

HEALTHCARE

# POLICY

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## Politiques de Santé

*Health Services, Management and Policy Research  
Services de santé, gestion et recherche de politique*

**Volume 17 ♦ Special Issue**

**Long-Term Care in Crisis:  
The Reality of COVID-19**

**Les soins de longue durée  
en situation de crise :  
la réalité de la COVID-19**

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# POLICY

## Politiques de Santé

*Health Services, Management and Policy Research*  
*Services de santé, gestion et recherche de politique*

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*Healthcare Policy/Politiques de Santé* seeks to bridge the worlds of research and decision making by presenting research, analysis and information that speak to both audiences. Accordingly, our manuscript review and editorial processes include researchers and decision-makers.

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Nous publions des articles savants et des rapports de recherche qui appuient l'élaboration de politiques et le processus décisionnel dans le domaine de la santé et qui abordent des aspects aussi variés que la gouvernance, l'organisation et la prestation des services, le financement et la répartition des ressources. La revue accueille favorablement les articles rédigés par des chercheurs provenant d'un large éventail de disciplines dans les sciences de la santé, les sciences sociales et la gestion, et par des équipes de recherche interdisciplinaires. Nous invitons également les décideurs ou les membres d'équipes formées de chercheurs et de décideurs à nous envoyer des articles qui traitent de l'échange et de l'application des connaissances.

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## Long-Term Care during COVID-19: A Special Look under the Hood

**L**ONG-TERM CARE (LTC) IS AN OFT-OVERLOOKED CRITICAL COMPONENT OF PROVINCES' health and social care systems. Its residents have borne a disproportionate share of the negative impact of the COVID-19 pandemic. *Healthcare Policy* believes that rules, regulations, policies and health system delivery factors that were associated with excess mortality and poor health and social outcomes in LTC should be closely examined so that the recent mistakes made in that sector can be avoided in the future.

Nine manuscripts in this special issue of *Healthcare Policy* focus on specific aspects of LTC, including policy analyses of the workforce, leadership, ownership type and resident neglect. In addition, several manuscripts describe specific provincial policy directives and their material impact on LTC residents' health, well-being and isolation.

The authors of the manuscripts in this special issue are experts in the field of LTC; they have devoted significant parts of their professional lives to improving the quality of life of LTC residents and the people who work in LTC homes. In my opinion, the readers of *Healthcare Policy* are fortunate in having these authors develop plans for avoiding future tragedies in the LTC sector and propose policy options for improving the health-related quality of life of LTC residents. I hope that you find this special issue of *Healthcare Policy* as compelling as I do.

JASON M. SUTHERLAND, PHD

*Editor-in-Chief*

## Soins de longue durée pendant la COVID-19 : coup d'œil sous le capot

LES SOINS DE LONGUE DURÉE SONT (SLD) UNE COMPOSANTE ESSENTIELLE SOUVENT négligée des systèmes de santé et de services sociaux des provinces. Les résidents des établissements de longue durée ont enduré une part disproportionnée de l'impact négatif de la pandémie de COVID-19. *Politiques de Santé* estime que les règles, réglementations, politiques et facteurs qui influencent la prestation du système de santé et qui sont associés à une surmortalité et à de mauvais résultats sanitaires et sociaux devraient être examinés de près afin que les erreurs récentes dans les SLD puissent être évitées dorénavant.

Neuf manuscrits du présent numéro spécial de *Politiques de Santé* se concentrent sur des aspects précis des SLD, notamment des analyses politiques de la main-d'œuvre, du leadership, du type de propriété et de la négligence envers les résidents. En outre, plusieurs manuscrits décrivent des directives politiques provinciales spécifiques et leur impact matériel sur la santé, le bien-être et l'isolement des résidents des établissements de SLD.

Les auteurs des manuscrits de ce numéro spécial sont des experts dans le domaine des SLD. Ils ont consacré une partie importante de leur vie professionnelle à l'amélioration de la qualité de vie des résidents des établissements de SLD et des personnes qui y travaillent. Selon moi, les lecteurs de *Politiques de Santé* ont de la chance que ces auteurs élaborent des plans pour éviter d'éventuelles tragédies dans les SLD et proposent des choix de politiques pour améliorer la qualité de vie et la santé des résidents. J'espère que ce numéro spécial sera tout aussi captivant pour vous qu'il ne l'est pour moi.

JASON M. SUTHERLAND, PHD

*Rédacteur en chef*

# COVID-19 and Long-Term Care: What Have We Learned?

## La COVID-19 et soins de longue durée : qu'avons-nous appris?

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### Abstract

The COVID-19 pandemic has led to thousands of deaths; of these, a disproportionate number has occurred in long-term care settings. The papers presented here deal with a number of issues highlighted by this crisis in several jurisdictions, including Ontario, Quebec and the Netherlands. Analyzing these may give us some insight into what is necessary to prevent this disaster from happening again.

### Résumé

La pandémie de COVID-19 a fait des milliers de morts. Un nombre disproportionné de ceux-ci a eu lieu dans des établissements de soins de longue durée. Les articles présentés ici traitent d'un certain nombre d'enjeux mis en évidence par cette crise dans plusieurs endroits, dont l'Ontario, le Québec et les Pays-Bas. Leur analyse peut nous donner une idée de ce qui est nécessaire pour empêcher que ce type de catastrophe ne se reproduise.

### Introduction

The COVID-19 pandemic has led to thousands of deaths, of which a disproportionate number have occurred in long-term care (LTC) settings. The papers presented here deal with a

number of the issues highlighted by this crisis and give some clues as to what is necessary to prevent this disaster from happening again. These issues are not unique to Ontario; there were similar problems in many other jurisdictions, including Quebec (Lavoie-Tremblay et al. 2022) and the Netherlands (Meershoek et al. 2022). Analyzing these may give us some insight into how best to manage future infectious disease outbreaks.

## Background

LTC is defined as the services needed to meet a vulnerable person's health or personal care needs when they can no longer perform everyday activities on their own (NIH NIA 2017). As such, it includes a variety of services that can be provided in a variety of settings by a variety of caregivers. The needs may be short-term (e.g., wound care after surgery) or long-term. The caregivers may include unpaid family members and friends but also paid workers. The services may include combinations of personal care "activities of daily living" (e.g., bathing, dressing, eating, mobility, taking medications), homemaker services (e.g., meals, transportation), home healthcare (e.g., nursing care to help a person recover from surgery or illness), and physical, occupational or speech therapy. The settings where these services may be provided can include the hospital (if alternative locations to receive the needed care are not available), the person's home, adult day care centres, retirement homes and/or nursing homes.

It is important to note that most LTC services (with the exception of medically necessary services delivered in hospitals or by physicians) do not fall under the terms of the *Canada Health Act* (1985). As such, there is no requirement for these services to be publicly paid for in Canada, although some provinces do choose to do so for some services for some populations. This special issue of *Healthcare Policy* focuses on care in LTC institutions (nursing homes).

In Ontario, LTC homes focus on providing care for individuals with extensive medical, physical or cognitive needs, who require access to 24/7 nursing care. According to the most recent data available at the time of writing, 54.8% of Ontario LTC residents were 85 years of age or older and the majority required support in activities of daily living (NIA 2020). Data from 2019 showed that 90% of LTC residents in Ontario had some type of cognitive impairment (OLTCA 2019).

Ontario LTC facilities are governed by provincial statutes, legislation and regulations, which events showed were often inadequate to deal with the problems that arose during the COVID-19 pandemic. Facilities in Ontario are licensed by the Ministry of Long-Term Care and governed by the *Long-Term Care Homes Act, 2007*, while nursing and personal support services are governed by *O. Reg. 79/10* (Government of Ontario 2011; Ministry of Long-Term Care 2020).

Within LTC, there are multiple ownership structures. In Ontario, these include for-profit, not-for-profit and public (municipally owned). As of March 31, 2021, there were 627 licensed LTC facilities in Ontario with 78,902 long-stay beds; 57% of these facilities were privately owned, 27% were non-profit/charitable and 16% were publicly (municipally)

run (CIHI 2021). Paid nursing care was provided by a mix of personal support workers (PSWs), registered practical nurses (RPNs) and registered nurses (RNs). Boscart et al. (2018) found that PSWs provided the bulk of nursing care (76.5%) in Ontario LTC facilities, followed by RPNs (17.3%) and RNs (5.9%). Additional services provided in LTC included dietary services, physiotherapy, recreation, food services, social work, administrative services and housekeeping/cleaning.

The funding models vary. In Ontario, the provincial government provides funding for nursing homes that is intended to cover the cost of staff and supplies for certain services (particularly nursing and personal care, plus some support services, as well as the costs for raw food). However, residents must also pay a fee for their accommodation costs. Government agencies determine who is eligible to be admitted to an LTC home and manage the wait lists.

On March 17, 2020, the provincial government declared a state of emergency because of COVID-19 (Rodrigues 2020). On March 22, 2020, the Minister of Long-Term Care issued the first of many operational and policy directives under the *Long-Term Care Homes Act, 2007*, many of which are listed on the AdvantAge Ontario website (AdvantAge Ontario 2022). Intended to address the myriad issues related to the pandemic, these directives referred to procedures and precautions, infection prevention and control (IPAC) measures and restrictions on visitation.

## Discussion

As demonstrated in this issue, there are a number of factors that were associated with better or worse outcomes for LTC residents. Some had been in place before COVID-19 but had a greater impact with the pandemic. Analysis of inspection reports (Crea-Arsenio et al. 2022) highlighted how complaints were not always well dealt with, giving rise to questions about how accountability is organized. Other ongoing problems included neglect (Akhtar-Danesh et al. 2022). However, there were also exemplar institutions who provided higher standards of care and thus had better results (Baumann et al. 2022b).

As noted in a previous special issue of *Healthcare Policy* on approaches to accountability (Volume 10, 2014), accountability has multiple dimensions (Deber 2014). Accountability means being answerable to someone for meeting defined objectives; it accordingly must define who is accountable for what, to whom and how, including what the consequences are for failure to meet the desired outcomes. The policy instruments involved may include financial incentives, regulations, information directed toward potential users and professionalism (including report cards and clinical guidelines). The activities may include fiscal accountability to payers, clinical accountability for quality of care and accountability to the public. For example, owners of LTC homes should see themselves as accountable to the residents and their families for providing high-quality and safe care and also to the province and to their governing bodies for how they spent their money (Wyers et al. 2014). Ontario had changed their accountability process by delegating much of the responsibility for hospitals and LTC to the regional local health integration networks (Berta et al. 2014).

The studies in this issue note that the problems in LTC, in general, had not been dealt with well. As noted in Oldenburger et al. (2022), problems within the facilities included resident care, human resources, governance, leadership and management, financing, physical infrastructure and supplies and training and preparation. In terms of staffing, there were concerns around staffing levels, training (Berta and Stewart 2022), hours and skill mix (including the use of regulated vs. unregulated workers) and full time versus part time versus agency nurses (Baumann et al. 2014). There were additional issues concerning other on-the-job resources (Berta and Stewart 2022): supplies (including food) and the type of care given (e.g., frequency of bathing). With respect to the physical structures of the homes, there were also issues about quality (including how many residents were in each room) and cleanliness (including insect infestations) (CAF JTFC 2020). From a regulatory standpoint, there were issues with how best to deal with complaints and the consequences of poor care. There were also major issues concerning who set the standards and how these were enforced (Armstrong and Cohen 2020)

One possible approach to ensuring that LTC homes have the right number and mix of healthcare workers is to use forecasting models (Dass et al. 2022). Indeed, one response by the Ontario government has been to increase the number of hours of care that LTC homes need to provide to their residents. Recent government announcements have increased both the hours of care as well as the number of regulated and unregulated workers (Ministry of Long-Term Care 2021).

In addition, there were a number of issues that would be difficult to regulate relating to personal interactions. One key problem that arose during the pandemic was the role of family members. On the one hand, isolation was important to reduce spread. On the other, this isolation was shown to cause significant distress to LTC residents and their families (Baumann and Crea-Arsenio 2022a). Another problem was the ongoing issue about the role of for-profit LTC homes and how to ensure that they met appropriate standards (Warnica 2021).

In addition to concerns relating to accountability, the papers in this special issue suggest that there needs to be more emphasis on an overall quality model: One must look beyond such admittedly important pieces of care, such as staffing or bed numbers, to examine the system of care and how the institutions are run. For example, with staffing, numbers are important but so are leadership, extended orientation and full-time work. The inspection reports (more than 5,000 written over a two-year period) can be seen as a canary-in-a-coal-mine view of a system that is deeply in trouble (Crea-Arsenio et al. 2022).

### Conclusion

These papers suggest that the LTC evidence is clear and the pieces that need reform are clear, but that these matters cannot be managed one piece at a time; some broader approaches will be necessary. The papers presented here speak to a number of issues exacerbated by the

COVID-19 pandemic; we hope they can offer some clues as to what is necessary to prevent this disaster from happening again.

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# Perspectives from the Netherlands: Responses from, Strategies of and Challenges for Long-Term Care Health Personnel

Regard sur les Pays-Bas : réactions, stratégies et défis chez le personnel de santé des soins de longue durée



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## Abstract

The outbreak of the COVID-19 crisis severely afflicted the Dutch long-term care sector. To protect vulnerable residents of nursing homes the government took several measures, of which the complete nationwide visitors' ban was the most restrictive. These measures had not only a large impact on residents but they also greatly impacted nursing home personnel. Based on a descriptive review and a few interviews, this paper discusses the measures taken in the Dutch long-term care sector and the challenges healthcare personnel encountered in terms of workload and well-being. It further explores the strategies that were implemented to support personnel to cope with these challenges.

## Résumé

La crise de la COVID-19 a gravement touché le secteur néerlandais des soins de longue durée. Pour protéger les résidents vulnérables des foyers de soins, le gouvernement a pris plusieurs mesures, dont l'interdiction complète des visiteurs à l'échelle nationale était la plus restrictive. Ces mesures ont non seulement eu un impact important sur les résidents, mais elles ont également eu un impact important sur le personnel des foyers de soins. Sur la base d'un examen descriptif et de quelques entretiens, cet article examine les mesures prises dans le secteur néerlandais des soins de longue durée et les défis rencontrés par le personnel de santé en termes de charge de travail et de bien-être. Il explore en outre les stratégies qui ont été mises en œuvre pour aider le personnel à faire face à ces défis.

## Introduction

As in many other countries, the Dutch long-term care (LTC) sector, already struggling with serious staffing issues, was severely afflicted by the COVID-19 pandemic. High rates of infections in nursing homes left residents susceptible to severe and oftentimes fatal complications due to their frailty and co-morbidities (van der Roest et al. 2020). In order to curb the rising infection rates, the Dutch government undertook several measures, including a visitor ban in all homes for the elderly (Schols et al. 2020). These measures had a large impact on residents who, without being able to go out or receive visitors, became socially isolated and lonely.

Simultaneously, COVID-19 response measures greatly impacted the healthcare personnel caring for nursing home residents. Staff were faced with an increased workload, often having to complete tasks with little to no access to personal protective equipment (PPE). Coupled with a shortage of healthcare personnel and testing materials, nursing home personnel were put under significant mental and physical stress to continue caring for susceptible residents. However, public recognition of the challenges that nursing home personnel encountered was rather low. According to nursing home associations, this lack of awareness is symptomatic of the low societal and political value accorded to the LTC sector in the Netherlands, creating concerns for elder care staffing, among other issues, in the long run. This paper will discuss the implications of the COVID-19 crisis for nursing home personnel and examine responses to these challenges.

## *Long-term elderly care in the Netherlands*

The Dutch LTC scheme aims to institutionalize only the frailest of patients that require 24-hour care, encouraging the rest of its elderly population to remain at home and actively “age in place” (Alders and Schut 2019). Nursing homes, alongside other forms of LTC facilities, therefore, only provide care for the most vulnerable people in Dutch society (Verbeek et al. 2020).

The Dutch LTC system is divided into three acts: the *Social Support Act* (*Maatschappelijke Ondersteuning*, WMO) (Rijksoverheid 2015), the *Health Insurance Act*

(*Zorgverzekeringswet, ZVW*) (European Commission n.d.) and the *Long-Term Care Act (Wet Langdurige Zorg, WLZ)* (Government of the Netherlands n.d.). The WMO decentralized LTC to municipalities, aiming to strengthen the roles of social networks in the provision of care, and supporting elderly citizens to continue participating and living in society. Entitlements include home help, transport facilities and house adjustments (Kroneman et al. 2016). Only when their social networks are insufficient or incapable of providing care is an individual eligible to receive formal care, thereby allowing publicly funded support to become available (Alders and Schut 2019; Kroneman et al. 2016). The ZVW offers home nursing and personal care for citizens who require care for less than 24 hours per day (Kroneman et al. 2016). This act included community nursing as a benefit in the Dutch mandatory health insurance schemes, improving incentives for coordination between community nursing, primary care, rehabilitation and hospital care for the elderly (Kruse et al. 2020a). In line with one of the main aims of the 2015 LTC reform, these acts organize care closer to the citizens in their communities, thereby containing costs and enabling tailor-made solutions that are more efficient for all stakeholders involved (Kroneman et al. 2016). The WLZ provides care to the most vulnerable people of Dutch society. With strict eligibility requirements, only someone who requires 24-hour supervision or care in the vicinity can receive WLZ benefits. Care under the WLZ can be provided at home – as long as it is safe and healthy for the individual to remain at home – or within a residential care institution, such as a nursing home for the elderly (Alders and Schut 2019).

All Dutch residents are automatically insured for LTC under the WLZ. Healthcare financing is primarily public, through premiums, tax revenues and government grants (Wammes et al. 2020). There are currently around 2,348 nursing homes throughout the Netherlands offering care for the elderly (*Zorgkaart Nederland* 2021). In 2019, there were 115,394 elderly residents with high-level care needs institutionalized within nursing homes (CBS 2020).

To receive WLZ benefits, the Care Needs Assessment Center (abbreviated Ciz in Dutch) evaluates whether the individual has met all conditions for WLZ care – including the need for 24-hour care or supervision – and issues a WLZ-care needs assessment, stating that this person is entitled to LTC (Government of the Netherlands n.d.). The elderly within nursing homes are provided with a supportive and home-like environment, equipped with care to maintain their functional abilities for as long as possible (Backhaus 2017). Residents receive access to 24-hour health and personal care by multidisciplinary care teams, including nurses, nursing home physicians, psychologists, dietitians and more (Schols et al. 2020). Unique to the Netherlands are these specially trained nursing home medical physicians, providing medical care to nursing home residents. Most of the 24-hour care or supervision is provided by nursing staff composed of registered nurses, certified nurse assistants and nurse aides (Backhaus 2017).

## Methodology

To investigate the implications of the COVID-19 crisis on nursing home personnel, the authors undertook a descriptive review combined with several interviews with nursing home personnel. Descriptive reviews are a qualitative tool used to determine the extent to which a pattern or trend can be found in a series of texts (Paré and Kitsiou 2017). A systematic search in Google Scholar was conducted over the period of March 2020, the start of the pandemic, until September 2021. The search terms used were *COVID-19, nursing home, long-term care, the Netherlands*. The Google Scholar platform was selected because professional publications and research reports in Dutch are better covered and more accessible on Google Scholar in comparison with PubMed. An additional search in PubMed with the same search terms did not result in additional sources.

The search resulted in 37 sources. The authors scanned all papers to investigate whether they met the inclusion criteria: a Dutch national focus, COVID-19 response measures, information on the first wave and relating to the LTC sector. There were no other exclusion criteria. All 37 sources were included in the analysis. For the analysis, the second author coded information resulting in the following main themes: national measures, consequences of COVID-19, measures taken in nursing homes, different types of challenges encountered by nursing home personnel and support structures to address the challenges. Based on the first coding, the second author identified patterns and similarities in the sources. These patterns were discussed with the other authors. These trends are presented in the Results section of this paper.

Because this review was done shortly after the start of the pandemic, the authors undertook six semi-structured interviews with different Dutch LTC personnel (a director, two team managers, two members of nursing staff and a vocational therapist) to check whether important trends were missed in official publications. These interviews also helped contribute to a more detailed understanding of the challenges discussed in the literature on a rather general level. The interviewees worked for three different nursing home organizations in different parts of the Netherlands. This selection was made to have a representation of the different levels (direction, management, work floor) of the nursing home organization. A semi-structured interview format was chosen due to its fluid and interpretative nature. During the interviews, the researcher asked a list of predefined questions in addition to open-ended and responsive questions as to what had just been said, allowing the interview to venture into new topics and reveal new insights (Wilson 2013). This provided the researcher with the freedom to explore new ideas and perspectives, bringing to light issues the researcher had not previously anticipated or encountered (Braun and Clarke 2013).

Participants were recruited through a public LinkedIn post and thereafter through a snowball technique to recruit additional participants from the acquaintances of individuals interviewed. Interviews were recorded on a mobile phone and later transcribed semi-verbatim into a Word document. All interviewee names were changed to ensure anonymity. The

authors received ethical approval (#FHML-REC/2021/003) from the Maastricht University Ethics Board for the interviews conducted. For the analysis of the interviews, the authors used the same themes found in the descriptive review. All themes and trends found in the review were confirmed by the interviews. The analysis of the interviews did not reveal major gaps but did contribute to a better understanding and additional insights. The following section will present the results of the descriptive review and interviews. The authors only refer explicitly to the interviews when discussing points that were not found in the literature. We refer to the interviewees with an initial and a number: D = director; T = team manager; N = nursing staff; V = vocational therapist.

## Results

### *COVID-19 and protection measures in LTC homes*

The outbreak of COVID-19 within the Netherlands posed significantly higher risks to the vulnerable residents institutionalized within nursing homes (Kruse et al. 2020a). The Dutch response primarily aimed to slow the spread of the virus, avoid a demand peak on the strained healthcare system and protect vulnerable population groups – primarily the elderly (Kruse et al. 2020a). Within the first wave, Dutch nursing homes registered 10,287 COVID-19 positive patients, with 1,915 recorded deaths (Verenso 2020b). With restrictive testing policies during the first few weeks of the first COVID-19 wave, figures are estimated to be higher (Schols et al. 2020).

In order to reduce the infection risks, several measures were taken. From the start, the general behavioural guidelines, such as hand washing and no handshaking that were enforced by the Dutch government, were implemented in nursing homes as well. With a rising number of cases, as in many other countries, the Dutch government created a nationwide visitor ban in all homes for the elderly (RIVM 2020). From March 19 to May 25, 2020, nursing homes closed their doors to visitors and non-essential working staff to protect the vulnerable inhabitants from contracting COVID-19 (Gerritsen and Voshaar 2020). This visitors' ban prioritized curbing the number of infections, replacing physical visits with calls and putting social and daytime programs on hold (van der Roest et al. 2020). Despite the visitors' ban, by the first week of April, around 40% of nursing homes reported COVID-19 infections, with over 200 resident infections a day (Sizoo et al. 2020).

