ADVOCATING FOR INCREASED FOOD HANDLING STAFF HOURS IN LONG TERM CARE HOMES In Ontario

ESSENTIAL FOR QUALITY NUTRITION, HYDRATION AND DINING CARE FOR OUR RESIDENTS

Long Term Care Action Group
Dietitians of Canada
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1. EXECUTIVE SUMMARY

Dietitians of Canada believe that the allocated hours for Food Service Workers (Food Handlers) in Ontario's Long Term Care (LTC) Homes must be increased immediately in order to effectively provide high quality, safe, nutritious food to Residents living in these Homes.

Nutrition, hydration and dining all play an **essential** role in the health and well being of Residents in LTC Homes and this requires a balanced approach between medical nutrition therapy and quality of life issues for our frail elderly. LTC Residents expect and deserve to receive individualized nutrition care and appetizing meals delivered by well-trained staff in a manner that meets their health and quality of life needs.

Today's Residents in LTC Homes are older, frailer and more culturally diverse than ever before. The complexities of their care needs have increased markedly, requiring multiple therapeutic nutrition interventions, food texture and fluid consistency modifications, attention to various and often multiple allergies, provision of culturally appropriate foods and restorative dining interventions to maximize independence. While there is always a balance between minimizing complex therapeutic diets and meeting Residents' medical needs, nutrition care needs must be individualized for each Resident. In order to accurately provide meals for each Resident and specialized products as required, Food Service Workers must follow detailed production sheets as well as complex therapeutic menus and comprehensive Resident information at the point of service. This necessitates both specialized training and increased daily staff hours for Food Service Workers (FSWs).

Food Service operations are also dealing with more resilient types of bacteria in the work place. Ever increasing time and vigilant attention must be paid by FSWs to follow safe and sanitary food handling and cleaning processes in order to reduce or prevent the risk of food-borne illness in the LTC Home populations.

The Long-Term Care Facility Design Manual (1998) focuses on smaller dining rooms of no more than 32 Residents in each Home area. This is far different from the Homes of the 70's and 80's where Residents were sitting in large dining rooms and often able to serve their own foods in a "cafeteria-style" manner. Today's smaller dining rooms and individual serveries require additional food service staff to prepare and serve meals right in the Residents' Home areas (RHAs), thus ensuring that as "Home like" an atmosphere as possible is achieved.

In the current LTC setting, Food Handlers/Food Service Workers, and their managers, find their multifaceted job to be extremely demanding. An increase in allocated time, as well as the necessary specialized training, is required in order to adequately fulfill the expanded role and perform the duties of a Food Service Worker with accuracy and efficiency and prevent the negative outcomes that can potentially result from inadequate FSW hours.

In order to effectively and safely meet the nutrition, hydration and dining needs of today's Residents, it is imperative that the allocated time for Food Handlers/Food Service Workers be increased immediately from the current minimum of 0.42 hours per Resident meal day to a minimum of 0.64 hours per Resident meal day.

2. BACKGROUND

A. The Changing Face of the LTC Resident – 2009

Residents coming to live in Long Term Care Homes have changed significantly since the Ministry of Health LTC Facility Program Manual and staffing standards were originally developed in 1993.

At the time that the Manual was developed, most Residents in LTC Homes were less frail, their medical needs were less complicated and the range and diversity of Nutrition Care interventions required were, therefore, less complex and less time consuming. Those Residents requiring more complex needs were usually cared for in either acute or chronic care facilities.

It is now recognized that it is important to keep our seniors safe, comfortable and cared for in their own Homes for as long as possible. Recent additional funding from the Ministry of Health and LTC for the "Aging at Home" strategy is helping to enable our seniors to remain in their Homes for longer than was previously feasible.

However, when seniors are no longer able to care for themselves in the community, with family and or Home care support, there are other options available. Retirement and rest Homes can be considered for those Residents who are still relatively independent with their activities of daily living. These Homes are currently not funded or regulated by the Ministry of Health. Acute care and chronic care hospitals can provide the acute care or long term care but only when the health care needs of seniors are so great that they cannot be met in other settings. Long Term Care Homes often become the most *suitable* option when Residents' health and personal care needs become greater than what retirement Homes can provide, yet not great enough to require admission to the limited number of hospital beds across the province. .

