periodically and are available to provide consultation to the registered nurse. RN's in these communities provide community health nursing services and care and respond to emergencies.

RN's with Remote Nursing Certified Practice designation:

> Diagnose and treat minor acute illness (including administering and/or dispensing Schedule 1 medications without an order).

> Carry out all activities included in reproductive health certification.

https://www.crnbc.ca/Standards/CertifiedPractice/RemoteNursing/Pages/Default.aspx

Select Standing Committee Question #3:

What best practices can be implemented to improve end-of-life care?

OVERVIEW

The literature suggests that seniors prefer to die in their own homes. Despite this, palliative care was among the top 10 conditions for which seniors were hospitalized in Canada in 2009–2010.

In the decade between 1996 and 2006, the proportion of Canadians dying in a hospital declined steadily, from 73% to 60%. This downward trend of in-hospital death corresponds with growth in community-based end-of-life care.

An important component in determining the most appropriate care for terminally ill patients is being responsive to their expressed needs.

When asked, most people have indicated that they would prefer to die at home in the presence of loved ones, yet almost 70% of Canadian deaths occur in a hospital. (Statistics Canada March 28, 2010).

The 2012 BC Select Standing Committee on Health interim report concluded:

> Improvements to the way the health care system provides care can reduce the cost of end of life care

> Medication of seniors can adversely affect their quality of life and increase costs; and,

> High costs in end of life care are also often associated with significant efforts made to sustain life rather than provide quality life.

SOLUTIONS

INCREASE PALLIATIVE AND HOSPICE CARE SERVICES

The Ministry of Health's 'Setting Priorities for the B.C. Health Care System' (February 2014) recommended "Improving end-of-life palliative care, including hospice space expansion where appropriate."

The Premier's Mandate Letter to the health minister dated June 1, 2013, deliverable #10: "...create hospice plan expansion and begin process of doubling the number of hospice spaces in B.C. by 2020."

Clearly, the government recognizes the need for more hospices and end of life care for those wanting to live their final days at home.

The Ministry of Health's 'End of Life Care Action Plan' (March 2013) concluded that individuals with life limiting conditions must be supported to remain at home in their community, "reducing the need for hospital or emergency department visits, and improving coordination of care across all settings".

Research shows that care immediately preceding death is the most costly. To address this, we need to implement a tried and true primary health care model for people willing and able to be supported in their own homes, which is both cost effective and honors the individual. At the same time, we must recognize that the most marginalized in society, who may not have homes conducive to end of life care, will continue to utilize acute care services.

ADVANCE CARE PLANNING

> Enhances end-of-life care, while reducing costs.

In recent studies, end of life conversations between patients and physicians were associated with fewer life-sustaining procedures and lower rates of intensive care unit (ICU) admissions.

The absence of ACP, in all its forms, was associated with worse patient ratings of quality of life in the terminal phase of the illness and worse ratings of satisfaction by the family during the terminal illness or in the months that follow death.

The researchers concluded that increasing communication between patients and their physicians is associated with better outcomes and with less expensive medical care. Furthermore, the results were consistent with other studies showing that the greatest cost differences come from a reduction in acute care services at the end of life.

The studies also reported that people with advanced cancer who had end-of-life conversations with physicians had significantly lower healthcare costs in their final week of life. Higher costs were associated with worse quality of death. A Canadian study found that systematically implementing an advance directive program in nursing homes resulted in fewer hospitalizations and less resource use. (Advance Care Planning in Canada: National Framework 2012)

http://www.advancecareplanning.ca/media/40158/acp%20framework%202012%20eng.pdf

Community nurses are well suited to play a larger role in end-of-life care, both in educating and supporting people around advance care directives and in working in inter-disciplinary teams to deliver palliative care.

Research is currently being carried out in BC that promotes the idea of palliative care being carried out as part of a continuum that starts much earlier in the life cycle. This supports individuals to plan and consider their wishes regarding dying at a time when they may be able to contemplate issues more fully.

Education is required to prepare nurses for this role in settings other than palliative care units or hospices. It is particularly needed in residential care but education alone will not provide appropriate end of life care in this setting. Increased staffing levels and resources are required in

residential care so that residents are not needlessly transferred to hospitals to die on gurneys in emergency department hallways.

End-of-life care is particularly suited to interdisciplinary teams but time and resources must be dedicated to team development and effective communication

OTHER BEST PRACTICES RESOURCES

> Registered Nurses of Ontario Toolkit: Implementation of Best Practise Guidelines: http://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

> Health Canada is developing an accreditation process for palliative and end-of-life care, including national standards and measurement tools.

> A model to guide hospice palliative care: Canadian Hospice Palliative Care Association http://www.chpca.net/media/319547/norms-of-practice-eng-web.pdf