In line with national measures, Dutch nursing homes followed the regularly updated COVID-19 directives developed by Verenso, the Dutch Association of Elderly Care Physicians (2020b). Information on how to act with a (suspected) case of COVID-19, including testing, isolation procedures and treatment, was disseminated across the Dutch LTC sector. Internal crisis teams within nursing homes worked to optimize communication, review infection control practices and implement new protocols for staff (Schols et al. 2020). To reduce the infection risk, many homes introduced rather strict compartmentalization, where healthcare personnel were allowed to visit only one department during their shift.

In most homes, residents infected with (suspected) COVID-19 were treated within their rooms as much as possible, whereas some nursing homes chose to create COVID-19 positive and negative zones to better manage the sick residents (Schols et al. 2020).

For the care of sick patients, the regular guidelines on treating viral respiratory tract infections and administering oxygen were followed, in addition to the advanced care planning treatment preferences of residents (Federatie Medisch Specialisten 2021; Schols et al. 2020). Upon recovery, residents could leave isolation when they no longer displayed any symptoms for at least 24 hours, had had no fever for 48 hours and if the start of the first symptom had been at least 14 days ago (Schols et al. 2020). Seriously ill residents unable to recover were provided with in-house palliative care and were granted special permission to receive visitors despite the nationwide nursing home visitor ban (Government of the Netherlands 2020).

Specific protocols were developed for the use of PPE, such as face masks, gloves and face shields. Nursing home personnel worked in close proximity to vulnerable residents with minimal to no PPE (Gerritsen and Voshaar 2020). The use of PPE was reserved solely for providing care to residents with confirmed and suspected COVID-19. This restriction on the use of PPE was probably partly motivated by the severe shortages in PPE during the first few weeks of the first wave. Furthermore, initial sick-leave policies for nursing home staff only allowed personnel with a fever to stay at home, whereas staff displaying only mild cold symptoms were asked to continue working (Schols et al. 2020).

The testing policy in nursing homes was rather restricted as well, perhaps partly motivated by a national shortage in testing capacity in the first few weeks of the first COVID-19 wave. Before April 6, 2020, elderly care physicians within nursing homes made the decision of whether to test residents for COVID-19 based on a national case definition of two of the following symptoms at minimum: fever or feeling feverish, cough or dyspnea (Schols et al. 2020). If two nursing home residents had already tested positive within an institution, the testing policy advised against testing any further due to a lack of available tests (Kruse et al. 2020a).

Prior to the pandemic, the LTC sector faced a shortage in care personnel. LTC institutions tried several methods to attract more personnel, including creating flexible worker schedules and reorganizing personnel responsibilities within LTC organizations. Personnel were encouraged to move between organizations to solve pressing shortages in staff (Kruse et al. 2020a). Toward the beginning of the pandemic, most nursing home organizations discouraged this mobility of professionals between nursing homes in fear of increasing the spread of the virus (Kruse et al. 2020b). Therefore, the pandemic worsened the LTC staff shortage situation.

### *Challenges for healthcare workers*

The first concern of most employees was the risk of infection. Particularly, employees who had to work without access to PPE in close proximity to vulnerable residents felt anxiety around personal infection and feared infecting either vulnerable residents or their families

at home (Gerritsen and Voshaar 2020). The interviews revealed that some care personnel also experienced serious pressure from their own family members, who felt indignant about their perceived exposure to risk due to lack of PPE and suggested that the employer should first take adequate measures (D1, N2, V1).

According to a survey with 2,902 respondents conducted by the Dutch Association of Nursing Staff, almost half the nursing staff expressed that they had experienced pressure to work without access to PPE (Kruse et al. 2020a). Initial sick leave policies asked staff members to continue working if they suffered from a mild cold without fever, which, in combination with initial restrictive testing policies and insufficient PPE, contributed to feelings of anxiety and not being heard (Schols et al. 2020). LTC personnel dealt with the shortage of PPE in different ways. Some reused the equipment or visited several patients with the same set, while realizing that this created additional risks in the spreading of the virus (N1). In some homes, care personnel used the same set for several visits in succession to one isolated resident during the whole day (N2, T2).

The compartmentalization of care and isolation practices reduced the risk of infections, but also generated additional challenges (Schols et al. 2020). In many care homes, personnel had to stay at the department for their entire shift. Interviewees mentioned there were no separate rooms where they could spend their breaks (D1, T2). Especially in departments for residents that suffer from dementia, it was impossible to keep distance and maintain isolation rules (Schols et al. 2020). Given their mental condition, residents were not able to understand these measures. For residents showing no symptoms of COVID-19, these rules were often relaxed; in cases of infection, however, there were some situations where care personnel didn't see other options than to use methods of coercion (T2).

The visitors' ban created additional challenges and a significant increase in workload for care personnel. Not only did they no longer have the care and support family and volunteers provided to residents, they now also had to organize digital and socially distant solutions for nursing home residents and their families (Verbeek et al. 2020). Creative constructions were often introduced; for instance, specific cabins with two compartments (Verbeek et al. 2020). In particular, the interviewees mentioned the "pausmobiel" (pope-mobile), a vehicle with glass sides in which families could visit their elderly loved one while staying protected (D1, N2). Especially for residents with dementia, this was the most comprehensible way of maintaining contact with their families (Verbeek et al. 2020). Occasionally, the visitors' ban was met with a lot of resistance from families who still insisted on seeing their family member in the nursing home (Verbeek et al. 2020). In some cases, serious threats against care workers were made (D1, T2). After the visitors' ban was lifted, monitoring family visits added to the workload, as some visitors did not respect the general behavioural measures as prescribed by the Dutch government (Verbeek et al. 2020).

Care workers also experienced emotional stress related to circumstances in which residents with COVID-19 passed away (N1, N2, T2). Care personnel working at the regular departments reported that some residents they knew quite well suddenly disappeared to

COVID-19–positive sections, and if they didn't recover, they never saw them again. This was often also the case for family members who were only allowed to visit in a rather limited way during palliative care, some of whom arrived too late due to the fatal deterioration of residents.

Altogether, this generated very high stress levels, placing both physical and mental consequences on staff well-being. According to the survey conducted by the Dutch Association of Nursing Staff, 74% of nursing staff indicated they experienced higher levels of pressure on their mental health due to the pandemic (Kruse et al. 2020a).

### *Support strategies for care workers*

Not all LTC homes encountered shortages of PPE. Some responded immediately to the first signs that COVID-19 was spreading in Europe and ordered additional equipment, although Dutch public health authorities still advised that no additional measures were required. This surplus was shared with other nursing homes, coordinated within the regional crisis teams in which LTC homes worked together. After Dutch nursing home associations raised the alarm of a severe lack of PPE in the LTC sector, the government launched a new centralized PPE allocation mechanism on April 13, 2020, which improved distribution to LTC facilities. This new distribution mechanism gradually increased the availability of PPE for nursing homes by mid-April (Kruse et al. 2020a).

To reduce the workload, some nursing homes focused on providing support to their staff, asking psychologists, occupational therapists, social workers and activity coordinators within nursing homes to work with patients in addition to nursing staff (Gerritsen and Voshaar 2020; personal interviews). Team leaders and managers gave support in caring for residents too. In addition, military nurses were brought in and Red Cross volunteers were recruited, while personnel from the catering and aviation sectors delivered support in non–care-related tasks (Kruse et al. 2020b).

Many nursing homes established “helplines” for nursing staff to address any problems healthcare workers were facing and to share ways to take care of themselves and others (Gerritsen and Voshaar 2020). Some nursing homes asked their psychologists and social workers to provide mental health support to care personnel. Some of the interviewees indicated that they preferred the last option as they knew these professionals already and they were familiar with the specific situation care personnel had to work in (T1, T2, V1). They also reported that team spirit – colleagues noticing when someone had a tough moment, stepping in for each other and giving a sympathetic ear when required – was essential in dealing with mental and emotional burden of the work (T2, N2).

On a national level, nursing home personnel were included in the initiative to provide a bonus for healthcare workers to acknowledge the additional efforts they made to provide care as best as possible in very difficult circumstances (Rijksoverheid 2021). However, the practical implementation of the bonus, where many care workers were excluded or never received the bonus at all, probably caused the opposite of what was intended (van Essen 2021).

## Discussion and Conclusion

The first few weeks of the COVID-19 outbreak within the Netherlands brought much uncertainty, as experts tried to develop an understanding of the never-before-seen SARS-CoV-2 virus. Nursing home staff continued to care for the elderly as safely as possible, trying to find a good balance between maintaining strict hygiene protocols and delivering quality personal care to residents (VWS 2020). The consequences of COVID-19 and the protection measures taken put nursing home personnel under significant mental and physical stress as they continued caring for susceptible residents. Lack of available PPE and testing capacity and the expectation to continue working even when presenting symptoms of sickness (other than fever) created fear among nursing home personnel and their families of infecting others or becoming infected. The visitor ban created additional strain, as professional nursing home personnel had to take over tasks normally done by family and volunteers and had to invent and organize alternative forms of communication between residents and their families and other social activities. Although additional personnel, such as health personnel from the military and the Red Cross, were mobilized, this was not enough to compensate for the shortage of staff, and it is mainly the resilience of nursing home personnel that kept the sector going. This investigation showed that management who arranged for PPE in anticipation of the pandemic; organized support from other nursing home health personnel, including team managers, in the daily nursing care of residents; and procured mental health supports for healthcare personnel, along with team spirit, probably contributed to this resilience.

This situation in LTC during the first wave of COVID-19 was not unique to the Netherlands. Many countries in and outside Europe encountered similar issues (Riello et al. 2020; Stelnicki et al. 2020; White et al. 2021). Shortage of personnel, for instance, was reported all over Europe, Canada, and the US (Kuhlmann et al. 2020; White et al. 2021). In these countries, a visitor ban was introduced in nursing homes as well, with huge implications for both residents and personnel. Together with lack of access to PPE, this put a huge burden on healthcare personnel in LTC internationally.

From the experiences during and challenges from the first wave, the Dutch Ministry of Public Health, Welfare and Sports and the LTC sector drew some important lessons (AWO-ZL 2020; VWS 2020). One of the most important lessons learned was the importance of focusing more on supporting the mental health and well-being of nursing home staff in times of emergencies. The provision of mental health support offers nursing home personnel the opportunity to seek help and openly speak about the stress they are facing (VWS 2020). As concluded in other studies, management has an important role here, both by making counselling and formal support services available for personnel and by encouraging peer support (Baumann and Crea-Arsenio 2022; Brandon et al. 2021; Lavoie-Tremblay 2022; Stelnicki et al. 2020). As mentioned in this study, a strong team spirit helped personnel to cope with the mental burden of the situation.

A second important lesson learned was the need to adopt a better balance of physical safety and quality of life in the national COVID-19 response. Looking back, the mandatory

nationwide visitor ban, which according to the ministry and LTC sector could have been avoided if access to PPE would have been in place, is no longer considered an appropriate measure (Verenso 2020a; VWS 2020). This visitor ban is now seen as a demonstration of focusing on the “medical model” mindset, where a strict top-down approach was implemented without acknowledging the importance of quality of life and input from the parties affected (AWO-ZL 2020). Similar conclusions with respect to the mandatory visitor ban have been drawn in other countries, such as Canada (Baumann and Crea-Arsenio 2022; Lavoie-Tremblay 2022).

Going forward, delegating some of the decisions rendered at the national government level to managers of nursing homes, might provide a better means by which to establishing the balance between safety and well-being (Verenso 2020a; VWS 2020). Providing this responsibility to managers would allow for more flexibility and customization according to the local circumstances and infections within nursing homes, rather than implementing a national strategy (AWO-ZL 2020; VWS 2020). Such tailor-made solutions would be designed in collaboration with all parties involved, including residents, families, and health-care workers, to best fit the needs of all affected and better ensure a balance between strict hygiene protocols and quality of life. Opening lines of dialogue between stakeholders will ensure open communication and knowledge sharing from the start of an outbreak to the end (VWS 2020).

Finally, alleviating occupational stress also rests on addressing nursing home staffing shortages. As mentioned before, during the pandemic some *ad hoc* measures, such as bringing in military health personnel, Red Cross volunteers and staff from hospitality and aviation, were taken by governments and the LTC sector. Furthermore, encouraging former care staff to temporarily return and provide support, creating staff-lending systems across nursing homes, and allowing volunteers and nursing students to work more hours helped to address the staff shortage (Verenso 2020a; VWS 2020). But even more important than finding additional staff in times of emergencies is recruiting staff in regular times. A prerequisite to make work in nursing work more attractive is to reward it better, financially and symbolically. In the Netherlands, the trouble around the ad-hoc bonus generated serious concerns as to whether staff shortage in LTC will be addressed adequately soon. As in other countries, the LTC sector was neglected for a long time and desire to work in the sector is relatively low (Baumann et al. 2022; Kuhlmann et al. 2020; Lavoie-Tremblay et al. 2022; Stelnicki et al. 2020). To make LTC disaster-proof in the future, a drastic change in policy is needed internationally.

### *Limitations*

Limitations of this study relate to the period during which this descriptive review was made – relatively shortly after the first wave of COVID-19, with the pandemic still ongoing. In this continuously evolving situation, new research and reports were released; with greater distance, insights and evaluation may change along with more long-term impacts of the crisis.

Furthermore, only a limited number of interviews were performed. Although information from these interviews was valuable, we did not reach saturation, so we may have missed some of the challenges healthcare personnel were confronted with and/or measures taken to address these challenges.

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# Exemplars in Long-Term Care during COVID-19: The Importance of Leadership

## Exemples en soins de longue durée pendant la COVID-19 : l'importance du leadership



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### Abstract

Early in the pandemic, many long-term care (LTC) homes struggled to manage resources and care for vulnerable residents. Using an appreciative inquiry approach, we analyzed exemplar homes in Ontario that remained free of COVID-19 in wave one and interviewed executive

directors, directors of care and staff. Findings demonstrate the importance of leadership styles; clear, consistent communication; focusing on staff and resident safety; using a team-based approach; and adapting staff roles to meet care needs. The exemplar homes showed what works in practice. The decisions and approaches that they implemented could be used to develop standards to improve LTC and strengthen the sector.

## Résumé

Au début de la pandémie, de nombreux foyers de soins de longue durée (SLD) ont eu du mal à gérer les ressources et à soigner les résidents vulnérables. À l'aide d'une approche d'enquête appréciative, nous avons analysé des foyers exemplaires en Ontario qui sont restés exempts de COVID-19 lors de la première vague. Nous avons interrogé les directeurs généraux, les directeurs des soins et le personnel. Les résultats démontrent l'importance des styles de leadership, d'une communication claire et cohérente, de se concentrer sur la sécurité du personnel et des résidents, d'utiliser une approche basée sur l'équipe et d'adapter les rôles du personnel pour répondre aux besoins en matière de soins. Les foyers exemplaires ont montré ce qui fonctionne dans la pratique. Les décisions et les approches qu'ils ont mises en œuvre pourraient être utilisées pour développer des normes visant à améliorer les SLD et à renforcer le secteur.

## Background

The long-term care (LTC) crisis in Canada is well documented. In a sector known to have significant issues, including staffing, quality of care and accountability, the advent of COVID-19 created a perfect storm (Estabrooks et al. 2020). The first wave of COVID-19 in Canada spanned the beginning of March 2020 to the end of August 2020. During this period, LTC residents accounted for 64.5% of pandemic-related deaths in Ontario, 69% in Québec and 57% in British Columbia (CIHI 2021b). By May 2020, 82% of all recorded pandemic-related deaths nationwide were connected to LTC settings (MacCharles 2020).

Evidence demonstrates outcomes for LTC residents are impacted by type and age of facility and associated regulatory framework, ownership (public/private), location (urban/rural), room configuration (solo/shared) and resident characteristics (Stall et al. 2021). Differences in staff mix (regulated vs. unregulated), staffing numbers, conditions of employment and models of care lead to inconsistencies in quality and application of standards and regulations. Homes provide on-site personal and nursing care, 24-hour access to medical services and subsidized accommodation under a publicly funded system. Care is provided by a mix of personal support workers (PSWs), registered practical nurses (RPNs) and registered nurses (RNs). Boscart et al. (2018) found that PSWs provide the bulk of care (76.5%) in Ontario homes, followed by RPNs (17.3%) and RNs (5.9%). Additional services include nutrition, physiotherapy, recreation, food services, social work, administrative services and housekeeping/cleaning.

In Canada, LTC is a provincial responsibility. COVID-19 has laid bare the long-standing failure to protect the most vulnerable population, and the consequences can be described

as catastrophic (CIHI 2020; Ministry of Health and Long-Term Care 2017, 2018, 2019; Webster 2021). LTC homes are governed by legislation and regulations. Homes in Ontario are licensed by the Ministry of Long-Term Care (MLTC) and governed by the *Long-Term Care Homes Act, 2007*, while nursing and personal support services are governed by *O. Reg. 79/10* under the *Long-Term Care Homes Act, 2007* (Government of Ontario 2011; MLTC 2020).

As of June 10, 2021, there were 626 licensed LTC homes in Ontario with 77,257 long-stay beds (CIHI 2021a; Stall et al. 2021). Fifty-seven percent of the homes were privately owned, 27% were non-profit/charitable and 16% were municipally run (CIHI 2021a). According to data from CIHI (2020), 54.8% of LTC residents in Ontario were 85 years of age or older and the majority required support in activities of daily living. Data from 2019 showed that 90% of LTC residents in the province had some type of cognitive impairment (OLTCA 2019).

On March 17, 2020, the Ontario government declared a state of emergency because of COVID-19 (Rodrigues 2020). On March 22, 2020, the Minister of Long-Term Care issued the first of many operational and policy directives under the *Long-Term Care Homes Act, 2007* (AdvantAge Ontario 2022). Intended to address the myriad issues related to the pandemic, these directives for LTC homes referred to procedures and precautions, infection prevention and control (IPAC) measures and restrictions on visitation. The directives had a profound impact on the LTC sector, residents and their families.

In contrast to LTC homes that struggled with COVID-19, some provided exemplary care and remained free of COVID-19 in the first wave of the pandemic. The purpose of this article is to (1) identify decisions and approaches that were effective in managing care and staff during the pandemic and (2) suggest strategies necessary for change in the LTC sector. Our study was conducted in Ontario. A similar study was conducted in Québec by Lavoie-Tremblay and colleagues in 2021, and their findings appear in this special issue (Lavoie-Tremblay et al. 2022). Ontario and Quebec are the two most populous provinces in Canada and were the hardest hit by COVID-19.

## Methods

### *Design and participants*

A case study design guided by appreciative inquiry was used (Bushe 2011; Cooperrider and Whitney 2001). This approach identifies organizational strengths and what works well in practice. Case study allows for an in-depth exploration of a select number of cases (Yin 2017). A purposeful convenience sample was selected based on the following criteria: no active cases of COVID-19 during the first wave, more than 100 beds and a variety of bed types. The research team e-mailed executive directors at four homes that met the criteria and invited them to participate in the study. Upon receiving their agreement, the research team

e-mailed directors of care (DoCs) at each home who then posted notices requesting staff participants for the study. Interested staff contacted the research team directly.

Semi-structured telephone interviews were completed between November 2020 and January 2021, with a convenience sample of managers and staff from each home. These interviews were conducted by a trained interviewer. Select members of the research team attended each interview. The interviews were 30 to 45 minutes long and were conducted until data saturation was reached. Questions focused on the decisions and strategies used to manage care during the pandemic, how facilities implemented and followed changing Ministry directives, how staffing was adapted to ensure a stable workforce and how daily roles changed to accommodate IPAC practices while caring for residents. To contextualize and interpret the study findings, the research team analyzed existing legislative and regulatory frameworks relevant to LTC as well as the MLTC directives that emerged during the pandemic (AdvantAge Ontario 2022).

### *Ethics*

The research instruments underwent ethics review and received approval from the Hamilton Integrated Research Ethics Board (HiREB Project #11526) at McMaster University. Participants were informed of the study's purpose prior to the interviews. They were also advised that participation was voluntary and they had the option to withdraw from the study at any time without penalty. To maintain anonymity, data were aggregated and site names and identifiers were removed.

### *Data analysis*

Interviews were recorded and transcribed verbatim and then coded into QSR NVivo 10.0 (QSR International Pty Ltd, Doncaster, Victoria, Australia). Texts were interpreted through thematic analysis (Boyatzis 1998). Preliminary coding was completed by three members of the research team who coded several texts independently and then shared their classifications. Themes were created based on a consensus process from the agreed upon codes, and findings were categorized under each thematic heading. Member checking was conducted and themes were refined over time.

### *Results*

All the homes that were contacted agreed to participate. They were located in urban settings but varied in age (less than 20 to more than 40 years) and number of beds (less than 130 to more than 200). They also had a mix of basic, semi-private and private rooms. In total, 16 interviews were conducted. Participants included DoCs, nurses (RNs and RPNs), PSWs, dietitians, social workers and staff from physiotherapy, recreation, food services, housekeeping/cleaning and reception. The diversity in participants from various roles in the LTC sector provides a thorough understanding of exemplar LTC homes.

The majority of participants identified as female and were over the age of 30. Two-thirds were employed full time and most of the participants had been working at the homes for up to 10 years. The following themes emerged from the interviews: recognizing the rapidly changing situation; assuring stability in an evolving environment; anticipatory decision making and early detection; implementing a team-based approach; reinforcing resident-focused decision making; implementing effective staffing and supply strategies; enhancing ongoing communication and consistent messaging; and mobilizing strategic partnerships and resources. The themes were interpreted within the context of the pandemic.

### *Recognizing the rapidly changing situation*

Managers had to make decisions in an uncertain environment to maintain continuity and consistency of care. Their role as leaders became increasingly vital for the daily operations of the homes and for staff guidance. Regarding the decisions that had to be made, one DoC commented, “We know what works and we know what we needed to do.” Another manager cited their commitment “to continue with excellent practices and proactive surveillances, pandemic and preventative measures” to safeguard residents and staff. A PSW mentioned how their manager accentuated the importance of the team and that, COVID-19 notwithstanding, the site was still a “facility with 24/7 care ... [and] everybody has a job to do.”

During the first three months of the pandemic, managers had to respond to more than 25 directives issued to LTC homes. Participants reported the directives were frequently revoked, revised and replaced, and the new versions often lacked clarity and were increasingly restrictive. Among the first directives were those limiting visitors and resident mobility within congregate care settings. Participants indicated these restrictions caused a great deal of anxiety. A DoC observed:

The staff were scared, families were extremely scared .... We do have some residents [who] are alert and they, too, were scared because they couldn't go out anymore.

Due to the fear and the changes precipitated by COVID-19, participants emphasized that care decisions had to be made using a humanistic rather than a solely rules-based approach. The managers fostered a stable, compassionate environment in which decisions continually focused on residents' needs. One PSW relayed, “I think it was always difficult working in long-term care, but when you take a pandemic or a situation like this ... you just do [it] because you genuinely care.” A DoC decided to make some accommodations in the home that allowed residents to go outside again:

When we came down to May, and it was getting quite beautiful out and people wanted to get outside ... the residents were [upset] because families weren't coming in, staff were all wearing masks, there were no happy smiling faces anymore. So I quickly got

maintenance on board with me and we got Plexiglas out on the balconies to divide the units so now residents were having breakfast and lunch out on the balcony.