The result is that the populations we now care for in our LTC Homes are *on average* much *frailer*, much *older* and *require much more complex care* to deal with their multiple co-morbidities than when the LTC standards were originally introduced in 1993. For instance, the average age in today's LTC Home is 83 (compared to 73 in 1990's).Today's Resident may be on dialysis for renal failure, have chronic illnesses such as diabetes, have significant swallowing problems, including needing enteral (tube) feeds, or have multiple allergies and food intolerances. These conditions all require specialized foods/meals and are examples of the ever-increasing complexity of nutrition care needs being managed in LTC Homes. The 2008 Clinical Statistics survey by the Gerontology Network of Dietitians of Canada indicated that 88% of Residents in LTC were rated as being at moderate to high nutrition risk.

While the average Resident age has increased overall, there are also younger Residents requiring LTC placement whose life expectancy previously was not as long. While generally not as frail as the elderly in our Homes, these younger Residents often have very different and complex medical and nutrition needs that have necessitated the LTC admission.

To meet the needs of today's diverse LTC Home population is extremely demanding; with some younger Residents but the majority aging and increasingly frail, and both groups presenting complex needs. Their nutrition care may require therapeutic diet interventions, texture modifications, attention to increasing allergies, recognition of culturally appropriate foods and the need for restorative and assisted dining. All of these food, nutrition and dining needs are planned by Registered Dietitians and the Interdisciplinary team and **implemented by front line staff, including Food Service Workers.**

B. The Importance of Quality Food for our Residents

The importance and recognition of the benefits of a quality nutrition, hydration and pleasurable dining in the "quality of life" and the "quality of care" for Residents in LTC is steadily increasing. Many Homes take a holistic approach to dining, by recognizing that food, beverages and pleasurable dining influence Residents' psychological and social well-being as well as their physical well-being. This approach must be provided by knowledgeable and well trained staff who can address Residents' individual needs.

However, for today's frailer Residents with increasingly complex needs, the provision of the quality care is becoming more of a challenge. The recent increase in articles on malnutrition and dehydration in Long Term Care settings speaks to the gravity of the situation. Providing a pleasant and supportive environment with tasty and attractive meals encourages Residents to eat better and remained better nourished.

Homes are often encouraged to buy and serve "locally" grown foods, as long as these foods are coming from approved suppliers. This movement, while admirable, often requires additional time from Food Service Workers in the preparation of these fresh foods versus purchasing foods already prepared. While no one would argue with the benefits,, for example, of serving fresh corn on the cob for our Residents or serving fresh peaches or strawberries, it must be recognized that it takes much more time to husk and prepare the corn; peel and slice the peaches or hull the strawberries than to use canned or frozen produce.

C. The Importance of Safe Food for our Residents

The increasing complexity of meals and the food and fluid textures required to meet Residents' therapeutic and functional needs increases the risk of bacterial contamination. Texture modified foods have increased surface areas potentially exposed to bacterial contamination and are subject to time and temperature variations during the processing stage. This increases the risk of food-borne illness. With a frail population, the outcomes of food borne illness are extremely serious. It is essential that staffing levels are high enough to ensure that there is adequate time and attention required to follow safe and sanitary food handling practices and thorough cleaning and sanitizing of production equipment and workplace areas.

D. The New Design Standards

When staffing levels, including those for Food Service Workers, were originally established in the early 90's, they were loosely based on existing staffing levels averaged among Homes and reflective of the nursing Home model of the 70's and 80's. This was often a one floor 60 bed nursing Home with a kitchen adjacent to the dining room serving Residents. These staffing levels also reflected the time required to serve the Resident population of the 1980's and were based on the knowledge and standards of nutritional care and hydration *at that time*.

The redesigning of LTC Homes or the building of new Homes has evolved in recent years and strives to provide a more Homelike environment for our Residents in smaller "Resident Home Areas" (RHAs). The design of the Nutrition, Hydration and Dining Program has also changed. For example, in a newly built Home with 128 Residents, there will generally be 4 meal service areas (serveries) each serving 32 Residents. Some of these will share a common kitchenette area, some will be completely separate. Some Homes have a centralized kitchen where the main menu items are centrally prepared and then portioned and delivered to these kitchenette and servery areas. Other Homes have much of their meal preparation done right in the service areas in each of the RHAs, requiring additional staffing but providing foods prepared closer to the Residents – a more Homelike environment.