### *Assuring stability in an evolving environment*

Managers were acutely aware of how the pandemic was affecting staff and residents and instituted novel practices to resolve issues and lessen the impact. For example, music therapy and iPads for family calls were used in an effort to combat residents' loneliness. A DoC described how their facility supported staff:

We gave them a room on the units .... We brought up lounge [chairs], a refrigerator [and] extra microwaves. All these things were bought and put in to make the staff feel like they had a place to go for their breaks.

Managers also encouraged problem solving among staff. An RPN recounted the following situation involving resident care:

At the beginning of COVID, there were two residents [who] would refuse to stay in their rooms and they would often try to walk the hallways .... So what I would do when I was giving medications [is] ... have them walk with me ... and I would just talk to them to keep them calm.

Managers and staff noted the need to be creative regarding resident mealtimes. Homes with large dining rooms were able to maintain centralized meals using social distancing, extra cleaning and by ensuring enough staff to provide support. In homes that did not have sufficient space in the dining room, alternate spaces for meals were created that allowed residents to practice safe distancing while still eating together rather than in isolation.

To address an important issue and assure stability, one DoC created a new role called *IPAC lead quality champion*. According to the DoC, the role was pivotal for "ordering swabs for COVID-19 and having much more rapid results ... education and self-monitoring for staff and families [and] cohorting of the staff."

### *Anticipatory decision making and early detection*

DoCs at the homes credited their extensive knowledge of and experience in the healthcare system, the LTC sector and IPAC for enabling them to anticipate and prepare. Most had healthcare backgrounds across different organizations. They drew on their expertise when devising mitigation strategies in advance of COVID-19 and they made the decision to initiate enhanced IPAC prior to the confirmed state of emergency.

The managers identified trends and threats before the pandemic was declared and made decisions that prepared their organizations. One DoC remarked, "In January [2020], we purchased PPE, gowns and gloves ... and we stored them without knowing that it was going

to be that bad because nobody had said anything about it before.” An RPN recalled that the “home took early action and put early interventions in place ... I think we were really ahead of it.” A manager described:

From the beginning, it was a proactive approach and not reactive .... We did everything to try to prevent the pandemic coming to us. We did surveillance, passive screening. We did hand hygiene, we reminded [people] about social distancing .... We [made] a contingency plan and a pandemic plan even before the government gave direction[s] with respect to human resources. We identified the minimum staffing needs and prioritized critical services.

Participants acknowledged that increased cleaning and disinfection in a timely manner was a crucial intervention. This was viewed as a shared responsibility within and across sites, and managers expanded staff roles to make certain it was achieved. A receptionist explained how she assisted with cleaning:

The director of care told us to wash the elevator buttons and everything that people were touching ... We had to sanitize the pens that people were using.

The managers encouraged continuous monitoring, which included staff and supplies. When breaches occurred, they took immediate action such as just-in-time training on hand-washing technique, wearing of masks and reverse isolation. One home engaged the Red Cross early to provide consistent and accurate IPAC guidance to all staff. This was completed over a four-week period in which agency personnel came in and established a plan of care for the home that included IPAC recommendations and advice on how to change and optimize staff roles.

### *Implementing a team-based approach*

The managers discussed how all staff were respected and everyone was seen as integral team members. They leveraged the collective skills and abilities of their staff to support resident care, enabling them to take on new roles and providing them with the necessary training. A food services worker shared how the “PSW and the food service worker [offered to] work together ... and the managers were listening and saying, “That’s a good idea.” An RPN reported:

We also had other departments crossing over and helping with the feeding. We had activation involved, management ... everybody down to the PT [physiotherapist] and the physiotherapist assistant jump[ed] in and help[ed] out with the serving as well, so it was a team effort.

A PSW said, “We’re very fortunate [that] our housekeeper helps feed. They don’t have to but ever since COVID she has helped and continues to help because she knows we need the help.”

To ensure that residents’ needs were met, managers expanded staff responsibilities and redeployed staff from other departments, including personnel who previously had no direct role in care. A DoC highlighted the importance of reorganizing roles in the facility:

Everybody is cleaning and everyone is taking ownership: the PSWs, nurses, kitchen [staff], all of them. I have a kitchen staff [who] on his break is going around and cleaning all the doorknobs. [The] knowledge [that] they have and the initiative [that] they take, you do not ask them to do any of that .... We are all working together to fight COVID.

### *Reinforcing resident-focused decision making*

It was evident from the interviews that resident safety was the priority. A DoC observed, “We did rounds on a daily basis to make sure that the people are safe.” As managers, they were required to make decisions. A DoC reported:

[We] are dealing with frail residents in very close quarters who depend on people to do things for them. ... Infection can spread very fast and easily. ... We’ve got a lot of things that need to be done to prevent something like that.

A strategy used by the managers was increasing staff to ensure infection control measures were maintained. A nurse indicated, “Before, it used to be one housekeeping staff per floor, but now it’s two housekeeping staff to each floor. We also have extra cleaners.” An activity assistant stated:

We make sure that when residents are gathered in a group, they are two metres apart. We clean their hands before and after the program and, of course, as staff we are always wearing masks throughout our shifts inside the building.

Throughout the pandemic, staff were encouraged to provide additional support to residents, especially during the time when all visitors were banned from entering the homes. One DoC described, “The nurses were not only focusing on the care but also keeping the residents entertained.” A nurse recalled, “In the locked unit we can feel it that they are sad, they are very irritated. So we try to entertain them by playing music [and] we dance – the PSWs, the other nurses and me.”

### *Implementing effective staffing and supply strategies*

To reduce the transmission of COVID-19, the Ministry ordered that LTC staff could work

in only one facility. Consequently, agency personnel could no longer be used to fill staffing gaps. The managers described mobilizing existing staff early to ensure care for residents was not disrupted. They quickly converted existing part-time employees to full-time hours. A DoC remarked, “We increased hours because we needed more staff.” Another DoC noted the change from 8- to 12-hour shifts resulted in less absenteeism because staff were working fewer days.

Recognizing the impact of COVID-19 and stress on both the professional and personal lives of their staff, the managers acknowledged their employees’ performance and empowered them to act. They were also aware of the need to safeguard their staff. A nurse said, “They would give us a bag filled with masks and hand sanitizer to take home so that we were prepared.” While some homes monitored PPE, staff did not indicate they had any challenges accessing it. A PSW commented, “We always have supplies, our DoC was really great for that ... If we need 10 masks, we can have 10 masks.” A DoC revealed, “We never had a shortage of PPE like ... other long-term care facilities. ... [This] is really important for staff morale because people are scared.” In discussing staff who had to self-isolate, the DoC at one home emphasized: “They got paid.”

### *Enhancing ongoing communication and consistent messaging*

The managers developed a comprehensive communication plan to ensure up-to-date information was disseminated clearly, consistently and continuously. Some managers implemented a strategy similar to the daily huddles<sup>1</sup> used in acute care settings. These were brief daily meetings to discuss the latest pandemic metrics and data, review protocols and modify plans as necessary to reduce the risk of infection. One DoC recalled, “When we talked about COVID and isolation, we talked about where we are going to isolate the residents and the washrooms that are shared by four residents that would make it difficult for isolation.”

Staff commented that managers repeated messages to reinforce key information. An employee reported, “All the managers will send us the same message. So we always receive two e-mails on the same content and it’s constant, and then we have [the] communication posted ... so everyone can see it.” A social worker identified an innovative strategy to reinforce the importance of communicating with and supporting staff:

They’ve been working really hard for a long time and burnout could happen. So we did a positive communication workshop to just help touch base with the staff ... [They] are at the core of everything that we do for residents and if they’re not OK, then the home is not going to be OK.

Communication was also used to keep residents’ families updated and lessen their fears. A DoC stressed, “It’s very important to ... be very transparent to them. Anything and everything we are reporting to them immediately.” Another DoC added, “Communication

is the biggest thing you can do. The families need to know ... People are scared, so build back trust with simple communication.”

Participants agreed that technology was helpful for transmitting and receiving information. An RN mentioned that their DoC sent weekly updates regarding test results or changes to protocols and practices (e.g., having to wear a mask to work). One DoC sent staff weekly e-mails “congratulating them on their great work.” A physiotherapist remarked:

There’s very good communication at different levels and exchange of ideas, suggestions and sharing experiences and how to manage the COVID-related issues because this is all new to everyone. I think that the strength is communication, and we appreciate the care and support.

### *Mobilizing strategic partnerships and resources*

Managers agreed that their relationships with external organizations, such as local hospitals, non-governmental organizations and public health agencies, were crucial and provided additional resources and expertise. A DoC indicated, “We are learning collaboratively through each other’s experiences.” They underscored how vital the support that they received during the critical first months of the pandemic was and how it helped them navigate the rapidly evolving situation. One DoC noted, “During the pandemic it was very important to not send the residents to the hospital for routine treatments ... so the specialist from the hospital would come to help.”

One home was able to access additional PPE from a charitable organization in the community, while another teamed up with a local hospital to expedite testing for staff. When a potential outbreak threatened one of the homes, the DoC immediately brought in an external organization with expertise in crisis management to conduct a comprehensive assessment and provide recommendations. The organization suggested purchasing additional equipment, streamlining processes, making staffing changes and implementing user-friendly IPAC procedures. External organizations also provided auxiliary staff to stabilize the homes.

### **Discussion**

This study is the first in Ontario to examine what LTC homes did well during COVID-19. None of the exemplar homes had an outbreak in the first wave of the pandemic. Findings demonstrate that it was important to mobilize the entire organization early to ensure residents were safe and protected. Leaders played a pivotal role in obtaining commitment from their staff. All cadres of workers, including regulated and unregulated staff, were involved in the provision of care.

An analysis of interviews with participants from the exemplar homes identified decisions and approaches that were effective in managing care and staff during the pandemic as well as strategies that can be implemented in the LTC sector. Leaders in the homes quickly realized the impact of changing Ministry directives on residents and staff. Their actions

were immediate and deliberate, and they recognized that additional training was required to enable staff to carry out their responsibilities. They enhanced collaboration and emphasized that the provision of care was a collective responsibility. Moreover, they monitored the situation on the floor rather than from their offices.

Although the pandemic created a rapidly changing situation, there was a clear and shared vision of safety for both staff and residents. Moving staff from different departments, expanding their roles and engaging everyone in the continuum of care demonstrated an organic rather than formalized approach to care. To this end, the homes did not isolate residents but reorganized dining spaces so that residents could eat together while maintaining social distancing as per IPAC and MLTC directives. In addition, residents' families were kept informed of the situation within the homes and the ensuing changes that were implemented to care for residents.

Managers struck a balance between mitigating risk and looking after their staff. To contain the spread of the virus, the homes followed isolation, cleaning and IPAC protocols. There was adherence to Ministry directives that included limiting the use of agency workers and mandating staff to work in only one facility. Exemplar homes converted part-time staff to full time to ensure a consistent, well-oriented workforce that could care for residents safely.

Communication and transparency are crucial mechanisms for countering misinformation and panic, both of which were widespread during the onset of COVID-19 (Garneau and Zossou 2021). Regardless of whether the communication is electronic or in-person, it "must have meaning for the people involved" (Baumann and Hinohara 2017). The managers in our study tailored their communication to their audience and provided positive messaging along with updates as the situation evolved. The communication within the exemplar homes followed the three-Cs approach: clear, consistent and continuous. An important strategy was to filter communication to reduce information overload while repeating crucial directives. Another important strategy was calling external organizations in early to establish plans of care and create strategies to reduce the spread of the virus. Partnerships with hospitals and non-governmental organizations allowed homes to access additional supplies and auxiliary staff as needed.

Ontario's Long-Term Care COVID-19 Commission (Marrocco et al. 2021) cited neglect of the LTC sector by successive provincial governments, "lack of pandemic preparedness" and the failure of "policy makers and leaders ... to take sufficient action, despite repeated calls for reform" (p. 2). A recent report urges a "comprehensive approach to improving the quality of care in nursing homes" (The National Academies of Sciences, Engineering, and Medicine 2022: 2). The exemplar homes in our study provide evidence for what works in practice and the decisions and approaches they implemented could be used to initiate change, strengthen leadership and provide guidance. Moving forward it is critical that governments and key stakeholders in the LTC sector, including executive directors and DoC, have integrated information that provides a foundation for rapid decision making and the development of comprehensive action plans for crises.

## Conclusion

The results of our study have significant implications for LTC practice and policy. Throughout the study, the role and involvement of leadership were evident. The homes that did well focused on empowering, educating and supporting employees and used agile and innovative strategies for staffing. They also prioritized resident-focused care, built on existing partnerships, established new links with both community and health services and enabled staff and families to participate more fully in meeting the needs of a vulnerable population. The decisions and approaches implemented by the exemplar homes in our study provide evidence for what works in practice and, more importantly, in a crisis.

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## Note

1. Daily huddle: A “brief, daily discussion focusing on the plan of action ... [not] centered on workflow issues but instead promotes discussion among coworkers regarding patient safety and goals of care” (Di Vincenzo 2017: 59).

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# Lessons from Long-Term Care Facilities without COVID-19 Outbreaks

## Leçons tirées des établissements de soins de longue durée sans éclosion de COVID-19



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### Abstract

*Background:* The COVID-19 crisis in long-term care (LTC) homes was devastating for residents and front-line workers. Recent reports have detailed what went wrong in LTC facilities, including equipment shortages, lack of preparedness, underestimation of COVID-19's virulence and bans on caregiver visits. Less is known about what went well in some facilities.

*Purpose:* To describe nurses' and other staff members' experiences and lessons learned in two LTC facilities in Quebec that reported no COVID-19 outbreaks during the first wave of the pandemic.

*Methods:* A case study design guided by appreciative inquiry was conducted, in which a case was defined as a LTC facility without COVID-19 outbreaks; two cases were included. Twenty-three healthcare team members from the two sites were recruited and interviewed between October and November, 2020.

*Results:* Several common themes were identified: being informed and respecting outbreak protocols; the presence of key outbreak protocols, which allowed for stable teams; a clear action plan; and access to materials and resources. Key management themes included team support and reward, ongoing communication and providing compassionate care to residents.

*Conclusion:* This study highlights several lessons learned that have the potential to strengthen the LTC health system.

### Résumé

*Contexte :* La crise de la COVID-19 dans les foyers de soins de longue durée (SLD) a été dévastatrice pour les résidents et les travailleurs de première ligne. De récents rapports ont détaillé ce qui n'allait pas dans les établissements de SLD, notamment les pénuries d'équipement, le manque de préparation, la sous-estimation de la virulence de la COVID-19 et l'interdiction des visites des proches aidants. On en sait moins sur ce qui s'est bien passé dans certains établissements.

*Objectif :* Décrire les expériences et les leçons apprises des infirmières et des autres membres du personnel dans deux établissements de SLD au Québec qui n'ont signalé aucune écloison de COVID-19 au cours de la première vague de la pandémie.

*Méthode :* Nous avons mené une étude de cas guidée par une enquête appréciative, dans laquelle un cas était défini comme un établissement de SLD sans écloison de COVID-19; deux cas ont été retenus. Vingt-trois membres des équipes soignantes des deux sites ont été recrutés et interviewés entre octobre et novembre 2020.

*Résultats :* Plusieurs thèmes communs ont été dégagés : être informé et respecter les protocoles en cas d'écloison; la présence de protocoles clés en cas d'écloison, qui permettent la stabilité des équipes; un plan d'action clair; et l'accès au matériel et aux ressources. Les principaux thèmes de gestion comprenaient le soutien et la récompense de l'équipe, la communication continue et la compassion envers les résidents.

*Conclusion :* Cette étude met en évidence plusieurs leçons apprises qui ont le potentiel de renforcer le système des SLD.

### Background and Purpose

In March 2020, the World Health Organization (WHO) declared COVID-19 a global pandemic. By the end of the first wave, over 10 million cases and more than 495,781 mortalities were reported worldwide and 8,504 deaths were reported in Canada (Flood et al. 2020). The

case-mortality rate increased vastly by age group: 20.1% for those aged 70 to 79 years and 34.4% for those aged 80 years and older (PHAC et al. 2020).

Long-term care (LTC) facilities provide 24-hour functional support for residents who are frail, require assistance with activities of daily living and often have multiple co-morbidities. Most residents are over the age of 80 and approximately 70% have dementia (Hsu and Lane 2020). These facilities are at the margins of the healthcare system, which is biased toward curative and acute care. Due to decades of chronic underfunding and understaffing, the LTC system was weak and vulnerable leading up to the pandemic (Doucet 2020). Sadly, it is within this context that COVID-19 spread through the vulnerable and weakened LTC facilities.

The first wave of the pandemic corresponds to the first six months, specifically from March 1 to August 31, 2020 (CIHI 2021a). During those first six months, about 69% of COVID-19 deaths nationwide were in LTC and retirement homes (CIHI 2021a). By the end of the first wave, nearly 4,000 residents in Quebec had died, representing about 0.05% of the total provincial population (CIHI 2021a; Institut de la Statistique du Québec [ISQ] 2020). In addition to the highest increase in excess deaths, LTC facilities in Quebec and Ontario had the largest proportion of outbreaks at 44% and 34%, respectively (CIHI 2021a).

In Quebec, as in most provinces, the first wave focused on personal protective equipment (PPE) and shortages of masks, visors and gowns for healthcare workers (Protecteur du Citoyen 2020). Distribution of PPE prioritized the hospital system, with allocation to LTC facilities discordant and uncertain. Management of LTC facilities was censured worldwide. The Quebec Ombudsman conducted an independent investigation of LTC facilities in the province and found several issues (Protecteur du Citoyen 2020). First, facilities were not prepared for the pandemic. Second, the virulence of COVID-19 was underestimated. Third, PPE was insufficient and unequally distributed. Fourth, banning caregiver visitors led to a further decline in LTC residents' physical and mental health and resulted in basic care needs not being met. Fifth, facilities were not prepared to provide the same intensity of care as hospitals but were expected to do so. Sixth, the deployment of relief teams in the form of military personnel was not expeditious. Finally, further challenges were created due to a lack of onsite management and decision-making power.

Internationally, staffing issues related to nurses and other healthcare providers have been cited as a common problem (Abbasi 2020). Before COVID-19, staff-to-resident ratios, employment status and compensation/sick leave were found to be problematic in Ontario LTC homes and were greatly exacerbated during the pandemic (Oldenburger et al. 2022).

While most of the literature has focused on pandemic-related issues and challenges, less is known about what was done well in LTC facilities that avoided outbreaks. To the best of our knowledge, no qualitative study has explored this issue. To address this gap our study aimed to describe nurses' and other staff members' experiences and lessons learned in two LTC facilities in Quebec that reported no COVID-19 outbreaks during the first wave of the pandemic (i.e., during the first 6 months between March 1 and August 31, 2020).

An appreciative inquiry approach was used (Bushe 2011; Cooperrider and Whitney 2001). A better understanding of what was done well during the initial contact with the pandemic can help inform LTC practices and inform policy changes not only in Quebec but also throughout Canada.

## Methods

A case study design guided by appreciative inquiry was conducted, in which a case was defined as an LTC facility without COVID-19 outbreaks between March 1 and August 31, 2020. Two cases were included. Case studies allow for an in-depth exploration of a select number of cases (Yin 2017). Emphasis was on exploring strengths rather than deficiencies and an appreciative inquiry approach was used to create the semi-structured interview questions (Cooperrider and Whitney 2001). Approval was obtained from the Institutional Ethical Review Committee from each facility and consent for voluntary participation was obtained from the participants. The study reported here is part of a broader Canadian research project dedicated to the study of LTC facilities in the healthcare sector (Baumann et al. 2022). It is important to note that the facilities included in this study are atypical of the majority of facilities in Quebec and Canada.

## Participants

A convenience sample was used. We invited all nurses and other healthcare providers from two LTC facilities in Montreal, QC, that remained free of COVID-19 outbreaks despite being in a red zone (i.e., a maximum alert area [Touzin and Duchaine 2020]) during the first wave of the pandemic. Potential participants were invited via an e-mail sent by key contacts (coordinators) at both LTC facilities on behalf of the principal investigator. Interested individuals were invited to contact the research assistant by e-mail to ask for more information, pose questions or indicate their interest in participating in the study. The research assistant contacted interested participants by e-mail or phone to answer any questions, review the consent form and plan the interview.

The first LTC facility, which was established in 1944, has a new building that opened in 1977. Today, this facility is a member of the integrated university health and social services centres. The centre has four units and can accommodate 134 residents. The healthcare team covering the day, evening and night shifts is equivalent to the full-time hours of 11 nurses, 17 licensed practical nurses (LPNs) and 46 resident attendants. The staff team consists of 124 personnel who hold part-time or full-time positions. None of the staff is contracted and there are no professional agency employees.

The second LTC facility, which was established in 1992, is within a hospital that has been part of the University Health Network since 2008. This facility is divided into three floors or units and has 143 single rooms, including 20 beds dedicated to residents who require ventilator support. The healthcare team covering the day, evening and night shifts is equivalent to the full-time hours of 12 nurses, 6 LPNs and 18 patient attendants. The staff

team consists of 68 personnel who are mixed into different care teams. They work full time or part time and are all unionized. There are no professional agency employees.

The following types of staff were invited to participate in the study: nurses, LPNs, nurse managers, infection prevention and control (IPAC) personnel, personal support workers (PSWs), housekeeping staff, nursing advisors and rehabilitation personnel. The overarching inclusion criteria were to be a staff member at one of the two LTC facilities, to have been working during the six months of the first wave, to be older than 18 years of age, to be able to speak French or English and to have access to the Internet and a phone.