Although more Homelike, these increased number of service areas have also greatly increased the workload for FSWs, as each area requires time to **set-up, stock, prepare for service, serve and clean after meal service.** Further, with this increased number of service areas, the Food Service Supervision/Nutrition Manager is no longer as readily accessible to the food service staff so the accuracy of preparation and delivery of these needs is often the ultimate responsibility of the Food Service Worker.
Establishment of the RHAS has also lead to expanded job responsibilities for those working in the units. FSWs in the smaller units may be assigned to other duties during the same shift, including personal care for Residents and housekeeping. Short staffing in other departments requires food service workers to provide occasionally assistance with feeding Residents or cleaning duties that would normally be done by other staff. Some homes may use a multi service staff approach which requires staff to move from one activity (such as changing adult briefs) to the next (such as preparing breakfast) significantly increases the risk of disease transmission. If long term care homes are using this multi skilled worker approach to Resident care or find that FSWs are occasionally faced with assisting other departments, sufficient resources must be available to provide staff with

a. education on disease transmission
b. time to adequately perform personal hygiene measures

E. Current Ministry of Health and Long Term Care (MOHLTC) Definition and Calculation and Standards and Criteria pertaining to Food Service Workers/ Food Handling Staff

Definition of Food Handling Staff:
Food Handling Staff are cooks, dietary aides and other individuals employed in the preparation and cooking of food and in the cleaning of kitchen equipment but does not include time spent by:

a) persons performing food supervisory duties
b) dietitians in the performance of their duties
c) nursing and personal care staff in assisting Residents with meals.

Ministry of Health and Long Term Care Facility Program Manual
Standards and Criteria:

Food Handlers hours
P1.38 Staffing requirements for food handlers shall be a minimum of 0.42 hours per day per meal day.
(This staffing level has only increased once since 1993; from .4 to .42; the equivalent of 2.5 hours/day in a 128 bed Home or 13 minutes per meal in each of 4 service areas.)

Food Service Worker Training
P1.39 100% of new hires for the position of Food Service Worker to be employed by the Nutrition and Food Services/Dietary Department will be required to have completed the Food Service Worker training program, or be enrolled in a Food Service Worker training program offered by an established college as listed in the Ontario Colleges of Applied Arts and Technology Act, 2002 or a registered private career college in Ontario. If this is not possible, then a written alternative plan must be developed and in place with evidence of ongoing recruitment.
Note: This requirement does not include students or seasonal workers hired on a part time/casual basis, or cooks/chefs who have a diploma from an established college as listed in the Ontario Colleges of Applied Arts and Technology Act, 2002 or a registered private career college in Ontario or cooks that have attained Interprovincial Standards Red Seal Program status.

3. THE ROLE / RESPONSIBILITES OF FOOD SERVICE WORKERS (FOOD HANDLERS) IN LONG TERM CARE – 2009

A. Role of the cook and food service worker

Food Handlers Hours are generally divided into **Cooks and Food Service Workers** with each performing a role in the provision of a Quality Nutrition, Hydration and Dining Program.

The **Cook's** role generally includes:

- Assisting in the development and use of standardized processes including recipes and production guidelines;
- Producing, presenting and taste testing a variety of appetizing meals and snacks for all Residents living in the Home;
- May include completing inventories, providing some assistance in ordering and/or receiving deliveries;
- Ensuring and maintaining safe, sanitary production practices and environment by following HACCP guidelines and cleaning schedules;
- Assisting in monitoring, evaluating and improving the dining program by assisting in the revision of standardized practices, recipes and menu planning to continue to meet the needs and expectations of the Residents.

The **Food Service Worker's** (Food Handling Staff) role includes:

- Assisting in the production of meals, beverages and snacks;
- Providing and ensuring all Residents are offered a choice at meals and snacks;
- Plating and serving attractive and appetizing meals;
- Following the Residents' dining care binder/roster so each Resident has his/her dining care needs met;
- Following the Home dining guidelines and policies and procedures to provide Residents with pleasurable dining;
- Ensuring and maintaining a safe, sanitary kitchen, following production, service and dining practices by following HACCP guidelines and cleaning schedules;
- Assisting in the monitoring, evaluating and improvement of the dining program by communicating observations and suggestions from the Residents, families and other team members to the appropriate person.