### *Data collection and analysis*

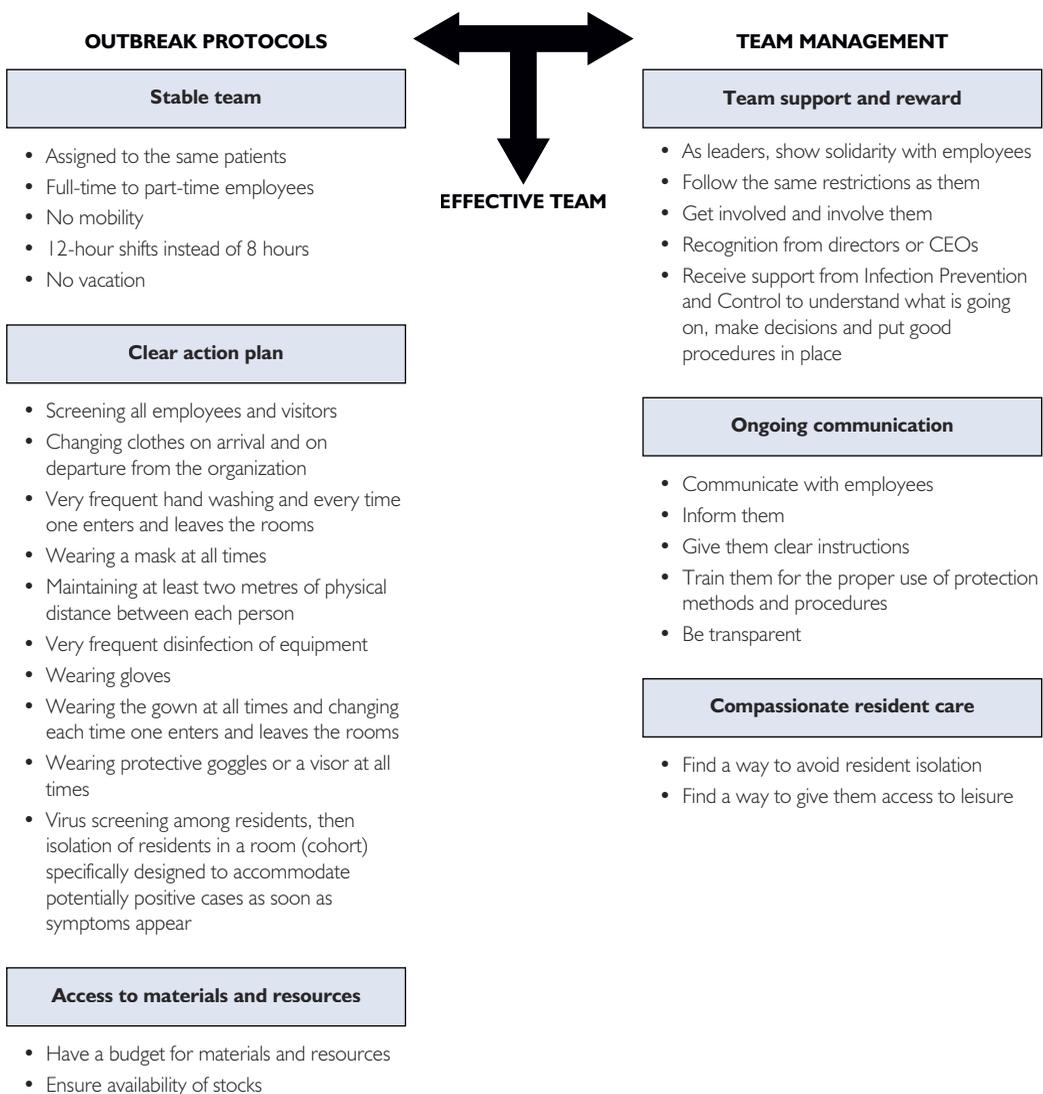
Data were collected from 22 individual interviews (Site 1:  $n = 15$ ; Site 2:  $n = 7$ ) using a semi-structured interview guide. This sample size per site was found sufficient to reach adequate data saturation. All interviews were conducted over the phone between October and November 2020 and were audio-recorded. The interviewer specified that the questions were specifically referring to the period corresponding to the first wave of the pandemic (i.e., from March 1 to August 31, 2020). Sample interview questions included “Describe what you did to face this pandemic?” and “How do you explain that you did not have any residents contract COVID on your site?” Each interview lasted about 30 to 40 minutes. Participants were allowed to respond in either French or English. The interviews were digitally recorded and transcribed verbatim. An audit trail tracked all material and documentation related to the data (Krefting 1991). The interviews were collected by a trained researcher with several years of experience in qualitative data collection and analysis.

Data were analysed using inductive thematic analysis as described by Miles and Huberman (1994). A full cross-sectional analysis of the two cases was then performed (Vallis and Tierney 2000). Theme-based strategies were applied to identify similarities and differences among the cases (Miles and Huberman 1994; Teddlie and Tashakkori 2009). This method of qualitative data analysis involves three concurrent activities: condensing the data, data display and verification of the data. Open coding involves the researchers reviewing the interview transcripts closely, line by line, and extracting sections that met the study objective. Codes are created by condensing the original data and categories are formed by clustering codes referring to similar concepts. As a second step, Miles and Huberman proposed creating data displays (e.g., graphs, charts) to define key concepts embodied in the analysis to illustrate how the concepts are interrelated. Data displays involve the elaboration and verification of the data as a continual process (Miles and Huberman 1994). To enhance confirmability and trustworthiness of interpretation, a subset of the data was coded and analyzed by two researchers with expertise in qualitative data analysis; consensus around the emerging interpretations was reached among researchers through discussions (Polit and Beck 2008). Descriptive statistics were generated through Excel based on demographic information provided by participants.

## Results

Several common themes were identified. As illustrated in Figure 1, participants (P1–P23) were able to be effective as a team by being informed and respecting outbreak protocols that were put in place early by their institution. The establishment of the protocols also allowed for a clear action plan and access to materials and resources. Furthermore, COVID-19 outbreak management and the success of the facilities in achieving zero cases were facilitated by team management. This included team support and reward, ongoing communication and the provision of compassionate resident care. Overall, the themes identified were similar in both facilities. However, some nuances were noted. These are detailed below when relevant.

**FIGURE 1.** Effective teamwork



## *Outbreak protocols*

### STABLE TEAM

According to participants, a stable team was achieved by ensuring adequate staffing and providing continuity of care to residents by assigning the same employees to the same residents. Part-time employees were offered full-time hours and the practice of employees working in other areas of the facility or in different facilities was eliminated, thereby reducing the risk of viral transmission. Some movement between floors of the facility was still allowed at Site 2 but prohibited at Site 1.

The first thing is to keep our residents safe ... the employees who have a part-time position, they have all been upgraded to a full-time position. (P4)

In addition, at both facilities, a stable team was achieved by not allowing any vacation leave. Site 2 also instituted 12-hour shifts instead of 8-hour shifts, which reduced the amount of staff turnover within a day.

### CLEAR ACTION PLAN

Participants from both sites highlighted several clear, effective actions. These included screening all employees and visitors for COVID-19 symptoms upon their arrival, requiring employees to change from their civilian clothes to their uniforms upon arrival and departure from the facility and maintaining physical distancing between each person. At Site 1, employees were screened for COVID-19 symptoms daily while at Site 2 they were screened three times per week.

[I]f, for example, we have a symptom, we have to go directly to be tested, not return. Finally, we will get tested and then we basically don't go back to work until we get the result. Then the employees are paid at that point, in COVID mode. (P17)

Rigorous IPAC practices were implemented at the facilities. Employees were required to always wear surgical masks, frequently disinfect equipment, wash hands upon entering and exiting patient rooms, wear PPE and adhere to proper donning and doffing procedures upon entering and exiting patient rooms. Residents were also screened daily. Any residents experiencing one or more COVID-19-like symptoms were immediately isolated to rooms that could accommodate a potentially positive case.

### ACCESS TO MATERIALS AND RESOURCES

Participants mentioned how their facilities budgeted and planned to ensure sufficient PPE for their daily use. Readily available stock for the employees ensured they had the proper resources to protect themselves and their residents.

## Lessons from Long-Term Care Facilities without COVID-19 Outbreaks

There was no shortage of stock, I mean, the PPE. Our head nurse bought extra in advance. She always made sure we had everything. We didn't lack anything. We had no excuse. (P21)

Furthermore, they were provided with teaching on proper IPAC practices, such as how to don and doff PPE before entering and exiting residents' rooms.

Education was becoming important ... The education department was doing practices. Videos have been put in place to show staff how to put on the N95, how to dress. (P3)

### TEAM MANAGEMENT

Participants mentioned team support and reward, ongoing communication and the provision of compassionate resident care.

### TEAM SUPPORT AND REWARDS

Participants described having team support and rewards, or recognition, for their efforts during the pandemic as key to their success. Support came from their colleagues – from nurses to the housekeeping staff – and from their leaders. The leaders showed their solidarity by following the same restrictions as their employees and by being on the ground and working alongside staff to face the crisis. Team leaders supported participants' involvement in COVID-19 management and encouraged them to share their input and feedback on the issues.

The management are very, very supportive, which makes a big difference like when you see the manager come in at night to give you support ... it makes a big difference. (P17)

Because of their teamwork success, participants reported receiving recognition from the director of the facility. Furthermore, they had continuous involvement from the IPAC team who, like their managers, made a collaborative effort to understand the situation at the facility and to ensure properly shared decision making and implementation of good practices. At Site 1, an IPAC team member was always present at the facility while at Site 2 the IPAC team was only contacted if needed.

### ONGOING COMMUNICATION

Participants recognized the importance of ongoing communication and transparency with employees. Ongoing communication involved informing all employees about any new decisions or changes to practices, providing them with clear instructions on any new protocols

and education and training around proper IPAC practices. Follow-up with communicated directives involved managers inspecting their facilities to ensure the measures were part of the daily practices.

I think communication was a really big key. So the fact that all communication from the top got to the bottom was really important. The way the message was communicated and who was communicating the message was important for me. (P16)

Being transparent involved being open with employees as well as giving them timely and accurate information about the COVID-19 situation and its impact on the facility.

Questions were answered on the intranet. We had our manager who [hosted] webinars every week. Even our director of nursing hosted webinars every week to answer the managers. So everything was transparent. (P1)

#### COMPASSIONATE RESIDENT CARE

Participants expressed that their primary goal was to ensure a safe environment for the residents. One measure put in place across Quebec was to temporarily restrict visitors to LTC facilities, which greatly diminished residents' social interactions. To mitigate this, the staff tried to maintain their well-being and decrease their isolation by providing access to leisurely activities (e.g., musicotherapy at Site 1), setting up video calls with residents' family members and even designating a staff member to organize activities.

We ma[de] them laugh and we danced. I have seen some of my PABs [préposé aux bénéficiaires]<sup>1</sup> just dance around them and they just laughed ... because it has been hard on the residents [and] they can't even go outside ... It's too much ... they're isolated. (P19)

### *Discussion*

The present study sought to identify what enabled the success of two LTC facilities in Quebec that remained free of COVID-19 outbreaks during the first wave. By identifying the measures and practices that proved successful in these facilities, more informed policies could be proposed and implemented throughout the country to protect our vulnerable elderly population.

Overall, the present results suggest that their success could be attributed to better management of movement within the facilities, including who entered and exited; screening of employees and residents for symptoms and their subsequent isolation and testing; the presence of managers on site; and rigorous IPAC policies such as ensuring sufficient stock and use of PPE. Other factors included strong leadership. A stable healthcare team included a larger complement of full-time workers and effective, daily communication that included

clear instructions and education on new protocols. Results from the present study highlight the important role played by managers and the significant impact of managerial transparency. It is likewise important to have leaders who show team support, reward, recognition and solidarity. Interestingly, although some minor differences were noted between the two successful facilities, most of the procedures and actions they employed during the first wave of the pandemic were very similar.

A similar study conducted in Ontario (Baumann et al. 2022) also identified key factors such as leadership, clear and effective communication, adequate staffing measures and staff recognition and respect as having been influential in successfully managing LTC homes during the first wave of the pandemic. Other recent studies suggested similar successful strategies, such as the early implementation of policy measures, including adequate staffing, limiting movement of workers between multiple sites and access to and proper use of PPE (Rios et al. 2020). Evidence is growing that LTC facilities that assigned staff to specific zones had fewer outbreaks (Rolland et al. 2020; Viray et al. 2021). Other effective strategies recently identified include sufficient PPE, adequate outbreak preparedness plans, statutory sick pay, sufficient staff-to-bed ratios, early detection and systematic testing, greater funding of LTC facilities and fewer shared rooms (Fernandes et al. 2021; Liu et al. 2020; Viray et al. 2021).

Most Canadian provinces imposed restrictions that prevented family caregivers from visiting and assisting in the care of their loved ones (CIHI 2021b). The International Long Term Care Policy Network published a review of the guidelines and practices regarding visits to residents in LTC facilities during COVID-19 (Low et al. 2021) and made it very clear that a complete visitor and family caregiver ban was detrimental to residents' cognitive and psychological health, but that LTC facilities should be better supported and should receive additional funding to ensure that they were able to implement safe practices around visits to residents. In the present study, it was found that staff went to great lengths to minimize the impact of the lost social connection that residents experienced because of the visitation ban. This was also observed in the LTC homes in Ontario that were successful in protecting their residents from COVID-19 (Baumann et al. 2022). The specific context of LTC necessitates a high degree of compassionate care, especially in difficult times (such as during the lockdowns due to COVID-19). This is an additional reason why LTC facilities need to be sufficiently staffed with individuals who are not overworked and who are treated well by their managers and the organization.

Calls to better prepare LTC facilities for outbreaks and to develop and implement guidance plans and programs for prevention and control have been made in Canada, Europe and the US (Baumann et al. 2022; Blain et al. 2020; Grabowski and Mor 2020; Werner et al. 2020). The results of the present study are in line with several policy changes recommended in recent months. Although the experiences of the two facilities that were included in the present study are atypical compared with those of the majority of facilities in Quebec and Canada, the findings suggest successful strategies that could be deployed if adequate resources are allocated to LTC and relevant policies are implemented. First, adequate staffing

and funding measures are of utmost importance (Ducharme 2021). Policy measures need to be implemented specifying adequate staff to patient ratios. Staff must be offered full-time employment with appropriate pay and benefits to ensure proper care as well as to limit multi-site transmission of viruses (Estabrooks et al. 2020; Hsu and Lane 2020). Policy measures regarding staff training and IPAC practices are necessary (CIHI 2021a).

Improved communication within LTC facilities and among parts of the healthcare system would benefit both staff and residents. In addition, access to PPE for all staff must be prioritized going forward. As suggested by Estabrooks and colleagues (2020), national standards regarding staffing, staffing mix, training requirements and protocols for outbreaks in LTC facilities would ensure adequate and uniform care for residents. Funding should be guaranteed to ensure proper inspections of LTC facilities and for the enforcement of these national standards (CIHI 2021a).

### *Strengths and limitations*

This qualitative study presents several strengths; however, some limitations must be highlighted. First, only two LTC facilities were included, which limits the generalizability of the findings. Most themes extracted from the data were common between the two sites, however, suggesting that strategies may be generalizable to other facilities. Second, both LTC facilities were in a large urban centre; more rural centres may have been impacted differently. Third, only qualitative data were collected in the present study and only from nurses and health-care providers. The perspective of other important actors such as residents and their family members would be highly informative. Finally, the interviews were conducted during the first three months of the second wave, which might have influenced participants' answers. That said, it should be noted that according to the Canadian Institute for Health Information (2021a), the second wave of the pandemic lasted until February 15, 2021. Thus, it is believed that even if the participants' responses were influenced by their experiences after the official end of the first wave, their insights were nonetheless highly relevant to the overall initial response to the pandemic.

### **Conclusion**

Due to COVID-19, the LTC sector has been changed forever. The provincial and federal governments must seriously consider and respond to what the pandemic revealed regarding the fragility of the sector. LTC must be put at the top of the planning process, not neglected at the bottom where it has traditionally been. The impact of COVID-19 worldwide has created many lessons to be learned. Evidence and the present study demonstrate that the proper implementation of IPAC policies was one of the most effective strategies for reducing COVID-19 outbreaks and mortality. The COVID-19 pandemic requires a deep analysis and reflection of how we care for vulnerable people. Lessons learned from this experience must be implemented to strengthen the LTC sector and more effectively protect our elderly population.

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## Note

1. Medical orderlies.

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# COVID-19 Issues in Long-Term Care in Ontario: A Document Analysis

## Enjeux liés à la COVID-19 dans les soins de longue durée en Ontario : une analyse de documents



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## Abstract

The COVID-19 crisis in long-term care in Canada has been characterized as a *crisis upon a crisis*. This study examines recent documents on the crisis in long-term care in Ontario, using document and thematic analysis to synthesize issues and recommendations from the perspectives of different groups and organizations. Thirty-three documents from 20 organizations were analysed and six thematic areas were identified: resident care; human resources; governance, leadership and management; financing; physical infrastructure and supplies; and training and preparation. The six common themes, as perceived by different perspectives, can inform policy makers on long-term care issues.

## Résumé

La crise de la COVID-19 dans les soins de longue durée au Canada a été qualifiée de *crise de la crise*. Cette étude examine des documents récents sur la crise dans les soins de longue durée en Ontario, au moyen d'une analyse documentaire et thématique pour synthétiser les problèmes et les recommandations du point de vue de différents groupes et organisations. Trente-trois documents provenant de 20 organismes ont été analysés et six domaines thématiques ont été dégagés : soins aux résidents; ressources humaines; gouvernance, leadership et gestion; financement; infrastructures physiques et fournitures; et formation et préparation. Les six thèmes communs, tels que perçus selon divers points de vue, peuvent éclairer les décideurs sur les enjeux liés aux soins de longue durée.

## Introduction

The Canadian healthcare system experienced a crisis in its long-term care (LTC) sector during the COVID-19 pandemic, with more than 26,000 resident cases and 6,080 deaths during the first wave (CIHI 2021: 6). Before the pandemic, LTC in Canada had already been experiencing significant issues for more than two decades, including staffing shortages, outdated infrastructure and increasingly complex residents (Berta et al. 2022; RSC 2020). Despite more than 50 previous reports, multiple public inquiries and evidence of these issues over the past decades, little action or observable shifts in policy have occurred. These challenges were exacerbated by the pandemic, resulting in a sector-wide crisis (Armstrong and Cohen 2020; Ontario Ministry of Long-Term Care 2020; RNAO 2020c). On March 27, 2020, the Ontario provincial government enacted emergency legislation to mitigate the COVID-19 crisis, including restricting LTC staff from working in more than one facility, restricting access of non-essential personnel into LTC homes and allowing redeployment of community and acute care health providers to the LTC sector (Government of Ontario 2020b). This was followed by requesting support from the Canadian Armed Forces (CAF) and the Canadian Red Cross Society and establishing a public inquiry: Ontario's Long-Term Care COVID-19 Commission (Government of Ontario 2020a).

Researchers in the US have reported on recommendations for improving LTC settings in the context of COVID-19, identifying recommendations related to resident quality of

care and healthcare (Vipperman et al. 2021). In the province of Quebec, public attention to the situation in LTC – similar to that in Ontario – has been described as a policy window (Béland and Marier 2020). The crisis in Ontario received significant attention. Many documents had been published from a variety of perspectives prior to COVID-19 on the state of LTC and play a key role in understanding the background and context of these issues. Since the pandemic, more documents have been published describing the situation in LTC as a *crisis upon a crisis*. Therefore, the question is this: How do documents from diverse perspectives describe the problems in LTC in Ontario and what are the recommendations they propose?

At the time of our review, no studies had been published analyzing public documents on the state of LTC in Ontario since the pandemic. This study examined recent documents from the perspectives of different stakeholder groups and organizations to synthesize issues and recommendations for addressing the crisis in LTC in Ontario.

## Methods

Documents can shed light on how groups perceive certain issues. Coffey (2013) describes documents as being constructed from a specific viewpoint, and argues to “[pay] attention to the knowledge that documents ‘contain’ about a setting but also examining the role and place [of] settings” (Coffey 2013: 370). Authors have argued that documents give underlying meanings, patterns and processes (Altheide et al. 2008), as well as provide understanding of historical roots, issues and conditions of a phenomenon (Bowen 2009).

Document analysis methodology is described as “[initially focused] on exploration, reading, looking, reflecting and taking notes [...], followed by identification of key terms, images, themes, and associated frames” (Altheide et al. 2008: 135). Dalglish and colleagues’ (2020) systematic READ approach (*ready* your materials, *extract* data, *analyse* data and *distil* your findings) in health policy was used. The search strategy began with a snowball approach, using a convenience sample of reports on LTC in Canada that were publicly accessible and published between January 2020 and February 2021. The search was expanded by a review of reference lists of reports; a manual search of government and organization websites; a Google search using terms such as “Long-Term Care,” “LTC” and “Canada;” and by reviewing online news articles on “COVID-19 in long-term care.” Inclusion criteria were documents tabled to the government for LTC reform or published by the government, describing the context in LTC just prior to and during the pandemic. Exclusion criteria were documents that provided limited detail or those that focused on a specific issue or intervention, including news articles, research studies and clinical guidelines. A title review was used to purposefully select public documents for inclusion that described generalizable issues and/or recommendations for the LTC context in Ontario.

Selected documents were uploaded to Atlas.ti qualitative software (ATLAS.ti Scientific Software Development, GmbH version 9, 2021). Coding of the documents followed an iterative approach, beginning with open and descriptive coding (Wood et al. 2020). This was followed by an inductive thematic analysis of coded excerpts to develop thematic areas

of related issues and recommendations within the documents (Braun and Clarke 2012). Organizations that published the documents were also grouped into perspective categories to examine similarities and differences in how different organizations defined the crisis in LTC.

## Findings

Thirty-three documents were included in the study, published from the perspectives of 20 different groups and organizations. These were further organized into six categories (Table 1) to compare how they defined the crisis in LTC.

**TABLE 1.** Categories, perspective groups, organizations and number of documents

Categories (n = 6)	Perspectives (n = 20)	Documents (n = 33)
Government/ department and commission public agencies	Canadian Armed Forces	1
	Canadian Institute of Health Information	1
	City of Toronto	1
	Ontario's COVID-19 Long-Term Care Commission	2
	Patient Ombudsman (Ontario)	1
	Province of Ontario (including the Ministry of Long-Term Care)	4
Academic	National Institute on Ageing – Toronto Metropolitan University	1
	Queen's University Working Group	1
	Royal Society of Canada	1
	2020 Ontario COVID-19 Science Advisory Table	1
Professional/ labour association	Canadian Labour Congress	1
	Canadian Nurses Association	1
	Provincial Geriatrics Leadership Office	1
	Registered Nurses' Association of Ontario	3
Policy think-tank	C.D. Howe Institute	1
	Canadian Centre for Policy Alternatives	2
Other non-profit organization	AdvantAge Ontario	5
	Canadian Long-Term Care Association	3
	Council on Aging of Ottawa	1
For-profit	Revera Inc.	1

The documents had an average length of 27 pages, ranging from five to 92 pages. The selected documents included government and organizational reports, pre-budget submissions and policy and position papers. Focus and format varied, from detailed issues with research evidence to broad discussion of multiple issues with general recommendations. Some organizations published more than one document during the sample period. Inductive coding produced 1,001 coded excerpts that were grouped into six thematic areas and ordered based on emphasis of the themes in the documents.

## Thematic areas

The thematic areas collate related issues and recommendations discussed in the documents. The following is a list of thematic areas, from greatest to least emphasis in the documents:

- (1) resident care; (2) human resources; (3) governance, leadership and management;
- (4) financing; (5) physical infrastructure and supplies; and (6) training and preparation.

#### RESIDENT CARE

Resident acuity and complexity of residents, including high levels of cognitive impairment, co-morbidities and need for active monitoring, were all seen as significant factors affecting workload and a challenge to meeting residents' needs. There is variation among documents in the number of hours of care residents are currently said to receive, from 2.45 hours per day (NIA 2020: 23) to 3.73 hours per day (Ontario Ministry of Long-Term Care 2020: 15). However, a number of documents (AdvantAge 2020c; CALTC 2020; CLC 2020; Marrocco et al. 2020a; Ontario Ministry of Long-Term Care 2020; RNAO 2020a, 2020c) cited a study in the US that identified 4.1 hours as the minimum care required to meet resident physical care needs (Centres for Medicare and Medicaid Services 2001). Increased care hours were perceived to help alleviate some of the burden on staff, yet few of these documents discussed which providers or what type of care constituted these hours. Additionally, the documentation and reporting requirements were described as putting additional burden on care providers, reducing time for resident care needs by both personal support workers and nursing staff (AdvantAge Ontario 2020a; CALTC 2020; Council on Aging of Ottawa 2020; Ontario Ministry of Long-Term Care 2020; RSC 2020).

Informal providers – such as family, friends and privately paid companions – provide significant psychosocial support as well as physical care needs to individuals (Berta et al. 2022; Ontario Ministry of Long-Term Care 2020). The Ontario government's decision to restrict informal providers from entering LTC facilities to prevent exposure of residents to possible infections from outside visitors added to staff burden and impacted quality of life of residents (City of Toronto 2020; PGLO 2020; Revera 2020). Documents described that care providers had difficulty meeting resident care needs before the pandemic, an issue that worsened dramatically during the pandemic. The addition of infection control protocols and the absence of informal providers added to workload and subsequently affected the care of residents.

#### HUMAN RESOURCES

Documents demonstrated that human resource issues, including staff-to-resident ratios, employment status (i.e., full-time, part-time, casual, and agency staff) and compensation, were major issues prior to the pandemic. Homes frequently operated short-staffed, while poor staff job satisfaction, burnout and inadequate time to provide care were described as significant issues related to retention (AdvantAge Ontario 2020c; CNA 2020; Ontario Ministry of Long-Term Care 2020; RNAO 2020c; RSC 2020):

[We] have heard repeatedly and consistently about critical staffing shortages pre-COVID and the reasons for long-standing recruitment and retention challenges

in long-term care homes. The staffing challenges have been well documented with numerous reports on the subject. COVID-19 exposed these challenges in stark terms.” (Marrocco et al. 2020a: 2)

Issues during the pandemic led to further crisis. Provincial legislation to prevent transmission limited care providers to working at one facility and inadvertently restricted access to part-time and casual staff, as LTC personnel often worked across multiple homes. Furthermore, fear of contracting COVID-19 and the increased care burden of caring for children at home led to fewer workers available (CAF JTFC 2020; Ontario Ministry of Long-Term Care 2020; Revera 2020). Documents recommended improved compensation and sick-leave benefits as well as increasing full-time positions as strategies to manage the crisis (City of Toronto 2020; C. D. Howe Institute 2020; Marrocco et al. 2020a; Ontario Ministry of Long-Term Care 2020; Revera 2020; RNAO 2020c; RSC 2020; Stall et al. 2021). The need to increase nursing staff (CNA 2020; Ontario Ministry of Long-Term Care 2020; RNAO 2020a, 2020c; RSC 2020), improve appropriate staff mix (Marrocco et al. 2020a) and engage allied health personnel were identified in several documents (Ontario Ministry of Long-Term Care 2020), concluding that these would improve quality of life and reduce risks such as resident falls and aggressive behaviour. Longer term recommendations suggested a comprehensive human resources strategy and improvement of public perception of LTC to attract and retain personnel (Ontario Ministry of Long-Term Care 2020; RNAO 2020c).

#### GOVERNANCE, LEADERSHIP AND MANAGEMENT

Provincial legislation – namely the *Long-Term Care Homes Act, 2007*, and its regulation (O. Reg. 79/10) – relating to the delivery of LTC in the province was described as strict and compliance-focused, with a punitive inspection model (AdvantAge Ontario 2020a; Ontario Ministry of Long-Term Care 2020). The Commission’s Second Interim Report recommended moving back to the annual inspection model (Marrocco et al. 2020b: 5). Many reports noted the lack of federal and provincial standards. In addition, concepts such as accountability and transparency were discussed as well as the need for standardized public reporting on inspections, resident outcomes, hours and quality of care and staffing (Armstrong and Cohen 2020; CALTC 2021; Marrocco et al. 2020b; RNAO 2020c). Documents affirmed there was a lack of capacity and resources to manage COVID-19. There were recommendations to improve collaboration and integration with the acute care system, including infection control capacity (Armstrong et al. 2020; Marrocco et al. 2020b; Revera 2020; RNAO 2020b):

Every long-term care home should have a partner organization to provide support for management, infection prevention and control, and staffing to prevent and respond to any COVID-19 outbreaks. This could be a municipality, a hospital or other organization that can provide resources. (Patient Ombudsman 2020: 7)

A select number of documents questioned the role of profit in LTC (Armstrong et al. 2020; CLC 2020), compared quality among different ownership types (AdvantAge Ontario 2020b; C.D. Howe Institute 2020; CALTC 2020; Stall et al. 2021) and suggested that reliance on casual and agency staff by private homes exacerbated the staffing crisis (CLC 2020).

#### FINANCING

There were several topics outlined that had financial implications. They included recommendations such as increased staffing, changes to compensation and benefits and the development and re-development of infrastructure. Additionally, the provincial funding model was described as inflexible and strict, preventing homes from meeting local needs and disincentivizing quality of care improvements:

When [interventions] are implemented [...] resident complications are prevented or resolved, resident acuity decreases. While this is good for residents, the home's [Case Mix Index] falls and funding in future years is decreased. [...] This penalty acts as a disincentive to improve patient outcomes. (RNAO 2020c: 32)

It was recommended “that the Ministry provides greater discretion to the licensees in their use of public funds in recognition of the unique needs of different operators and resident groups” (AdvantAge 2020a: 10).

#### PHYSICAL INFRASTRUCTURE AND SUPPLIES

Lack of basic supplies and physical infrastructure were perceived as major issues in managing the spread of COVID-19 (CAF JTFC 2020; Ontario's Long-Term Care COVID-19 Commission 2020a; Patient Ombudsman 2020). Infrastructure was described as impractical for social distancing and isolation, with 40% of existing infrastructure not meeting current standards (Drummond et al. 2020; NIA 2020: 7). The public inquiry's final report also addressed this issue, proposing a new model in which private capital and investment be used for development and management of LTC infrastructure, while not-for-profit or public “mission-driven” organizations manage care delivery for residents (Marrocco et al. 2021).

#### TRAINING AND PREPARATION

Documents written during the pandemic identified significant issues related to infection control training, including lack of specially trained infection prevention and control personnel, the need for improved infection control training (CALTC 2020; City of Toronto 2020) and training essential visitors and informal providers entering LTC facilities (Armstrong et al. 2020; PGLO 2020). Also, orientation and training of agency and new staff was recognized as a significant issue before – and worsened during – the pandemic (CAF JTFC 2020; City of Toronto 2020; Marrocco et al. 2020b; Revera 2020; RSC 2020).

## Discussion

LTC is a highly complex system. It comprises a blend of private for-profit, not-for-profit and public operators; a mixed funding structure of public money and individual resident contributions; a role for families as care providers and decision makers; and diverse needs of the resident populations. The documents reviewed for this study demonstrated that there were many common issues identified in LTC, including resident care, human resources and governance, leadership and management. These topics represented different perspectives, including those of academic researchers, advocacy groups, provincial government, public agencies and numerous professional and labour associations. Documents indicated a concern about burnout and retention of LTC providers and many recommendations were made for increased staffing. While issues of infrastructure and training were observed, they lacked emphasis among the documents.

Ontario's Long-Term Care COVID-19 Commission published its final report in April 2021, echoing many of the themes of our analysis: "[many] of the challenges that had festered in the long-term care sector for decades – chronic underfunding, severe staffing shortages, outdated infrastructure and poor oversight – contributed to deadly consequences for Ontario's most vulnerable citizens during the pandemic" (Marrocco et al. 2021: 11). It is important to emphasize that these issues were not unique to one province, as they were raised in reports from other provinces across Canada (Béland and Marier 2020; CLC 2020; Drummond et al. 2020; RSC 2020).

Within Canada, LTC is primarily regulated by provincial legislation and policies. This is where reform begins but also where the challenge lies as recommendations may not directly translate into changes in policy. As well, perceived problems and proposed changes can conflict among diverse stakeholders' perspectives. One example is the province's announced increase of care hours residents receive in provincially regulated homes. Existing legislation identifies the minimum care residents are to receive (e.g., two showers a week, daily changes, grooming), not minimum time or staffing (*Long-Term Care Homes Act, 2007*; *O. Reg 79/10*). Mandating four hours of daily care may require clear policy and legislative changes articulating what type of care or interventions constitute the four hours and how it is calculated; presently, the only staffing requirements for care is that one registered nurse be present in the facility at all times (*Long-Term Care Homes Act, 2007*). However, *O. Reg 79/10* made under the *Long-Term Care Homes Act, 2007*, provides a calculation of minimum nutritional staffing hours per week in LTC; therefore, there is precedent in the existing legislation for similar detail for care staff. The caveat is that such detailed legislation may have the consequence of further restricting LTC operators' flexibility to use funds to address local needs.

Another example of where issues and recommendations were seen to conflict is with respect to reporting requirements and accountability. Documentation and reporting requirements in LTC were described as a burden for care providers, taking away from time to

address resident needs. Existing legalisation identifies mandatory documentation for resident assessments and care plans, as well as reporting to the ministry and law enforcement for specific incidents. However, the responsibility for daily documentation remains implicit to demonstrate the achievement of the fundamental principle of *Long-Term Care Homes Act, 2007*, that each home is to provide a comfortable, safe and secure place to live and where residents' "physical, psychological, social, spiritual and cultural needs [are] met" (*Long-Term Care Homes Act, 2007*). Reducing requirements for documentation and reporting could make it more difficult to prove that homes are meeting this mandate and also conflicts with the recommendation for increased accountability. Alternatives could be to increase staffing levels or employ technology platforms to reduce the burden of documentation; however, this could have significant financial implications.

There are other examples of system-wide changes implemented since the pandemic, such as British Columbia temporarily classifying all LTC staff as public employees to guarantee wages and sick benefits (Hager and Woo 2020). While the Ontario government has commenced formulating policy actions to address the challenges experienced by LTC homes, staff and residents, these reforms may fall short of achieving their goal, given the complex considerations needed to implement effective change in the sector. New models of LTC, such as a mix of private investment for LTC infrastructure and management by "mission driven" organizations, suggested by the Ontario commission's final report (Marrocco et al. 2021) and development of federal standards for LTC (HSO 2021) also align with recommendations from the documents. However, it is yet to be seen if and how they will be implemented and what impact they may have.

### *Limitations*

Limitations of this study relate to the variation of the documents, including size, focus and the period and context in which they were written. Documents analyzed provided perspectives from January 2020 – three months before the province of Ontario declared a state-of-emergency over COVID-19 – to the end of the second wave in February 2021. Although this time had been the most devastating in LTC in terms of COVID-19 cases, outbreaks and deaths, the situation continues to evolve and more data, research and reports continue to be released. Therefore, results of this document analysis should be considered from the perspectives and context from which they were written and how this may have affected the emphasis on certain issues in LTC.

### **Conclusion**

The pandemic's disproportionate impact on LTC has garnered intense focus among leaders and policy makers at multiple levels, as well as the public. This study helps contribute to our understanding of the crisis in LTC from the perspective of diverse stakeholders and identifies six key areas of concern: (1) resident care; (2) human resources; (3) governance, leadership

and management; (4) financing; (5) infrastructure and supplies; and (6) training and preparation. These provide a roadmap for policy reform. However, as the study demonstrates, the issues that emerged as prominent during the COVID-19 pandemic are not new issues faced by this sector. Furthermore, although the documents detailed many issues in LTC, what was seen as key issues in these areas and the recommendations the groups made to address them varied and presented some conflict. Many of the trade-offs for proposed policy reform have significant financial implications and long-term policy commitment. The mix of government, for-profit and public operators, care providers, residents and families in the financing and delivery of care represents a complex system of stakeholders with varying power and priorities. With leaders and policy makers at all levels promising change for LTC, moving forward with any of the proposed recommendations will require a model of care, regulation and standards that address the many concerns described by multiple documents.

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# What Is Old Is New Again: Global Issues Influencing Workers and Their Work in Long-Term Care

Faire du neuf avec du vieux : les enjeux mondiaux  
qui influencent les travailleurs et leur travail dans les  
établissements de soins de longue durée



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## Abstract

We offer a broad understanding of contemporary issues relevant to the long-term care (LTC) sector and its workers, globally, and the concurrent evolution and involution of these workers' roles, their work and policy environments. While contemporary, most issues are also longstanding and fall into two broad categories: issues relating to the work environments in LTC, including resource availability and worker support, and issues relating to the changing nature of LTC work. We identify five key challenges that relate to the system structures of the LTC sector.

## Résumé

Cet article présente les problèmes actuels liés au secteur des soins de longue durée (SLD) et à ses travailleurs, à l'échelle mondiale, ainsi que de l'évolution et de l'involution simultanées des rôles de ces travailleurs, de leurs environnements de travail et des politiques. Bien qu'actuels, la plupart de ces problèmes sont présents depuis longtemps et se répartissent en deux grandes catégories : les problèmes liés aux environnements de travail dans les SLD, notamment la disponibilité des ressources et le soutien des travailleurs, et les problèmes liés à la nature changeante du travail dans les SLD. Les auteurs dégagent cinq défis clés liés aux structures systémiques du secteur des SLD.

## Introduction

The European Commission's Policy of Public Health calls aging "one of the greatest social and economic challenges of the 21st Century" (Yepes-Baldo et al. 2018). Demographic shifts over recent decades are heavily influenced by people living longer than ever before. People entering long-term care homes (LTCHs) are older and frailer, with multiple age-related morbidities, and up to 70% of residents live with Alzheimer's disease and age-related dementias (ADRD) (Alzheimer's Disease International 2020). Researchers and practitioners alike have voiced concerns about the implications of longstanding resource shortfalls on residents' quality of care and quality of life, and on the quality of work and life for care staff (OECD 2020). Increasingly, over the past 20 years, some human resource shortfalls have been met through the immigration of workers, particularly in Asia and the developed West (Munkejord and Tingvold 2019; OECD 2020; Yu and Perng 2014). The reality, however, is that the severity of these issues will continue to amplify as the global population ages and demand for services grows. And demand *will* grow. Globally, as early as 2030, 1 in 6 people will be 60 years of age and older (WHO 2021), and the size of the LTC workforce will need to increase by 60% by 2040 to meet the demand of older persons requiring LTC (OECD 2020).

### *What is old is new again: The "current" crisis in LTC*

The ongoing pandemic exposes gaps in preparedness and resources for LTCHs globally (Armstrong 2021; Berta and Dawson 2021; Estabrooks 2021) that are rooted in longstanding structural deficits, including persistent underinvestment in the sector; understaffing and lack of adequate and standardized staff training; and safety issues that are poignantly illustrated by efforts to implement infection protocols (OECD 2020; Oldenburger et al. 2022). In the first pandemic wave, an average of 38% of COVID-19 related deaths were connected to LTCHs and retirement homes in OECD countries, with considerably higher averages in some countries including Canada (~80%) and France (50%) (CIHI 2020; OECD 2020). The situation in the LTC sector during the COVID-19 pandemic is being described as a "crisis upon a crisis," as the LTC sector was already facing staffing shortages, an aging infrastructure, and the need to provide more complex care (Oldenburger et al. 2022: 54).

## Purpose

Through this review we sought to gain a broad understanding of longstanding and contemporary issues relevant to the LTC sector and its workers globally and the concurrent evolution and involution of these workers' roles and changes to their work and policy environments. We focus specifically on nursing staff and healthcare aides who, together, provide the majority of direct care to LTC home residents. Our review spans geographies and time. Our findings stand to inform LTC policy that attends to enduring historical influences, current constraints, and emerging future trends influencing workers in this sector.

## Methods

We completed a scoping review (Arksey and O'Malley 2005; Levac et al. 2010) to address this question: What is known about (features of and associations among) LTCH work environments, the nature of LTC work, and workers' (nursing staff and care aides') roles, work attitudes, and work outcomes? Databases included Medline, CINAHL, PsychINFO, EMBASE, Scopus and PSNet. We included publications through to March 2021; no restrictions were placed on publication date, design or geographic location beyond restricting our search to English language or translated studies only. Peer-reviewed articles and reviews were included; editorials and opinion pieces were not. To qualify for inclusion, articles needed to focus on staff who (1) work in LTCHs; (2) provide or assist in the direct care of LTC residents; and (3) are designated as a healthcare aide, personal support worker (PSW), registered nurse (RN), licensed practical nurse (LPN) or equivalent role. More detailed inclusion and exclusion criteria are noted in Box 1. Our final search strategy and inclusion criteria yielded 1,070 results. Removing duplicates left 686 articles. Our review of titles and abstracts for these, followed by full-text review, led us to exclude 408 articles. All data were synthesized and the evidence mapped following the guidance of the PRISMA-ScR guidelines for scoping reviews, with the exception of protocol registration (Tricco et al. 2018).

Data from the remaining 278 articles (see Appendix 1 for the complete bibliography, available online at [www.longwoods.com/content/26853](http://www.longwoods.com/content/26853)) were extracted into a table prepared as an Excel spreadsheet. Two authors (WB and CS) initially independently extracted data from a subset of articles for consensus, minimization of error, and clarity between reviewers regarding the choice of data selected for extraction. Discussion led to the identification of additional data extraction fields and to the development of categories within fields to facilitate coding of data from the articles. Information related to article characteristics, aim, research approach, context (including jurisdiction), level of analysis, types of participants (roles) and main findings was collected and entered into the data-extraction spreadsheet. Article characteristics were summarized graphically and descriptively (see the results below). Thematic analysis techniques (Braun and Clarke 2012) were used to organize key findings across the 278 included articles. Specifically, we used inductive thematic analysis to identify data patterns, and generate themes and sub-themes (Boyatzis 1998; Braun and Clarke 2012)

**BOX 1.** Inclusion and exclusion criteria

<b>Date:</b>	No date has been set limiting the scope of articles sourced.
<b>Exposure of interest:</b>	The participants of selected studies must be formal caregivers who have received training either as healthcare aides or as registered nurses and who work in an institutional/residential LTC facility.
<b>Geographic location of study:</b>	While the scope of this review will not be limited to a specific geographic region, included studies will be limited to those using sites whose organizational form resembles a residential/institutional LTC home.
<b>Language:</b>	In the interest of time, the studies included in this review will be limited to English language or translated studies only.
<b>Participants:</b>	Studies will be restricted to those whose participants work in an institutional/residential LTC facility, provide care or assist in the care of LTC patients and have been trained as either a registered nurse or a healthcare aide.
<b>Peer review:</b>	Peer-reviewed studies will be included, as will reports from government departments and professional associations.
<b>Reported outcomes:</b>	The reported outcomes must be critical or important to the area of interest covered in this review. For inclusion, studies should explore associations and relationships between/among work environments, workers' roles, workers' attitudes, and work outcomes in LTCH settings.
<b>Setting:</b>	Study settings will be restricted to sites providing institutional/residential LTC that employ health providers (healthcare aides or registered nurses) to distribute care to patients.
<b>Study design:</b>	All study designs will be looked at for this review.
<b>Type of publication:</b>	For the purpose of this review, only original studies and other reviews will be sourced. This excludes editorials and opinion pieces.

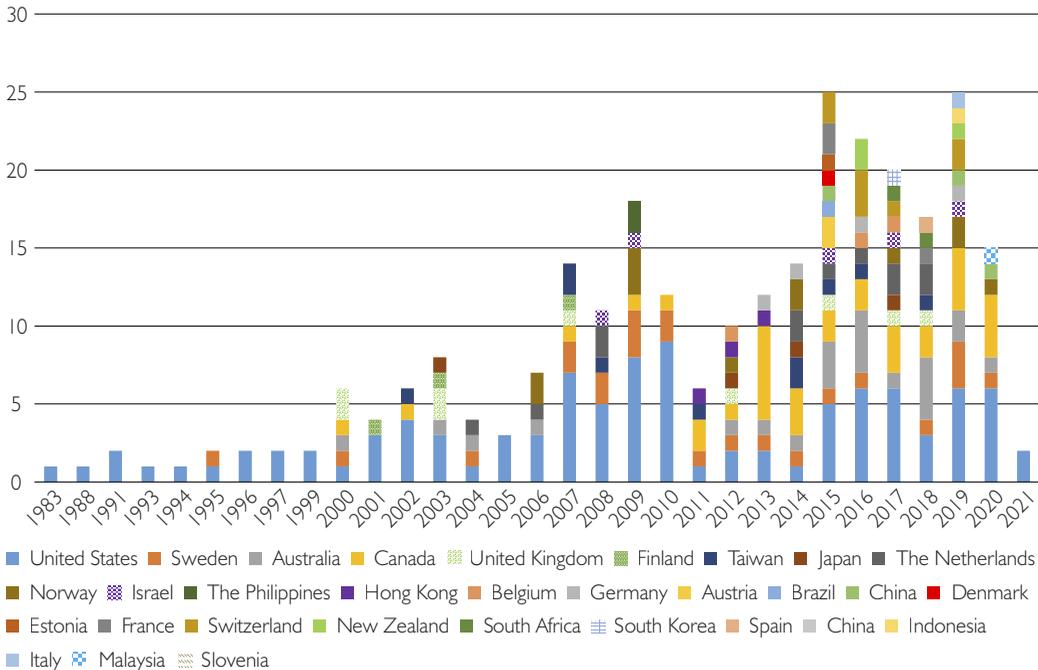
and identified these in an extension of the data-extraction sheet. We followed the analytic steps recommended for thematic analysis, including familiarizing ourselves with the data, generating and applying a coding scheme and generating and refining themes and sub-themes. When generating and refining themes, we organized them into two broad categories or issues that were representative of the data: (1) those relating to LTC work environments, distinguishing between external and internal environments, and (2) those relating to the nature of LTC work. In addition to generating sub-themes relating to each of these main themes, we made note of how the main themes (and sub-themes) related to one another and how they related to the work outcomes of workers. To ensure rigour (Krefting 1991), multiple researchers (WB and CS) worked to analyze the data (in a literature review, the content of the included articles is the data and this is the focus of the analysis) and recorded major decisions and findings. While WB and CS led the data analysis, the other author (AB) contributed to the identification and differentiation of themes and sub-themes, to their refinement, and to the identification of the five key challenges to the sustainability of LTC presented in the Discussion section.

## Findings

Figure 1 summarizes the origins of the articles, excluding two reports prepared by international entities, included in the review. The figure underscores the extensiveness of the issues globally that we describe below. Of the 278 articles included in the review, 145 (~52%) were

quantitative studies, 90 (~33%) were qualitative studies, 25 (~9%) were mixed or multi-methods studies, 16 (~6%) were reviews and 2 (~0.01%) were reports prepared by global entities that focused on the state of the LTC sector.