B. Production of meals - The role of the cook

A qualified and trained cook is generally required for 3 meals a day, starting approximately 1-2 hours in advance of the first meal and available until the last meal is served. All Residents are provided with choices and variety in meals based on their nutrition needs, their chewing and swallowing abilities and their cultural and/or ethnic preferences. An example of the complexity of the production, preparation, panning and delivery of these meals items is provided below. In the example provided below, there are 35 items to be prepared for one dining area for one meal. In a 128-bed Home with four dining areas, the cooks would need to portion this food into 140 containers to provide for each Resident's dietary needs and choices.
(35 items x 4 dining areas = 140).

Minimum Cook time requirements: Approximately **16 hours/day**.
(This will vary based on the amount of food that is outsourced, the actual number of special items required to meet all Residents' needs and expectations and the amount of assistance provided by the Food Service Workers.)

Example of Minimum Food Production in One Dining Area

Meal	Choices	Food Item		Texture #1 regular	Texture #2 minced	Texture #3 pureed
Noon or Supper	Choice #1	Condiment	Cranberry Sauce or Jelly	√	same	√
		Gravy	Chicken Gravy	√	same	same
		Entrée	Roast Chicken	√	√	√
		Starch	Oven roasted Potatoes	√	√	√
		Vegetable	Mixed Vegetables	√	√	√
		Dessert	Apple Crisp	√		√
		Diet Dessert	Diet Apple Crisp	√		√
	Choice #2	Garnish	Parsley	√	same	√
		Gravy	Beef Gravy	√	same	same
		Entrée	Meatloaf	√	√	√
		Starch	Mashed Potatoes	√	√	√
		Vegetable	Broccoli Spears	√	√	√
		Dessert	Butterscotch Pudding	√	same	same
		Diet Dessert	Diet Butterscotch Pudding	√	√	√
		Special diet or cultural meal	Vegetarian Lasagna	√	√	√

C. Service of Meals

Food Service Workers are required in each service area for 3 meals a day.

Note: the following calculations are based on a 128 bed Home with 4 dining areas

Advance Meal Set-up
Although Homes will vary in their processes, advance servery set up requires a minimum of the following duties: setting up the steam table, taking and recording of food temperatures and setting up "show plates". In some Homes, salad and desserts are also portioned and garnished in the servery area; other Homes may require rethermalization in the servery; in others the FSW may go to the main kitchen and assist with portioning there.

Advance Meal Set-up time
4 service areas x 3 meals x .5 hour per meal: **6 hours**

Service Time Requirements
Best Practices generally require about 1 hour service per meal in each service area in order to provide for each Resident's nutrition needs, supervision and encouragements needs and to provide pleasurable and unrushed dining.

Service time requirements:
4 service areas x 3 meals x 1 hour per meal: **12 hours**

Snack and Beverage Passes
Beverage and snack carts are required 3 times per day with set up and clean up being about 30 to 45 minutes each. Actual time needed will depend largely on the number of special order nourishments also required.

Beverage/Snack time requirements:
4 service areas x 3 passes x .75 hour per pass: **9 hours**

D. Maintaining a Safe and Sanitary Environment
Setting and cleaning up each dining and servery area requires approximately 1 hour per meal depending on the interdisciplinary team roles, including the time and ability of other team members such as PSW's and Environmental services to assist.

Dining Room and Servery Cleaning and Set up time requirements
4 dining areas x 3 meals x 1 hour per meal: **12 hours**

Each area will also have ware washing requirements, sometimes done in the individual servery areas, sometimes requiring transporting dishes to a central ware washing area, and then washing and returning to the Resident Home Area.
Each area also requires food, paper and cleaning supplies to be stocked and replenished on a daily basis.

Ware washing and stocking time requirements
4 service areas x 3 meals x 1 hour per meal: **12 hours**

The main kitchen requires daily cleaning and sanitizing of all equipment, surfaces and small wares used for the preparation and delivery of meals. The main kitchen also requires regular cleaning of all refrigerators, stoves, vents and hoods, storage areas and floors.

Main Kitchen cleaning time requirements
Time will vary but approximately **6 hours** per day.