**FIGURE 1.** Articles included in the review, by country and year of publication



## Issues relating to LTC work environments

### RESOURCE AVAILABILITY

Resource availability in LTCHs is highlighted as problematic in dozens of studies across diverse jurisdictions. Persistent human resource shortages in the LTC sector have been identified in Australia (Moyle et al. 2003; Wells et al. 2019), Brazil (Mariano et al. 2015), Canada (Morgan et al. 2002; Song et al. 2020), France (Pélissier et al. 2015), Malaysia (Yasin et al. 2019), Taiwan (Yu and Perng 2014), Norway and Denmark (Krane et al. 2014), the US (Pfefferle and Weinberg 2008; White et al. 2019, 2020; Zhang et al. 2019) and other countries. Multiple studies show that resident care quality relates directly to staffing levels (Anderson et al. 2004; Armstrong 2021; Cohen-Mansfield 1997; Flackman et al. 2007). Other studies link staffing levels and staff outcomes: lower levels are associated with staff physical health, including back/joint pain (Dhaini et al. 2016), work stress (Bae and Brewer 2010; Islam et al. 2017; Lapane and Hughes 2007), intention to leave (Senecal et al. 2020) and work effectiveness (Temkin-Greener et al. 2009; 2010). Limited staffing is also shown to lead to presenteeism, with staff working when they are ill (Joseph et al. 2013).

The pandemic has tragically highlighted the severity of endemic resource and staffing shortages in LTC (Leskovic et al. 2020; White et al. 2021). It has been suggested that upwards of 50% of COVID deaths in LTCHs could have been prevented through infrastructure and workforce investments in adequate staff training, improved environments and prioritizing care quality and safety (OECD 2020).

Beyond human resources, the myriad impacts of the lack of availability of on-the-job resources have been documented. An Australian study helpfully categorized these resources as physical, psychosocial and environmental, and all were deemed fundamental to work performance (Jeong and Keatinge 2004). One study set in the Philippines found that lack of resources was a key root cause of RNs' "inability to provide optimum care" (de Guzman et al. 2009) while a Canadian study similarly noted that limited time negatively impacted workers' ability to provide whole-person care (Sims-Gould et al. 2010). A Dutch study found that physical and emotional resources buffered stress for workers, suggesting the importance of matching job resources to job demands (van den Tooren and de Jonge 2008).

Workers in LTC are poorly compensated, relative to other health sectors and the broader labour market, and relative to the demands of their work. Undercompensation is directly associated with pervasive recruitment and retention issues in LTC (Armstrong 2021; WHO 2015). This is not a recent observation. Persistent staffing shortages noted in the early 1980s in the US LTC sector were attributed to "limited material rewards" for nursing personnel and care aides (Halbur 1983: 399). A more recent scoping review on care aides in the US, Canada, Australia, the UK, Denmark, Brazil, Ireland, Taiwan, New Zealand, Norway and Japan called for comprehensive government intervention, including education, health and immigration, in order to jointly address severe resource concerns around the care aide workforce (Hewko et al. 2015). Others have called for improvements to care aides' working conditions, such as "training, career opportunities, appropriate workloads, flexible work hours and ... meaningful authority to make decisions." (WHO 2015: 136).

#### LTCH CHARACTERISTICS

LTCH location, size, resident mix and ownership type are associated with worker attitudes, and worker and resident outcomes.

1. *Rural versus urban location:* For rural workers, smaller pools of workers, inclement weather (Joseph et al. 2013), economic marginalization (Meyer et al. 2014) and limited access to services/resources (Morgan et al. 2002) can lead to absenteeism and create more resource-constrained circumstances. Nurses working in LTCHs in Estonia's capital were more dissatisfied with work schedules/shifts and salaries than nurses in rural LTCHs (Sepp et al. 2015), and care aides in the US were less likely to leave rural LTCHs (Choi and Johantgen 2012). Another Canadian study found that RNs working in rural LTCHs were more satisfied with their jobs than their urban counterparts (Kulig et al. 2009), and a US article suggested that RNs in rural LTCHs were more

- influenced by job satisfaction and serving community than by pay (Pan et al. 1995). While there is emerging awareness of the different challenges confronting workers and managers in urban and rural LTCHs on the part of policy makers (Estabrooks 2021), some researchers note that current funding models are not sufficiently nuanced to incorporate local needs (Oldenburger et al. 2022) nor do they take into account the diverse needs of foreign-born workers who are employed disproportionately in urban LTCHs (Aboderin 2007; Khatutsky et al. 2010; Rapp and Sicsic 2020; Sloane et al. 2010).
2. *LTCH size*: Care workers in small-scale Dutch LTCHs have higher job satisfaction, lower work demands and higher levels of worker autonomy than those in larger-scale LTCHs (Adams et al. 2017b; Willemse et al. 2014). In the US, Belgium and Sweden, care workers in small-scale LTCHs have higher job satisfaction, lower work demands, more time with residents, less burnout and improved communication/teamwork (Halbur 1983; Vermeerbergen et al. 2017). Swedish LTCHs with more beds had higher rates of workplace violence (Isaksson et al. 2009).
  3. *Type of ownership*: Job satisfaction and turnover have been the foci of research in the LTC sector since the mid-1990s, largely driven by concerns of poor retention and care quality. Turnover rates for care aides are higher in for-profit homes in the US (Banaszak-Holl and Hines 1996; Kennedy et al. 2010), Canada, Australia and the UK (Hewko et al. 2015). For-profit homes also have lower worker satisfaction (Decker et al. 2009; Probst et al. 2010), more resident hospitalizations for infection (Zimmerman et al. 2002), poorer work environments (White et al. 2020), lower hours of direct care per resident and overall poorer performance (Estabrooks 2021). In Finland, job security and concern over stability were highest among care workers in for-profit homes and lowest in not-for-profit homes (Heponiemi et al. 2012).
  4. *Resident mix*: Studies emphasize positive outcomes for staff and residents working in specialized units – for example, where residents experience similar morbidities such as ADRD or Parkinson’s disease (Lee et al. 2013; te Boekhorst et al. 2008) and negative outcomes for those working in units requiring more heterogeneous resident care (Morgan et al. 2002). That said, several studies identified that work was more challenging for staff in ADRD and psychiatric units, with lower job satisfaction and increased emotional exhaustion and work stress (Chamberlain et al. 2016; Isaksson et al. 2009; Zimmerman et al. 2005).

#### WORKPLACE HEALTH AND SAFETY

Workplace health and safety issues in LTC, largely focused on infection control and prevention (Castle et al. 2009; Lee et al. 2018) and workplace injuries (OECD 2020), have been a focus across many jurisdictions for over a decade. The most prevalent types of worker injury include back pain/injury, joint pain and shoulder pain/injury (Iridiastadi et al. 2019; Yeung 2012). Musculoskeletal disorders and symptoms are common among LTCH care aides (OECD 2020; Yeung and Yuan 2011; Zhang et al. 2016) and nurses (Sepp et al. 2015).

One report of OECD countries notes that over 60% of LTC workers experience physical risk factors at work, resulting in high levels of absenteeism (OECD 2020: 22). Increases in these risks over time correlate with increasing proportions of older people requiring LTC who have greater frailty and who are living with dementia (Morgan et al. 2012).

In an effort to understand injury prevalence in LTC, safety culture has been examined. In the Netherlands and other OECD countries, safety culture in LTCHs is worse than in acute care hospitals, with less safety-focused training for LTC workers (Buljac-Samardzic et al. 2016; OECD 2020). Safety and safety culture improvement interventions relying on education and training have had mixed success (Koo et al. 2016). Studies in the US (Castle et al. 2009) and Canada (Joseph et al. 2013) suggest that workplace health and safety interventions should specifically target care aides through infrastructure investments since they are more likely to detect safety problems (Joseph et al. 2013) and less likely to report them (Hughes and Lapane 2006). Others suggest management intervention to enhance workplace safety (Berta et al. 2018; Perreira et al. 2019). A US study recommended employee training to manage expectations of safety practices (Banaszak-Holl et al. 2017), while a study of Swiss nursing homes showed clear associations between safety culture and quality of resident care (Zúñiga et al. 2015). One Canadian study notes, “[F]eatures of work environments such as available resources, communication, and leadership ... are starting points for interventions to improve worker health and well-being.” (Hoben et al. 2017: 798).

#### MANAGEMENT AND LEADERSHIP

Management and leadership unquestionably influence LTC workers and their work. Numerous studies over the past 20 years in diverse health systems including the US (Brannon et al. 2002), Canada (McGilton et al. 2014), Taiwan (Kuo et al. 2014), the Philippines (de Guzman et al. 2009), Norway (Heponiemi et al. 2012) and South Korea (Lee et al. 2018) demonstrate strong positive associations between management support and LTC workers’ attitudes and work outcomes. Management and supervisor support is significantly associated with workers’ work attitudes including job satisfaction (Bondevik et al. 2017; Choi et al. 2021; Rahnfeld et al. 2016; Söderlund and Fagerberg 2019; Wallin et al. 2012; Willemse et al. 2015); feelings of commitment to the organization (Kostiwa and Meeks 2009); perceptions of safety culture (Vaismoradi et al. 2020); perceptions of the general work environment (Backman et al. 2018; Tellis-Nayak 2007); and work engagement (Biggs and Carr 2019; Bishop et al. 2008; Caspar and O’Rourke 2011). Supervisory and management support is also associated with work outcomes, including job retention (Banaszak-Holl et al. 2017; Berta et al. 2018; Gao et al. 2015; Gaudenz et al. 2019; Hsieh and Su 2007; Huang and Bowlblis 2020; Stearns and Darcy 2008); likelihood of leaving the job (Culp et al. 2008; Mittal et al. 2009; Nakanishi and Imai 2012; Rosen et al. 2011); burnout (Anderson et al. 2004; Chu et al. 2014; Cooper et al. 2016; Hunt et al. 2012; Yeatts et al. 2018); job stability (Heponiemi et al. 2012); ability to complete work (Sawan et al. 2018; White et al. 2020); empowerment to speak up (Escrig-Pinol et al. 2019) and to act

autonomously (Elliott et al. 2017); participation in quality improvement initiatives (O'Brien et al. 2013; Tyler and Lepore 2017); involvement in supportive programming and social activities (Castle and Ferguson-Rome 2015; Huai-Ting et al. 2008); and capacity to manage difficult job aspects such as resident death (Irvin 2000). One study of LTC nurses in France found that strained relationships with managers are a primary factor contributing to their intention to leave (Pélissier et al. 2018).

## *Issues relating to the nature of LTC work*

### MODELS OF CARE

Resident-centred models of care are replacing task-based medical models, giving workers and residents significantly more autonomy in care planning and provision (Brown et al. 2016; Dhimi and Donnelly 2020; Jones and Moyle 2016; Laakso and Routasalo 2001). To some extent, this is a consequence of older adults now entering LTCHs who “demand more choice, service quality, and autonomy, while needing more intensive care and resources” (Zuniga et al. 2015: 860). While a recent integrative review directly links resident-centred care models and resident quality of life (Rajamohan et al. 2019), research conducted as early as 2002 in Canada (Morgan et al. 2002), Sweden (Haggstrom et al. 2004) and the US (Castle and Ferguson-Rome 2015; White-Chu et al. 2009) showed the beneficial effects of individualized care.

The interprofessional relationships and communication required of resident-centred care have been shown to enhance LTC workers' job satisfaction, work motivation and job performance, including resident care quality in Canada (Caspar et al. 2013; Leclerc et al. 2014; Sims-Gould et al. 2010), Italy (Vainieri et al. 2019), New Zealand (Fryer et al. 2016), Norway (Munkejord and Tingvold 2019), the Netherlands (Adams et al. 2017b), Switzerland (Gransjon Craftman et al. 2016), Taiwan (Tsai et al. 2016) and the US (Dellefield et al. 2015; Ersek et al. 1999).

### WORK AND WORK DESIGN

Work and work design in LTC is changing. Work in LTC has evolved over recent decades in response to changing resident care needs. Nurses now fill multifaceted roles as supervisors of care aides and paraprofessionals and carry out complex care duties and administrative tasks acting as “administrator, manager, supervisor, coordinator, or surveillance person” (Montayre and Montayre 2017: p. 45). With increased paperwork and administrative duties in LTCHs, RNs and LPNs spend less time on direct resident care (Lane and Philip 2015; Oldenburger et al. 2022), delegating some duties (e.g., incontinence care) to care aides (Ostaszkiwicz et al. 2016). Some researchers refer to the “tyranny” of excessive paperwork that prevents RNs from assisting care aides in resident care (Jervis 2002), and others find that it is associated with decreased job satisfaction and cooperation among nurses and the care aides they supervise (Cherry et al. 2007; Storm et al. 2017). A Swiss study found that rationing

documentation increases the odds of better care quality (Zúñiga et al. 2015) and technology has been suggested as a way to reduce the paperwork burden (Oldenburger et al. 2022).

Care aides spend most of their workdays assisting residents with activities of daily living, typically engaging in short repetitive tasks (Mariano et al. 2015; Qian et al. 2012) that are – particularly within increasingly resource-constrained work environments – susceptible to frequent interruptions as they assist another resident or care worker (Mallidou et al. 2013). Historically, care aides have also been instrumental in meeting residents' needs for psychosocial care, especially for residents without family members (Chamberlain et al. 2020) or those living with dementia (Chung 2013; Marshall et al. 2020; Moss et al. 2003; Ødbehr et al. 2014). Care aides, especially, see psychosocial care as an essential element of their role (Holmberg et al. 2013), ranking it higher in importance than physical tasks (Gray et al. 2016).

However, psychosocial care is increasingly forfeited when care is rushed as shown in studies in Canada (Knopp-Sihota et al. 2015; Song et al. 2020), Sweden (Haggstrom et al. 2010), the US (Bowers et al. 2001) and Israel (Ron 2008). Rushed care is also associated with neglect of dental care (Lindqvist et al. 2013; Malmedal et al. 2009a, 2009b).

#### ROLE CLARITY

Role clarity is a pervasive issue, with studies in Canada, the UK, Japan, Australia (Hewko et al. 2015), Belgium, Australia and the US (Crogan and Shultz 2000), Norway (Eriksen 2006) and France (Pélissier et al. 2015) showing that task shifting to care aides, along with the expansion of nurses' roles, contributes to tension between nurses and care aides, toxic work environments (Pickering et al. 2017), lower job satisfaction (Ron 2008) and reduced staff retention (Cohen-Mansfield 1997).

#### EDUCATION AND TRAINING OF STAFF

Education and workforce training of LTC staff do not match the work environment. A recent global report observed that “LTC workers do not always have enough training on geriatric conditions, interpersonal skills, care after hospital discharges, and management of emergencies or bereavement” and that this directly impacts resident care quality (OECD 2020: 14). As with other issues identified above, the observation that worker training and skills are incommensurate with the needs of people entering LTC is not new. Studies of nurses in Taiwan (Li et al. 2008), Canada (McGilton et al. 2014), the Netherlands (van Rumund et al. 2014) and China (Zhang and Sun 2019) identified unmet training needs over a decade ago based on the increasingly complex physical and socio-psychological care required by LTCH residents. Specific skill deficits noted in other studies of nursing staff include palliative care in Australian LTCHs (Lane and Philip 2015), infection prevention knowledge in South Korean LTC settings (Lee et al. 2018) and medical error detection and reporting in Swiss LTCHs (Vaismoradi et al. 2020). In some studies, care aides themselves call for more knowledge on complex care, including dementia care and behavioural handling

(Aloisio et al. 2019; Braun et al. 1997; Ericson-Lidman et al. 2014; Levin et al. 2003), palliative care (Fryer et al. 2016), pain management (Zwakhalen et al. 2017) and psychiatric care (Hasson and Arnetz 2008). Beyond meeting critical knowledge needs for improving resident care, training offers opportunities for professional development, which care aides consistently rate as poor or lacking in the LTC sector (Castle et al. 2006; Yamada and Sekiya 2003).

Research has accumulated since the mid-1990s (Streit and Brannon 1994) from the Netherlands (Collet et al. 2018), Norway (Kada et al. 2009), Sweden (Engstrom et al. 2011) and the US (Jervis 2001) that demonstrates direct relationships between work outcomes and worker training. Education intervention studies show significant improvements to care quality for residents experiencing dementia in Sweden (Hasson and Arnetz 2008), Norway (Kada et al. 2009) and Australia (Moyle et al. 2016) and to residents' dental health in Sweden (Wadensten et al. 2009).

## Discussion

While the range of themes and sub-themes observed across the articles included in this review is admittedly broad, the themes are relatable. Aspects of external environments in which LTC homes operate (e.g., resource allocation policies across healthcare, market characteristics within LTC) and their internal work environments (e.g., structural and operational, including resource availability, compensation, nursing home characteristics, management support) appear to be associated with the work of LTC (i.e., the nature and scope of work) and to workers' attitudes and outcomes (including but not exclusive to performance). In this section, we synthesize our findings further to identify five key areas that represent the main challenges to the sustainability of LTC, globally, that warrant attention and action.

### *Under-resourcing is endemic to LTC*

Chronic under-resourcing profoundly influences LTC workers' jobs, work outcomes (including resident care quality and quality of life) and staff work attitudes and outcomes (Song et al. 2020). Under-resourcing in the LTC sector has been highlighted for decades, with researchers and practitioners alike calling for oversight and industry leaders to address shortfalls in human and physical resources. Understaffing and under-resourcing relate to recruitment, retention and turnover, all of which are also identified as key issues in the sector. Recruiting LTC workers is challenging because work is physically demanding and is carried out in resource-poor and undervalued care settings, with limited opportunities for professional growth (Berta et al. 2018; Chamberlain et al. 2019). These same features make turnover high in LTC, particularly among nurses with more job mobility than care aides. Some countries have begun to address these recruitment challenges. Japan, for example, has introduced a unique 3-level certification system as a career ladder for care aides, attracting younger people to the profession (Yamada and Sekiya 2003).

### *Health human resources research needs to progress beyond computing staffing ratios*

Studies in LTC have historically focused on staffing ratio formulations and their correlation with resident care outcomes. Human resources research in other industries extends well beyond these metrics. Human resource management (HRM) attends to people, their work environments and workplace culture and engaging them through fulfilling work and opportunities for personal growth. Strategic HRM considers employees' motivations and incorporates this knowledge into recruitment and retention strategies. As identified by researchers and many global reports, strategic HRM is virtually absent in the LTC sector. Several years ago, for example, the WHO noted the urgent need for "training, career opportunities, appropriate workloads, flexible work hours and giving care workers meaningful authority to make decisions" (WHO 2015: 136). These are aspects of HRM that are normative considerations in most industries. Health human resources in LTC must progress beyond staffing ratios to a more sophisticated understanding of the workforce where "increasing retention rates through better job quality and training" is a policy priority (OECD 2020: 11). The COVID-19 pandemic has underscored the essentiality of investments in human resources in an industry so prone to health and safety risks (OECD 2020).

### *Work environment matters*

The context/environment of LTC work influences worker attitudes and outcomes, findings corroborated in voluminous amounts of literature on work psychology and organizational behaviour and in the growing literature on health work psychology. Applying established theories of human behaviour to worker behaviours in the LTC sector is likely to afford insights that can improve the modifiable features of work context and influence worker attitudes and outcomes. Our findings on management and leadership suggest great value in investments in developing LTC leadership (Rodriguez-Monforte et al. 2020; Schwendimann et al. 2016; Tong et al. 2017; Tyler and Lepore 2017; Wagner et al. 2018). Across numerous studies in diverse settings, competent supportive leadership is associated significantly with worker attitudes and outcomes – from job satisfaction and organizational commitment to turnover intentions – and is related to a positive safety climate and quality of resident care. In some studies, leadership had protective or compensatory effects: mitigating challenges like care worker burnout from resource shortages and offsetting resource deficits that negatively impacted care quality (Yeatts et al. 2018). LTC workplace health and safety issues, common across jurisdictions, often relate to modifiable features of work context, including structural barriers. Several studies place the onus on managers to create work environments that support training around health and safety and support workers in voicing experiences and concerns (Hoben et al. 2017). Admittedly, this is challenging in chronically under-resourced work environments, but a few studies highlight substantial benefits including improved safety climate (White et al. 2020), increased reporting of health and safety issues (Hughes and Lapane 2006) and increased job satisfaction (Schwendimann et al. 2016). A recent global report promotes developing "numerous innovative

models of safety standards, from legislation on staffing ratios to advanced accreditations that may be effective for improving ... safety of care.” (OECD 2020: 27). Relatedly, Denmark, Sweden, Norway, Finland and Portugal are developing national indicators for health and safety in LTC settings (OECD 2020).

### *Role clarity*

Role clarity is both an old and emergent issue in LTC that merits addressing. Shifts to reliance on unregulated workers for most direct resident care has re-surfaced role clarity as an issue in the LTC sector (Dellefield et al. 2015). Researchers across numerous countries (Hall and O’Brien-Pallas 2000; Hsu et al. 2007; Perry et al. 2003; Shannon and McKenzie-Green 2016) have long called for role re-articulation in the LTC system to involve policy makers, LTCH administrators and stakeholders in the active implementation of standards that clarify role boundaries.

### *Revolutionizing training and education*

Revolutionizing training and education in LTC may be key to many outstanding issues. There is distinct disconnect between staff training and education and the contemporary care needs of LTC residents. Training in this sector is simply not commensurate with the needs of increasingly frail residents with multiple chronic conditions and diagnoses of AD/DRD. Numerous studies, across time and jurisdictions, conclude by urging LTC policy makers and LTCH managers to prioritize education and training of nurses and care aides, emphasizing direct benefits to LTCH residents and other staff (Band-Winterstein et al. 2019; Brannon et al. 1988; Chen et al. 2018; McGillis Hall et al. 2011; Pélissier et al. 2018; Yeatts et al. 2018). Additionally, some experts urge policy makers and industry leaders to set minimum standards for education for all direct care workers (Estabrooks 2021).

Leveraging linkages between training and education, worker attitudes and outcomes and health human resources is particularly promising. Recently synthesized work showed linkages between worker training/education and work attitudes and outcomes, including retention and care quality (WHO 2015). Investment in training may increase retention, as it has with a Japanese care worker training initiative that demonstrated positive effects on worker retention and equipped workers with skills appropriate to care needs of LTC residents (OECD 2020). We appreciate that this comes with far-from-trivial costs. With greater investment in worker training will come an expectation that wages are reflective of enhanced skills. Beyond who is responsible for funding the training is the question of who is responsible for providing the training. Quality concerns from inconsistent training, and severe resource constraints on LTC operators, suggest that higher levels of governance are best to take responsibility for revolutionizing training and education. A few national initiatives are promising. Japan’s national licensing system for care aides both improved retention and facilitated recruitment of younger, more highly trained workers through established career ladders (Yamada and Sekiya 2003).

## Limitations

Our search strategy was limited to publications in English and translated into English; thus, potentially relevant studies in other languages were excluded. Second, grey literature was not included, excluding observations produced by policy entities; this omission was outweighed by the inclusion of peer-reviewed literature to ensure the quality of data reviewed (Adams et al. 2017a). We incorporated reports prepared by global entities like the World Health Organization into our background and discussion sections, and these frequently if judiciously synthesize both peer-reviewed and grey literature. Finally, the definitions of “nurses” and “care aides” varies internationally; hence, we consulted with experts in LTC to ensure that we included search terms that addressed our interests in this review of global literature.