However, the complexity of the situation is increased, as the Food Service Workers hours need to be spread to cover all meal times and beverage/snack passes. This means that staffing is generally required in each service area approximately 30 minutes before and 30 minutes after the first and last meal and/or snack set up and service to ensure proper production and a safe and sanitary work and service environment.

Based on Resident's needs and expectations, breakfast service generally starts at approximately 8:00 Am and evening snack pass is ends about 8:00 PM. In order to staff each area you requires about 13 hours/per service area
13 hours/dining room x 4**= 52 hours**

Total Estimated Required Hours as indicated above	
A. Production (cook) Hours	**16 hours**
B. **Service of Meals**	
Advance Meal Set-up	**6 hours**
Meal Service Time	**12 hours**
Snack and Beverage Passes	**9 hours**
C. Maintaining a Safe and Sanitary Environment:	
Dining Room Cleaning	**12 hours**
Ware washing and stocking time requirements	**12 hours**
Main kitchen	**6 hours**
Total: 73 hours labour, excluding breaks, lunches, education etc**. for 128 bed home**	

E. Meeting nutrition requirements

Food Service Workers are required to meet the nutrition needs of all Residents in the long term care Home under the direction of the Registered Dietitian and Nutrition Manager and according to their designated food/beverage needs and preferences within the currently allocated hours Nutrition care is individualized for each Resident and therefore, dietary rosters/kardexes must be closely followed by servery staff. This requires offering each Resident only those foods and beverages allowed on a prescribed diet or texture modification, when applicable, as well as adhering to food preferences and tolerances while respecting Residents'' right to choice. With the complexity of Residents' special needs and the variety of diets now being offered in long term care Homes, Food Service Workers are being asked to contribute to their care, including the preparation of many specialized products. This workload is far greater than what the Ministry of Health and LTC standards anticipated in the early 1990's when Registered Dietitians were not even mandated to be in Long Term Care Homes. While Registered Dietitians always strive to reduce complex therapeutic nutrition interventions with LTC Residents while respecting quality of life issues; individualizing care to optimize nutrition status remains the number one goal. Registered Dietitians assess Residents' needs and establish individual a nutrition care plan for each Resident. No two Residents will have exactly the same care needs – therefore, each Resident will have specific nutrition interventions, even if this is just following food likes and dislikes. Certainly meeting the more complex needs of Residents (i.e. Residents who require nutrition interventions for diabetes, renal disease, skin integrity and swallowing problems), requires very specific and detailed nutrition interventions. Food service workers must follow these individual dietary rosters/kardexes exactly in order to ensure that Residents receive the nutrition interventions that they require

4. Human Resource Issues

A. What Current Staffing Levels provide

According to the current allocation for staffing levels of Food Handlers; a 128 bed Home would be required to provide 53.76 hours/day of Food Service Worker time (128 x .42 hours per day). Breaks, lunches, education sessions, etc. reduce this time by approximately 1 hour/8 hour shift or ~6.72 hours/day leaving 47.00 hours per day of actual Food Service Worker productive time. The difference between the minimum requirement and the 73 total hours estimated above is approximately **26 hours per day of Food Service Worker time.**

The recommended staffing of .64 hours/day of Food Service Worker time would provide the same 128 bed home with 82 hours per day (128 x .64). Breaks, lunches, education sessions, etc. would reduce this time by approximately 1 hour/8 hour shift or ~10 hours/day providing approximately the required 73 hours per day of actual Food Service Worker productive time

Surveys show that Food Handlers are dedicated to their job and wanting to provide quality care to their Residents. To do this often requires that they come in to work early, miss or shorten their coffee or meal breaks and/or leave later than their scheduled shift. In one survey of 17 Homes, it was estimated that a total of 90.93 hours per week were provided by Food Handlers who did not feel they could complete their jobs in the allotted time. They felt *Residents would not receive the care and service they were supposed to* - if FSW staff did not volunteer these additional hours. Staff reported "feeling an obligation to stay after their shift in order to get their work done.

Safety of the Food Handlers was cited as also being a concern. Food Service Worker staff reported feeling exhausted and some reported taking short cuts in order to complete their required duties.
Staff turnover is also a concern. Food Handlers frequently are hired and often stay only a short time, citing "work load" as the reason for leaving LTC. This is not only expensive in terms of advertising and training for the LTC Home, but does not foster a positive image of what it is like to be *employe*d in a LTC Home in Ontario – certainly not a desirable outcome when human resources are scarce.

5. Improvements to date

To improve nutrition care and reduce nutrition risk factors, there have already been many positives changes. These include the following:

- Due to strong advocacy and recognition of the importance of quality food, the raw food cost funding has increased to $ 7.15/meal day;
- The Ministry of Health and Long Term Care and Homes across the province have recognized the growing need for increased registered dietitian time over and above the minimum requirement in order assess and plan nutrition care to best meet Residents' needs. A recent survey by the *Gerontology Network of Dietitians of Canada* indicates that the average number of hours per Resident in Ontario has increased from the minimum 15 minutes per Resident per month established in 1993 to 21.36 minutes per Resident per month (Dietary Statistics Survey May 2008).
- The menu planning process has improved and now requires that the both the Residents' Council and the Registered Dietitian approve each menu cycle. Each Home's menu provides meals that reflect Residents' preferences in a nutritious manner;
- Food Service Worker time has increased (minimally) from 0.4 to 0.42 hours per Resident meal day and there is recognition of the importance of providing additional time for heavy cleaning activities as well as time requirements if a Home has both LTC and retirement beds;
- The hiring qualifications of Food Service Workers have been increased, recognizing the importance of well trained staff in these positions.

6. The Ongoing Challenges and possible /outcomes

A. Challenges and outcomes

Not providing adequate food handler hours to prepare and serve food in a safe and sanitary environment does a disservice both to our Residents and to our employees. Staff coping with workloads that are too demanding are unable to provide care and service for Residents in a way that is consistent with optimal quality of life and may take "shortcuts" that do not support the Home's policies, procedures and guidelines for quality care and result in negative outcomes.

- *Possible outcomes if shortcuts* are taken in the set up of meals in the steam tables:
    - Staff not taking time to check and follow the therapeutic menu resulting in planned portion sizes and serving utensils not being accurately used so the Resident does not receive accurate portions and therefore does not benefit from the planning and interventions of the interdisciplinary team
    - Staff not recording food temperatures at point of service potentially resulting in food being served at unsafe or unpalatable temperatures for Residents.

- *Possible outcomes if shortcuts* are taken in production:
    - Production staff may not prepare all menu items, alternate choices, texture modified foods and special orders limiting Residents choices at mealtimes.
    - Production staff may not have sufficient time for additional preparation time required for fresh fruits and vegetables, higher fibre Home-made baked goods, etc. limiting the variety and use of local and more nutritious foods.

- *Possible outcomes if shortcuts* are taken in following the individualized dining plan for each Resident :
    - Staff may not check the dining plan resulting in Residents not receiving their individualized planned nutrition care.
    - Resident may not receive the foods he/she enjoys and will eat therefore negatively impacting food intake.
    - Residents may not receive assistive devices or assistance and encouragement he/she requires to manage/enjoy the meal and allow for independent in self-feeding
- Possible outcomes if shortcuts are taken in the delivery of meal service:
    - Presetting tables with beverages in advance of meal service may mean that these beverages are not held and served at appropriate temperatures for safety and palatability. Presetting could also limit the choices Residents can make.
    - Staggering meals and having one staff member serve 2 dining areas often requires removing food from the steam table before all Residents have completed their meals. This does not allow the opportunity for quality meals/choices for Residents who may arrive in the dining room late or for those requesting second helpings.
    - Another shortcut could be staggered meals to accommodate staffing levels resulting in inadequate delivery of meals (no one except nursing to serve Residents).
    - Hurried meal service limits the opportunity for Residents to complete their meals and to socialize during the dining experience.
- *Possible outcomes if shortcuts* are taken or in cleaning:
    - Unsanitary or unsafe work environment increasing the risk of food borne illness, increased breakage of small wares, and/or risk of staff injury.
    - Inadequate attention being paid to cleaning and sanitizing policies and procedures, such as checking and recording the wash and rinse temperatures of mechanical dishwashers

- *Possible outcomes if shortcuts* are taken overall in the department:
    - Inadequate time to accurately monitor, document, evaluate and improve the Nutrition, Hydration and Pleasurable Dining program provided to individual Residents and to Residents as a whole.