## Conclusion

The findings that we summarize in this review were derived from original studies and research reviews focussed on LTC workers, and their work environments, in more than 30 countries spanning more than 30 years. Global demographic shifts have led to increased demand for LTC, and for LTC workers. Tasks and care models for these workers are increasingly complex but the structures of LTC systems, including funding structures driven by policy on aging, largely remain woefully out of step with the challenges confronting the LTC sector and its workers. Our review demonstrates that these are global phenomena that have arisen due to longstanding issues common across jurisdictions.

Some of the literature that we reviewed suggests ways in which to begin to address these issues and describe ongoing initiatives that stand to afford highly relevant insights. For example, efforts in Europe to develop national indicators for health and safety warrant earnest evaluation in terms of their influence on worker recruitment, retention and well-being. And the long-term effects and outcomes of initiatives like Japan’s national licensing system, relating to strategic health human resources and professional advancement, certainly merit attention as they promise to afford insights into the types of training and education and other forms of investment needed to develop and retain knowledge workers in this sector. Initiatives like these also stand to inform others to formulate standards that clarify role boundaries in this sector, where role clarity is identified as an increasing concern with reliance on unregulated workers to provide direct care necessitated by pervasive resource scarcity in the sector.

We note that the five key challenges presented above relate to the system-structures of the LTC sector, with most identified through research that began many years ago. This is not to suggest that these are intractable issues – instead we aim to highlight them as real, and enduring, and in want of serious consideration because they are longstanding, pervasive and at the root of concerns for the sustainability of the LTC sector.

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# Forecasting Staffing Needs for Ontario's Long-Term Care Sector

## Prévoir les besoins en personnel pour le secteur des soins de longue durée en Ontario



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### Abstract

This paper presents a forecasting model for personal support workers (PSWs) and nurses (registered nurses [RNs] and registered practical nurses [RPNs]) for Ontario's long-term care (LTC) sector. In the base-case scenario, the model projects a shortfall in the supply of full-time equivalent (FTE) workers required to meet the expected demand for care for all workers by 2035, which would require an estimated increase of 11,632 FTE PSWs, 6,031 FTE RNs and 10,178 FTE RPNs entering the market by 2035. The results of this paper may have important implications for health human resources policy planning in Ontario's LTC sector.

## Résumé

Cet article présente un modèle de prévision pour les préposés aux bénéficiaires (PAB) et les infirmières (infirmières autorisées [IA] et infirmières praticiennes autorisées [IPA]) pour le secteur des soins de longue durée (SLD) en Ontario. Dans le scénario de référence, le modèle prévoit une pénurie de l'offre de travailleurs équivalents temps plein (ETP) nécessaire pour répondre à la demande de soins prévue pour tous les travailleurs d'ici 2035, ce qui nécessiterait une augmentation estimée de 11 632 PAB ETP, 6 031 IA ETP et 10 178 IPA ETP sur le marché d'ici 2035. Les résultats de cet article pourraient avoir des répercussions importantes sur la planification des politiques en matière de ressources humaines en santé dans le secteur des SLD en Ontario.

## Introduction

COVID-19 has disproportionately affected Canada's institutional long-term care (LTC) sector (CIHI 2021b) and highlighted issues that pre-date the start of the pandemic. One such issue is the adequacy of staffing, which was considered low pre-pandemic (Berta and Stewart 2022; PHAC 2020). Moreover, there are longstanding concerns as to the adequacy of the supply of direct care staff to meet increased demand associated with the aging of the population (Laporte et al. 2016).

LTC in Ontario is primarily staffed by personal support workers (PSWs), who provide the majority of direct care to residents (Long-Term Care Staffing Study Advisory Group 2020). Registered nursing staff (registered nurses [RNs], registered practical nurses [RPNs] and nurse practitioners) provide the second-largest amount of direct care, followed by allied health professionals and programming support (Long-Term Care Staffing Study Advisory Group 2020). In a report submitted to the Ontario Ministry of Health and Long-Term Care, on behalf of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario, Sharkey (2008) recommended a minimum of 3.5 hours of direct care from PSWs and nurses (RNs and RPNs), the skill mix consisting of 2.5 PSW hours and 1 nurse hour (RN and RPN). In 2018, however, a decade later, Ontario LTC residents were still estimated to be receiving, on average, 2.75 hours of direct care from PSWs and nurses, with the skill mix consisting of approximately 1.9 PSW hours and 0.8 nurse hours (RNAO 2020).

As a result of COVID-19, several new policies were announced for the LTC sector, including increases to hours of direct care, increased wages for direct care workers and funding for the training of new workers (see the next section for more details). Despite this, it is unclear whether the future supply of workers (PSWs, RPNs and RNs) will be sufficient to meet the demand. It is also unclear how long the above policies will need to be in place to ensure a sufficient supply of workers over the longer run. Finally, the above policies generally target PSWs, who are unregulated workers; it is unclear whether additional policies will be required for the regulated nursing workforce and whether the policies aimed at PSWs can be

expected to have knock-on effects on nursing labour supply. This may be particularly important given the impacts of stress and turnover intention, which was a concern pre-COVID-19 (Estabrooks 2021) and has been shown to be significant in the nursing labour force in the COVID-19 era (RNAO 2021).

Health human resource (HHR) planning for PSWs and nurses has not received significant attention in the HHR planning literature. In most countries, HHR planning has focused predominantly on doctors due to the length and cost of training (Ono et al. 2013). In Canada, Denton et al. (1995) developed a forecasting model for physicians, RNs and RPNs, respectively, in Ontario. More recent models have focused on physicians and RNs (Tomblin Murphy et al. 2009, 2012) with one study focusing on jointly forecasting the supply of PSWs, RNs and RPNs (Laporte et al. 2016). A review of the literature suggested that these models generally focused on staffing ratios, and the effects of the level of wages or changes in wages were seldom considered in HHR modelling, with only one of 26 forecasting models incorporating such an effect (Ono et al. 2013). This wage effect will be important to incorporate given the attention placed on PSW wages before and throughout the pandemic. Finally, these studies were developed before the COVID-19 pandemic. It is therefore unclear if the predictions of these models will hold given the impact of COVID-19 on HHR. To our knowledge, this study is the first to investigate projections for PSWs, RNs and RPNs for the LTC sector using data and policy scenarios from the COVID-19 era. These are compared with a base-case status quo using data from the pre-COVID era.

The purpose of this paper is to present a forecasting model jointly for PSWs, RNs and RPNs in Ontario's institutional LTC sector. Although not an exact science, and requiring many assumptions, HHR forecasting models allow for policy experiments that can explore the effects of different scenarios on the supply and demand of workers, taking into account changes in the supply of one type of worker on the supply needs of the others, thereby helping to identify the most efficacious policy levers for decision makers to ensure an optimal supply of healthcare labour (Laporte et al. 2016). Model uncertainty increases the farther into the future the projection period extends, so we employ a modest projection window, producing forecasts up to and including 2035 using publicly available data, as well as microdata from the Statistics Canada Labour Force Survey (Statistics Canada 2015) and the University of Toronto. Ethics approval was obtained from the University of Toronto Research Ethics Board.

Along with this section, this paper is divided into six sections. The next section (section two) describes the policies announced for Ontario's LTC sector. Section three describes the methodology and data sources for the forecasting model. Section four presents the results of the forecasting model. Section five presents a discussion of the results, and section six offers concluding remarks.

## Review of LTC Policies in Ontario during COVID-19

In late 2020 and early 2021, a number of policies relating to staffing in Canada's LTC sector were announced. In October 2020, the Government of Ontario announced funding for a temporary wage enhancement for PSWs (Government of Ontario 2021d). The magnitude of the increase was to vary by sector with a \$3.00/hour increase for PSWs in LTC. This has been extended many times and was set to end on March 31, 2022 (Government of Ontario 2021e). It is important to note that the wage increase is ultimately paid by LTC homes, and there have been delays in applying the increase in some homes (Wilson 2021). At the time of writing, there were calls to make this temporary wage increase permanent (McKenzie-Sutter 2021), with the Government of Ontario proposing legislation to do so on March 29, 2022 (Government of Ontario 2022b).

In November 2020, the Government of Ontario committed to increasing hours of direct care from 2.75 to 4 hours per resident per day (Government of Ontario 2020). The exact skill mix associated with this policy was not stated, but it is likely that the four hours includes both PSW and nurse time. As a result, the new Government of Ontario commitment would actually require 0.5 more hours of direct PSW and nursing care compared with the 3.5 hours recommended in Sharkey (2008). It is also important to note that while all LTC homes are expected to adhere to the regulated minimum, the skill mix used may vary across LTC homes (Hsu et al. 2016).

In December 2020, the Government of Canada announced \$23.2 million to develop and implement an accelerated online program to train approximately 4,000 new PSW interns (Government of Canada 2020). Shortly after, in February 2021, the Government of Ontario announced a tuition-free, accelerated PSW training program (Government of Ontario 2021a). This was designed to allow 8,200 new PSWs to be ready to work in Ontario's LTC sector by fall 2021.

Finally, in March 2021, the Government of Ontario announced funding to help build the 30,000 LTC beds (Government of Ontario 2021b) that was promised by Premier Ford during the 2018 election campaign (Breen 2018). It is important to note that our model forecasts the number of LTC residents rather than beds. That said, an increase in the estimated number of individuals would likely require the building of beds to meet the increased demand.

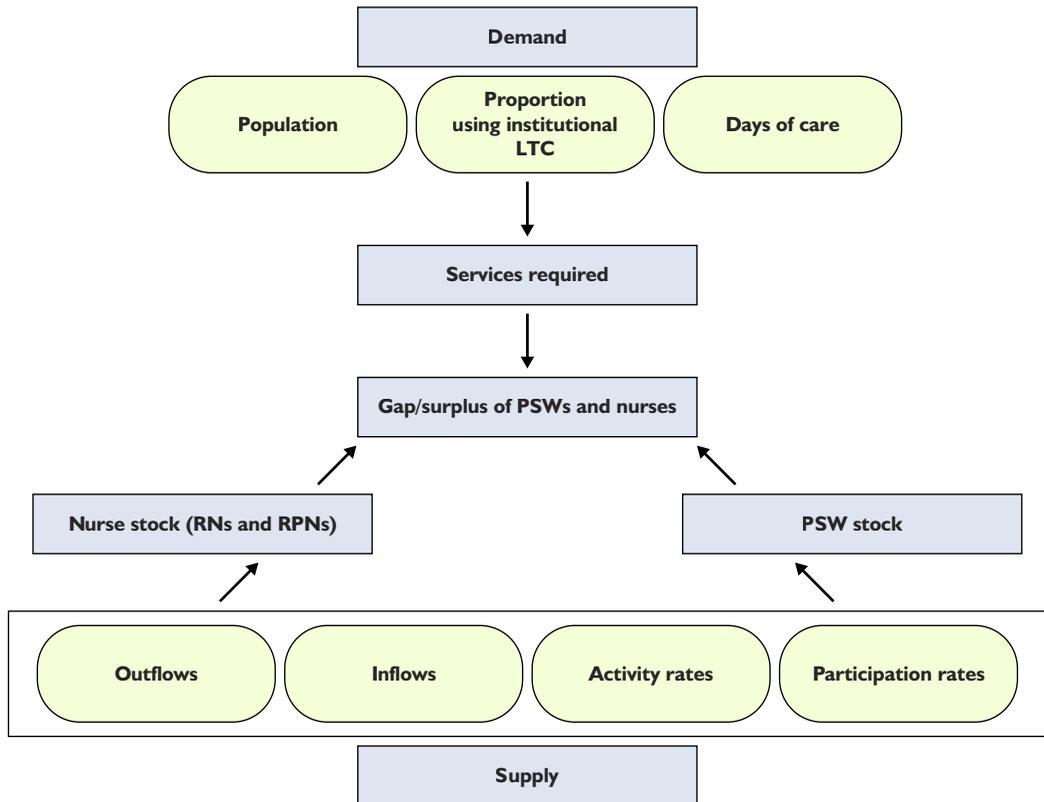
The effects of these policies on the surplus/shortfall of workers are explored further in the Results section.

## Methods

Figure 1 shows the conceptual framework that underpins the forecasting model, which was adapted from the general model in Tomblin Murphy et al. (2012) as well as Laporte et al. (2016), which had focused, as we do here, on the LTC sector. The two main elements of the model are the demand and supply sides, the interaction of which ultimately determines the

size of the shortfall/surplus expected. Each element in Figure 1, as well as the data source used, is described in more detail below.

**FIGURE 1.** Framework underlying the forecasting model



LTC = long-term care; PSW = personal support worker; RN = registered nurse; RPN = registered practical nurse.

### *Modelling demand*

The demand side of the model relates to the expected number of people that will require a given number of LTC services over the forecast interval (i.e., until 2035). The number of services required, in the context of institutional LTC, refers to the total number of patient days in a given year. Following Birch et al. (2007), we calculated the number of services required as the product of the population (by age group), the proportion using institutional LTC and days of care in a given year. These terms are defined in more detail below.

#### POPULATION

The population of Ontario by age and sex was obtained from Statistics Canada for the years 2019 to 2020, as well as for the years 2021 to 2035 (Statistics Canada 2019, 2021a).

#### PROPORTION USING INSTITUTIONAL LTC

The estimated proportion of the population using institutional LTC in Ontario was based on data obtained from the CIHI Continuing Care Reporting System (CCRS) for fiscal year (FY) 2018/2019 (CIHI 2019). The CCRS contains data on individuals receiving continuing care services in hospitals or LTC homes in Canada (CIHI n.d.). Combining this with the population age distribution, we were able to calculate the proportion of each age group that has received institutional LTC for each year. It is important to note that data from the 2020/2021 CCRS file is available but reports fewer LTC residents than previous years due to issues relating to the COVID-19 pandemic, including fewer admissions (CIHI 2021a). In addition, the 2019/2020 CCRS file contains data from the fourth quarter of FY 2019/2020 (CIHI 2020), which may also have been impacted by COVID-19. For the purposes of this paper, we based our forecasts using data one year before COVID-19 to minimize the impact of anomalous effects of COVID-19 on the trend of LTC use, namely the curtailment of inflows into institutional LTC.

#### DAYS OF CARE

LTC homes in Ontario must operate at 97% occupancy of long-stay beds staffed at every point in the year to receive 100% of the Level of Care (LOC) per diem funding from the province, with some noted exceptions (Ontario Ministry of Health and Long-Term Care 2019). Hence, we used 365 as the estimated days of care for all LTC residents in all age/sex groups for all levels of health. Laporte et al. (2016) illustrates the validity of this approach using data from Statistics Canada's Residential Care Facilities Survey (Statistics Canada 2021b) for fiscal years 1996/1997 to 2009/2010.

### *Modelling supply*

Supply refers to the number of full time equivalent (FTE) providers (PSWs, RPNs and RNs). This does not equal the total number of providers since a given worker may not work full-time hours (referred to as the activity rate in Birch et al. [2007]). We must also incorporate the fact that workers may have administrative tasks as well, and so their time may not be completely spent on direct care; this is referred to as the participation rate (Birch et al. 2007).

Using a stock-flow approach (Birch et al. 2007), the stock of workers in the LTC sector at any given time is determined by the number of workers in the previous year, minus outflows that have occurred between the previous and current year, plus inflows of workers to that sector in the current year.

#### OUTFLOWS

##### **PSWs**

We estimated the relationship between intention to leave the current employer and wages using individual data on PSWs in Ontario as reported in Berta et al. (2018) (see Appendix 1: Table A1) (Appendix 1 is available at [www.longwoods.com/content/26852](http://www.longwoods.com/content/26852)). We found a

2.2% reduction in the probability of intending to leave for each \$1.00 increase per hour in PSW wages. It is important to note that, given the cross-sectional nature of the data, we could only use intention to leave rather than actual turnover rates. We observed from the sample data that 15% of PSWs intended to leave their current employer in the next year. In terms of actual turnover, it has been estimated that 25% of PSWs with two or more years of experience leave the LTC sector annually (Long-Term Care Staffing Study Advisory Group 2020). It has also been suggested that staff have experienced frustration within the LTC sector, which can lead to high turnover. Thus, our measure of outflow may be an underestimate of the true outflow, such that our results provide a conservative estimate of the projected gap in PSWs.

For the purposes of this analysis, we required a base-case wage (i.e., wages in 2019) as well as the annual rate of change in PSW wages in Ontario. We used the Statistics Canada Labour Force Survey for Ontario to calculate the average wage paid to PSWs working in the LTC sector for each year between 2006 and 2019, which is presented in Appendix 1 (Figure A1). We calculated the average wage to be \$22.00/hour in 2019, with an average annual increase of 2.03% per year using the annual Labour Force Survey data from 2006–2019. We used these parameters in our base-case scenario, then allowed PSW wages to change following the previously described LTC wage-increase policies announced by the Government of Ontario (Government of Ontario 2021e).

### **Nurses**

Unfortunately, individual-level data on nurse intention to leave and wages was not available for use in this study. Laporte et al. (2016) calculated retention rates (called “stickiness” in their paper) for RNs and RPNs working in LTC in Ontario using data from the College of Nurses of Ontario (CNO). The authors found that the stickiness measure ranged from 82–87% (84% average) for RNs and 82–84% (83%) for RPNs using data from 2005/2006 to 2009/2010.

In terms of more recent data, a survey conducted by the RNAO in 2021 found that 45.2% of LTC nurses were somewhat likely, likely or very likely to leave the nursing profession after the pandemic (RNAO 2021). It is important to note that, pre-COVID-19, there was evidence to suggest that the percentage of nurses leaving the profession was lower than the percentage of nurses who intended to leave the profession (see, for example, Lee et al. 2017). Despite this, there may be reason to suspect that a large percentage of nurses will leave the profession in the COVID-19 era, particularly given the reports of stress and turnover intention (RNAO 2021). Moreover, the Government of Ontario announced a retention bonus of \$5,000 for nurses (Government of Ontario 2022a), which may signal that policy makers are expecting large turnovers for this profession. In addition, as the general population ages, many nurses may be close to retirement. Finally, there is a significant relationship between intention to leave and turnover for nurses (Lee et al. 2017). In our base-case scenarios, we utilized the average stickiness figures from Laporte et al. (2016). We then used the

results from the RNAO survey in an alternative policy scenario to obtain an upper-bound estimate for the number of nurses expected to leave the profession over the next five years (i.e., as a sensitivity analysis). We assume that losses from this sector would converge to their pre-pandemic levels for the remainder of the projection period.

#### INFLOWS

Laporte et al. (2016) calculated inflows for nurses in Ontario's LTC sector using the CNO database. In this paper, inflow is defined as the percentage of nurses who are working in a particular sector in year "t" who were not working in that sector in year "t-1," following Alameddine et al. (2006). The authors calculate an average of 1,117 RNs and 1,751 RPNs per year between 2006 and 2009.

For PSWs, no population data on this workforce exist in Ontario. Using the December cycle of the 2016–2020 Labour Force Survey, we calculated the number of PSWs who were hired within the year. The results are presented in Appendix 1 (Table A2). We observed a large increase in the number of PSWs entering LTC in 2020 (18,750), which in part may have been due to the policies attracting PSWs into the sector that took place as a result of COVID-19. In our base-case scenario, we use 8,438 as the annual PSW inflow rate (average over 2016–2019). We then used the 2020 inflow of 18,750 as the estimated inflow of PSWs into LTC as an upper-bound estimate of the inflows into LTC.

#### ACTIVITY RATES

To obtain a FTE measure for RNs and RPNs, we calculated the yearly hours worked for each nurse in Ontario using data from the 2011 CNO database. We multiplied the reported number of weeks worked by the average number of hours worked per week. We then averaged the results by the number of nurses in each age category working in institutional LTC. Finally, we divided the average by 1,850 annual hours (Note: 1,850 annual hours is the amount used to calculate FTEs in LTC by the Ontario Ministry of Health and Long-Term Care's Health Analytics Branch (Health Analytics Branch 2012) to obtain a FTE equivalent measure (see Appendix 1: Table A3).

For PSWs in LTC, in Ontario, we calculated the average usual hours worked by age at their main job for the year 2019 using data from the Labour Force Survey. We then multiplied this by the average number of weeks worked by PSWs using data from the Health Support Workers (HSWs) Worklife Survey, which was calculated to be 44.75. We then divided by 1,850 to obtain an FTE measure.

#### PARTICIPATION RATES

Participation rates were obtained from Laporte et al. (2016) using the CNO database, which started asking members about the proportion of time spent on direct professional services in 2011. This measure is averaged across age groups for nurses in LTC for 2011 to calculate participation rates for RNs and RPNs (see Appendix 1: Table A4).

For LTC PSWs, it has been estimated that 58% of their time is spent on hands-on direct care, 31% on hands-off direct care (i.e., tasks related to the preparation of direct care), 8% on documentation/charting and 3% on miscellaneous indirect care (e.g., reviewing policy or care plans) (Dijkema and Lewis 2019). We therefore assume a 58% activity rate for PSWs across all age groups.

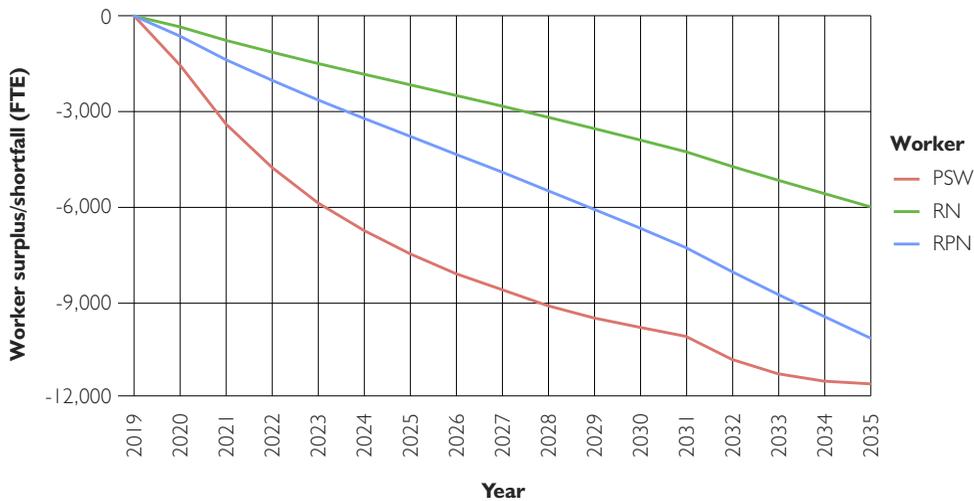
## Results

For brevity, we focused on the forecasted shortfall/surplus of workers over the forecasting interval. Full forecasting results for the number of residents in LTC, number of FTE providers required (demand) and number of FTE providers available (supply) are available upon request.

### Base case

Figure 2 presents the base-case results. We project a shortfall of workers for the entire forecasting period. By 2035, we project a gap of 6,031 FTE RNs, 10,178 FTE RPNs and 11,632 FTE PSWs.

**FIGURE 2.** Projected gap/surplus of workers (FTE), 2020 to 2035



FTE = full-time employment; PSW = personal support worker; RN = registered nurse; RPN = registered practical nurse.