Ultimately, inadequate staffing can inadvertently result in substandard provision of care that may negatively impact on the quality of care and services to our Residents. Negative outcomes may include:

- poor food and fluid intake which can lead to dehydration, weight loss, poor skin integrity, difficulties in bowel and bladder function including constipation and increased incidents of urinary tract infections
- an unpleasant or rushed dining environment which does not allow adequate time for restorative dining and maintenance of functional abilities which could improve Resident self-confidence and quality of life;
- Less assistance with ADLs, as related to readiness for attending and consuming meals (dentures, glasses, positioning, etc.) and feeding self;

B. Long Term Implications of these challenges on human resources/staffing requirements and standards

1. With the increased workload requirements, there is an increased risk to the Food Handlers of injuries and lost time as a result of rushing to complete the job.

2. With an aging and shrinking workforce, the work environment and job satisfaction will be important in hiring and maintaining a qualified workforce to deliver quality care. Staff working in LTC show a passion and dedication to the Residents who are like family to them. They express extreme frustration when they are unable to deliver the quality of service and individual care that they know would enhance the quality of life for a Resident: e.g. peeling and slicing an apple for a snack instead of a cookie; the extra few moments when showing the Resident choice to positively encourage and support the Resident's anticipation of a meal; or the extra time to stay with a Resident encouraging them to chose and consume an extra beverage.

3. For each dining area, in order to have staffing available to meet Residents' needs and expectations and to prepare, provide and clean for 3 meals and 3 snacks daily means staffing from approximately 7:30 AM to 8:30 PM. This creates an additional staffing challenge as this requires the use of part-time employees. Staffing the part-time shifts creates additional difficulties as appropriately qualified staff are required. Having completed their FSW training, the qualified employees seek and are often able to find full-time employment, creating ongoing training and retention concerns in the industry.

4. Food Handlers continue to struggle to provide quality nutrition and dietary care in the .42 hours/Resident meal day currently established as a minimum level. These time constraints can result in Food Handlers not having the time to check the resources at the point of service to ensure each Resident receives the individual care appropriate for his/her frailty and complexity of care including therapeutic diet interventions, texture modifications, allergy diets, culturally appropriate foods and restorative and assistive dining interventions planned by Registered Dietitians and Interdisciplinary team.

5. In many Homes, Food Handlers frequently miss breaks, have shortened lunches and work before and after their scheduled shift in order to get the work done. This increasing workload and pressure results in increased sick time and workplace injuries. It also makes LTC a less attractive work environment, so an increasing number of younger qualified staff leave for more attractive work environments. , This leaves Homes with more aging staff who struggle with all the changes to their work environment and may not have the skills and, in many cases, literacy required to meet the complex needs of today's Residents and the demanding work environment.

6. With an aging and shrinking workforce, the work environment and job satisfaction will be important in hiring and maintaining a qualified workforce to deliver quality care.

7. Summary and Recommendations

As we strive to improve the quality of care and services that we provide in Long Term Care Homes in Ontario, and recognizing the increasing needs of our Residents and the demands placed on all well-trained team members adequate resources **must be provided** to enable Food Service Workers to perform their duties with efficiency and accuracy and prevent the negative outcomes that can potentially result from inadequate food service worker hours.

RECOMMENDATION

In order to effectively and safely meet the nutrition, hydration and dining needs of today's Residents, it is imperative that the allocated time for Food Service Workers be increased immediately from the current minimum of 0.42 hours per Resident meal day to a minimum of 0.64 hours per Resident meal day.

Appendices and References

Coalition: Province's Long Term Care PR Announcements are an Insult to Seniors
"In the past decade, the average age of long term care Residents has increased from 73 to 86 years of age." September 14, 2001 http://www.web.net/ohc/docs/sep14.htm

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People Caring for People: A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario, Shirley Sharkee
Page 12
"The average age of LTC Residents is 83 years. Those under the age of 65 years account for less than 6% of total Residents. More than 85% of Residents are classified as requiring high levels of care including constant supervision and assistance in performing one or more activities of daily living (ADL) including dressing, eating or toileting."

Survey of Unpaid ("Free") Time Provided by Dietary Personnel
Barker, Blagrave and Associates, Professional Dietetics Corporation November 2008

This paper has been reviewed by the Communicable Disease/Infection Control Committee of the Canadian Institute of Public Health Inspectors Ontario Branch Inc.