It is important to note that this base-case scenario is unlikely to be a valid reference case, given the Government of Ontario's commitment to increasing hours of direct care (Government of Ontario 2020). It is, therefore, likely that this would be an underestimate of the expected gap of workers across the forecasting interval. We investigate the effects of this increase in minimum direct care requirement in the next section.

### *Increases in staffing ratios*

For this scenario, we increased hours of direct PSW and nursing care from 2.75 to 4 and held the distribution of skill mix in the base-case constant. These results are presented in Appendix 1 (Figure A2). By 2035, we project a gap of 11,203 FTE RNs (increase of 86% from the previous scenario), 18,709 FTE RPNs (increase of 84% from the previous scenario) and 37,779 FTE PSWs (increase of 225% from the previous scenario).

Because the Government of Ontario has committed to increasing hours of direct care from 2.75 to 4 hours (Government of Ontario 2020), we consider this to be the new reference scenario going forward (i.e., models presented below are compared with this scenario).

### *Increases in PSW wages*

From the new reference scenario, we investigated the impact of a permanent increase to PSW wages of \$3.00/hour. We observed that a permanent increase in PSW wages of \$3.00/hour reduces the gap across all periods (see Appendix 1: Figure A3). This adds an additional 22,645 of PSW FTEs to the projection and reduces the expected shortfall by 60%.

This wage increase does not affect the gap of nurses, as there has not been a policy announced regarding wages for that labour force.

### *Increases to inflow of PSWs into LTC*

We next modelled the impact of increasing investments on PSW training on the projected gap of workers, the results of which are presented in Appendix 1 (Figure A4). Assuming these investments persist throughout the forecasting period, we forecast that the initiative has the potential to eliminate the projected shortfall in PSWs over the entire forecast period, resulting in a surplus of 14,494 by 2035. Similar to the above scenario, we assume this increase does not affect the supply of nurses, and thus is not expected to affect the projected gaps of the RN and RPN LTC labour forces.

### *Incorporating increased nurse turnover intention due to COVID-19*

We next modelled the impact of changing nurse retention from 83–84% to 54.8% using the turnover intention data from RNAO (2021). These results are presented in Appendix 1 (Figure A5). We find that the gap of RNs and RPNs is expected to increase to 12,362 and 19,984 FTE by 2035, respectively. In percentage terms, this represents a 10% and 7% increase in the gap for RNs and RPNs, respectively, in comparison to the increased staffing reference scenario.

## **Discussion**

The purpose of this paper was to present a forecasting model for PSWs and nurses (RNs and RPNs) in Ontario's LTC sector. Our models suggest that the Government of Ontario's commitment to increase hours of direct care from 2.75 to 4 will result in a significant expected shortfall in RNs, RPNs and PSWs leading up to 2035. These results assume that

the same skill-mix distribution in 2018 (RNAO 2020) holds when hours of direct care are increased and more of each type of worker (PSWs and nurses) will be required.

### *Policy implications*

The results of the forecasting model suggest that the policies relating to PSWs may be helpful in reducing the expected shortfall in these workers but will likely need to be in place for many years. The results also highlight the need for policies relating to nurses in LTC. We find that increases to direct hours of care will result in a significant shortfall in the number of both RNs and RPNs throughout the forecasting period. Moreover, this shortfall is expected to worsen once increased turnover intention due to the impacts of COVID-19 (e.g., burnout) is incorporated into the analysis. Given the Government of Ontario's commitment to increase hours of direct care, policies relating to the nursing labour force will be important to consider. At the time of writing, the Government of Ontario had announced funding to: 1) add 2,000 nurses to the healthcare system (Government of Ontario 2021c) and 2) provide a lump-sum retention incentive for Ontario nurses of up to \$5,000 per person (Government of Ontario 2022a). The effects of these scenarios would likely reduce the projected gap of nurses found using this model. It is unclear, however, how long these programs would need to be in place to eliminate the expected gap. Future research using the model framework presented here may wish to explore this further.

One scenario we did not evaluate is the impact of unmet demand for LTC services – what the expected shortfalls would have been had all individuals currently on the waitlist for institutional LTC been taken from the list and placed in institutional LTC. Incorporating these individuals would have aggravated the forecast shortfall of PSWs by 2035, as well as further increased the expected shortfall of nurses. CIHI (2021a) noted that there were fewer admissions to LTC as a result of COVID-19 in FY 2020/2021, so it is unclear how long this trend will continue for individuals on the LTC waitlist. Future research may wish to explore this as data become available. It is also important to note that the participation rates calculated for this paper are unlikely to hold throughout the forecasting period, as it has been recommended that current patient documentation and charting processes be modified to free up time for direct care to residents (Long-Term Care Staffing Study Advisory Group 2020). Increasing participation rates would help reduce any expected shortfalls throughout the forecasting period. Finally, some may argue that four hours of direct care may not be necessary for every resident in LTC. For the purposes of this report, we performed a separate analysis using 3.5 hours of direct PSW and nursing care as suggested in Sharkey (2008) (but using the same skill-mix distribution as the base case) and obtained similar results.

### *Model limitations*

This study faced limitations that are worth noting. First, it would have been helpful to model staffing requirements as a function of quality indicators. The CCRS is rich in resident health data but does not contain detailed information about staffing level and mix. Future

research may wish to explore this issue in greater detail. In addition, at the time of writing, the Government of Ontario had not announced the exact skill mix that would be used when hours of direct care increased (RNAO 2020). For the purposes of this analysis, we held the base skill-mix distribution constant throughout the forecasting period. It is difficult to say if this will be the case, however, as research has found some evidence of substitution between the PSW and RPN labour forces in the provision of patient days of care (Hsu 2015). In addition, our model uses resident data from 2018/2019, and does not consider potential changes in LTC use as a result of COVID-19. There is evidence to suggest that individuals may be less inclined to enter LTC due to the pandemic and will increase savings for their old age (Achou et al. 2021). However, such effects if any may not be seen within the forecasting period, as the majority of newly admitted LTC patients have care needs that cannot be cost-effectively met elsewhere (Tanuseputro et al. 2017). Another limitation is that our population projections were constructed pre-COVID-19 and, subsequently, do not incorporate the resulting demographic effects attributed to the pandemic (Statistics Canada 2021a). It is unclear, however, what impact this will have on the projections as the percentage of individuals using LTC may remain constant given the aging of the population. Finally, the large increase in PSW inflow into LTC observed in 2020 may have been partially driven by regulation introduced by the Government of Ontario that limited LTC employees to working in only one home (*O. Reg. 146/20*). For the purposes of the model, the Labour Force Survey was the best source of data to quantify the potential increase in PSWs entering LTC resulting from the various policies attracting new PSW workers. Future research, using longitudinal data on PSWs, may wish to explore this further.

### *Contributions to the literature*

The results of our study are consistent with other studies pre-dating COVID-19 that projected a gap of nurses and/or PSWs. Tomblin Murphy et al. (2009) project a shortfall of RNs in Nova Scotia (all care sectors combined) throughout their forecasting period (up to and including 2020). Similarly, Tomblin Murphy et al. (2012) project a shortfall of RNs in Ontario (all care sectors combined) throughout their forecasting period (up to and including 2022). Laporte et al. (2016) project a gap of RNs, RPNs and PSWs for the majority of the forecasting period (2010–2025). Our study adds to the existing literature by investigating the effects of policies announced during COVID-19 on the projected demand, supply and gap of these workers in LTC. This includes the effect of wages, which is seldom incorporated into HHR models. We also use more recent data, including parameters from the COVID-19 period.

With respect to the generalizability of the results, it is important to note that despite using Ontario-specific parameters, the trends identified in this paper are likely to hold in other jurisdictions as well. More specifically, although the magnitudes may vary, it is likely that initial gaps in LTC workers exist in other jurisdictions. Policy makers in other jurisdictions who are considering increases to hours of direct care will also need to consider policies

to influence the future supply of workers given the demand they will face. It is likely that the policies proposed for Ontario will need to be considered in these jurisdictions as well.

## Conclusion

This paper presents a forecasting model for PSWs and nurses (RNs and RPNs) in Ontario's LTC sector. The model is used to explore the effects of LTC policies announced during the COVID-19 period on the forecasted surplus/shortfall of these workers up to 2035. The results suggest that, in the absence of significant policy intervention, large gaps in the availability of these workers are likely to persist and grow well into the future. The model can be extended should new policies relating to LTC staffing be announced. The model can also be modified to explore similar LTC policies that have been enacted in other jurisdictions.

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# Frequency of Neglect and Its Effect on Mortality in Long-Term Care before and during the COVID-19 Pandemic

Fréquence de la négligence et son effet sur la mortalité  
dans les établissements de soins de longue durée avant et  
pendant la pandémie de COVID-19



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## Abstract

Neglect of vulnerable adults living in long-term care (LTC) homes has been well documented. It often presents first in the physical symptoms of decubitus ulcers, dehydration and urinary tract infections (UTIs). A retrospective cohort study was conducted to examine

the relationship between neglect and 90-day mortality among LTC residents in Ontario. An index of neglect was created. Of 106,765 residents, more than one-quarter were found to have at least one indicator of neglect: 13.1% had decubitus ulcers, 13.5% had dehydration, 6.2% had a UTI. Residents who exhibited clinical signs of neglect had higher risks of death within 90 days, both before and during the COVID-19 pandemic.

## Résumé

La négligence des adultes vulnérables vivant dans des foyers de soins de longue durée (SLD) est bien documentée. Elle se présente souvent d'abord par les symptômes d'ulcères de décubitus, de déshydratation et d'infections des voies urinaires (IVU). Une étude de cohorte rétrospective a été menée pour examiner la relation entre la négligence et la mortalité à 90 jours chez les résidents des SLD en Ontario. Un indice de négligence a été créé. Sur 106 765 résidents, plus d'un quart présentaient au moins un indicateur de négligence : 13,1 % avaient des ulcères de décubitus, 13,5 % avaient une déshydratation, 6,2 % avaient une IVU. Les résidents qui avaient des signes cliniques de négligence présentaient des risques plus élevés de décès dans les 90 jours, et ce, tant avant que pendant la pandémie de COVID-19.

## Introduction

Neglect of vulnerable adults living in care homes has been documented in many countries (WHO 2021). The World Health Organization (WHO) identifies neglect as one of five main types of abuse, which occurs more frequently in long-term care (LTC) compared with community settings (WHO 2021). In Canada, the National Initiative for the Care of the Elderly (NICE) defines neglect as the “[r]epeated deprivation of assistance needed by the older person for activities of daily living” (NICE 2012: 99). Acts of neglect can be intentional or unintentional, whereby active neglect is perpetrated by purposefully withholding care and basic needs and passive neglect results from inadvertently failing to provide care due to a lack of knowledge, experience or ability (RNAO 2014).

LTC residents are at risk of neglect because many individuals face complex care needs, resulting in physical and cognitive decline and increasing reliance on care providers for daily living. Functional impairment and poor health have been shown to be associated with greater risk of abuse and neglect among older adults (Acierno et al. 2010; Amstadter et al. 2011; Burnes et al. 2015; Lowenstein et al. 2009; Pillemer and Finkelhor 1988; Podnieks 1992). In the province of Ontario, neglect is defined under *O. Reg. 79/10*, section 5 of the *Long-Term Care Homes Act, 2007*, as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents” (Government of Ontario 2011: 70).

While its legislative definition is comprehensive, neglect among older adults in LTC is difficult to identify and, thus, quantify or measure. As Collins (2006) notes, “many entities can mimic elder neglect, and many age-related changes can result in pathology that may be

confused with maltreatment” (p. 157). Furthermore, neglect is often underreported because residents may be dependent on abusive caregivers and are fearful to disclose incidents of neglect in case of retaliation or negative experiences (Hayley et al. 1996; LoFaso and Rosen 2014). As a result, several studies have used various clinical indicators as measures of the presence of neglect (Akaza et al. 2003; Choi and Mayer 2000; Cooper et al. 2006; Ogioni et al. 2007). These clinical signs and symptoms differ across studies not only due to the ambiguity involved in identifying neglect and the hidden nature of older adults’ experiences of neglect but also due to the lack of timely data on clinical signs of neglect. Although neglect is difficult to characterize and is measured in various ways, it has been associated with adverse health outcomes, such as increased hospitalizations and mortality (Friedman et al. 2017; Powers 2014).

Only a few studies have examined a composite index of neglect (Friedman et al. 2017; Fulmer and Ashley 1989). Friedman and colleagues (2017) developed a clinical signs of neglect scale (CSNS) in the US based on clinical signs identified in the literature and by experts in older adult care provision. The authors noted that more research is needed to comprehensively analyse the validity of the scale and improve inter-rater reliability. Fulmer and Ashley (1989) conducted an exploratory factor analysis to test the construct validity of items on an abuse assessment instrument related specifically to neglect, and determined that skin alterations, nutritional deficits and bowel/urinary incontinence were three key constructs of neglect among older adults. Several research studies demonstrate that these constructs, realized as the presence of decubitus ulcers (pressure ulcers), dehydration and urinary tract infections (UTIs), encompass clinical signs of neglect for older adults (Clarysse et al. 2018; Cooper et al. 2006; Dyer et al. 2003; Friedman et al. 2017; Himmelstein et al. 1983; Powers 2014).

Pressure ulcers, dehydration and recurrent UTIs are preventable, yet are prevalent within institutional care settings (Collins 2006; Friedman et al. 2017; Gibbs 2014; LoFaso and Rosen 2014; Powers 2014). Evidence suggests pressure ulcers can be avoided through proper hygiene, systematic risk assessment and regular repositioning (Lyder and Ayello 2008; Yap et al. 2018). According to Bunn et al. (2019) low-intake dehydration can be prevented if residents are presented with, and in some cases assisted in drinking, adequate amounts of fluid. Recurrent UTIs can be avoided if residents receive a timely diagnosis and treatment (Nace et al. 2014). Genao and Buhr (2012) suggest that clinicians often experience challenges in diagnosing UTIs among residents due to communication barriers (especially among patients diagnosed with dementia and stroke), as well as a high prevalence of chronic genitourinary symptoms such as incontinence, urgency, frequency, and nocturia. In addition, there is a lack of a gold-standard laboratory test to confirm clinical suspicion of UTI. Although pathophysiological changes typify aging, clinical symptoms can be documented as signs of neglect (Collins 2006; Friedman et al. 2017; LoFaso and Rosen 2014).

Several government task forces, research and media reports have brought attention to the significant experiences of neglect that residents of LTC homes have been facing for

decades (Charpentier and Soulières 2013; Long-Term Care Task Force on Resident Care and Safety 2012; Keefe et al. 2018; Russell 2020). These protracted situations of neglect received national attention as record numbers of residents died following the COVID-19 pandemic, during which neglect and abuse of older adults were increasingly exposed (Beattie and Reddekopp 2021; CAF JTFC 2020; Howlett 2021). The stressful circumstances placed on residents and their caregivers during the pandemic may have increased the potential for perpetrating acts of neglect given the isolated environments and stressful working conditions faced by residents and caregivers in the sector, respectively. This study aims to determine the incidence of neglect defined by the presence of pressure ulcers, dehydration and UTIs and assess the association between neglect and 90-day mortality of LTC residents before and during the pandemic in the province of Ontario.

## Materials and Methods

### *Data sources*

A retrospective cohort study using administrative resident-level databases was conducted. The analysis focused on LTC residents in Ontario from January 2019 to December 2020. Population-based health administrative data sets from ICES and the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) 2.0 were accessed. The RAI-MDS (CIHI 2011) contains information on clinical, functional and psychosocial characteristics of residents. Resident demographic and mortality data were obtained through the Registered Persons Database (RPDB). COVID-19 data were obtained from the Ontario Laboratories Information System (OLIS), which includes infection test data from hospitals, commercial laboratories, provincial public health laboratories and assessment centres. All records used were de-identified and anonymized, as they were linked across data sets via unique encoded identifiers.

This study included all residents of LTC homes in Ontario aged 65 years and older (residents younger than 65 years of age were excluded from this study). Residents without a COVID-19 test in their records were also excluded because their COVID-19 infection status was not known. The age groups for residents were coded as 65–69, 70–74, 75–79, 80–84, and  $\geq 85$  years. An index of neglect was created using three variables: presence of pressure ulcer, insufficient fluid (none consumed in the previous 3 days) or overall dehydration and UTI in the last 30 days (See Appendix 1: Table A4 for definitions) (Appendix 1 is available online at [www.longwoods.com/content/26851](http://www.longwoods.com/content/26851)).

For each resident in the study, the following variables were included in the analysis: result of last COVID-19 test (positive or negative, from March 2020); region of Ontario (Central, Southwest, East, North) where the LTC home is located; income quintile based on postal code of the LTC home; frailty index (classified as robust, pre-frail, frail); ownership category of the LTC home (municipal, non-profit, for-profit); and Changes in Health, End-stage disease, Symptoms and Signs (CHESS) co-morbidity score. The income quintile was

coded as 1 (lowest income level) to 5 (highest income level). The CHES score values range from 0 (no instability in health) to 5 (high unstable health).

This project was approved by the ICES Privacy and Legal Office. ICES is a prescribed entity under section 45 of Ontario's *Personal Health Information Protection Act* (2004). Section 45 authorizes ICES to collect personal health information, without consent, for the purpose of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of the allocation of resources or planning for all or part of the health system. Projects conducted under section 45, by definition, do not require informed consent.

### *Statistical analysis*

Descriptive statistics were used to describe the sample characteristics. Summary statistics were reported as mean and standard deviation (SD) for the only continuous variable (CHES co-morbidity score) and as frequency and percentage for categorical variables (for all other variables, please see Table 1). An independent two-sample test was used to compare CHES co-morbidity scores between neglected and not neglected groups. A Chi-squared test was used to compare different levels of each categorical variable based on neglect status. We used a backward logistic regression analysis with a significance level of  $\alpha = 0.05$  to investigate the association between death within 90 days of assessment and neglect and each of its three components, separately, while adjusting for the other variables. Less than 1% of some variables were missing, and a casewise deletion approach was used in analysis. All statistical analyses were conducted using Stata/MP 15.1 (Stata Corporation, College Station, TX).

### **Results**

There were 106,765 residents 65 years of age and older living in Ontario's long-term care homes from January 2019 to December 2020. Of these older adults, 30.75% ( $n = 32,832$ ) were assessed pre-COVID (between January 2019 and February 2020), while 69.25% ( $n = 73,933$ ) were assessed during COVID (between March 2020 and December 2020). Over one-quarter (27%) of residents had at least one identified indicator of neglect: 13.1% had decubitus ulcers, 13.5% had dehydration and 6.2% had a UTI.

There was no difference in the rate of neglect based on sex ( $p = 0.178$ ). Residents 85 years of age and older and frail were more likely to have at least one of the three indicators of neglect than those who were younger and less frail. There was a significant association between age group and rate of neglect ( $p < 0.0001$ ). Rate of neglect was 21.4% ( $n = 1,175$ ) among the youngest age group (65–69 years) but increased to 29.6% ( $n = 17,832$ ) among those over 85 years (Table 1). Also, rate of neglect significantly increased based on frailty status of the residents: it was only 8.2% ( $n = 726$ ) in the robust group but increased to 33.8% ( $n = 24,677$ ) in the frail group ( $p < 0.0001$ ). Approximately 31% ( $n = 6,739$ ) of residents living in municipal homes, 28.2% ( $n = 7,980$ ) of those living in not-for-profit and 26.1% ( $n = 14,760$ ) of individuals residing in for-profit facilities presented with signs of neglect in

our sample. A higher proportion of residents exhibited clinical signs of neglect if they lived in a facility located in rural settings (29.5%;  $n = 4,109$ ) compared with urban areas (27.3%;  $n = 25,154$ ) or if the home was situated in the northern (33.0%;  $n = 4,444$ ) or southwestern (32.0%, 11,630) regions of the province. Most notably, 50.6% ( $n = 10,746$ ) of residents who died within 90 days of their assessment displayed signs of neglect, whereas only 21.9% ( $n = 18,592$ ) of surviving residents were observed to have signs of neglect (Table 1).

In adjusted logistic regression models examining the relationship between neglect and resident mortality, our analysis shows that prior to COVID-19, individuals residing in LTC homes who exhibited clinical signs of neglect had 55% (odds ratio [OR] 1.55, 95% confidence interval [CI]: 1.46, 1.64) higher risk of death within 90 days of their last assessment compared with residents who did not experience neglect. Other notable risk factors for 90-day mortality prior to COVID-19 included advanced age (OR = 1.61, 95% CI: 1.38, 1.88) and pre-frail (OR = 2.41, 95% CI: 2.06, 2.82) or frail status (OR = 4.21, 95% CI: 3.63, 4.89). For each unit increase in the CHES score, the odds of death increased by 2.06 (95% CI: 2.01, 2.10). Women had 26% decreased odds of death compared to men (OR = 0.74, 95% CI: 0.70, 0.78). Residents living in rural communities, in facilities located in the southwestern and eastern regions of Ontario and within non-profit and for-profit homes had lower odds of mortality compared with individuals living in urban areas, facilities in the central region and municipal homes, respectively (Table 2).

**TABLE 1.** Characteristics of LTC residents 65 years of age and older in Ontario, from the Continuing Care Reporting System, January 2019 to December 2020

Characteristic	Not neglected $n = 77,286$	(%)	Neglected $n = 29,479$	(%)	Total	$p$ value
<b>Age group</b>						
65–69	4,316	78.6	1,175	21.4	5,491	< 0.0001
70–74	6,638	76.4	2,055	23.6	8,693	
75–79	9,575	75.0	3,191	25.0	12,766	
80–84	14,394	73.4	5,226	26.6	19,620	
85+	42,363	70.4	17,832	29.6	60,195	
<b>Sex</b>						
Male	25,306	72.7	9,525	27.3	34,831	0.178
Female	51,980	72.4	19,954	27.6	71,934	
<b>CHES score</b>						
Mean (SD)	0.94	1.0	2.54	1.56	106,762	< 0.0001
<b>Frailty</b>						
Robust	8,140	91.8	726	8.2	8,866	< 0.0001
Pre-frail	20,895	83.7	4,076	16.3	24,971	

## Frequency of Neglect and Its Effect on Mortality in Long-Term Care

Characteristic	Not neglected n = 77,286	(%)	Neglected n = 29,479	(%)	Total	p value
Frail	4,8251	66.2	24,677	33.8	72,928	
<b>Income quintile</b>						
1 (low)	22,354	71.4	8,948	28.6	31,302	< 0.0001
2	16,924	73.3	6,171	26.7	23,095	
3	14,048	73.4	5,083	26.6	19,131	
4	12,723	72.1	4,922	27.9	17,645	
5 (high)	10,638	72.0	4,128	28.0	14,766	
Missing					826	
<b>Location</b>						
Urban	66,889	72.7	25,154	27.3	92,043	< 0.0001
Rural	9,828	70.5	4,109	29.5	13,937	
<b>Facility's region</b>						
Central	21,724	77.6	6,258	22.4	27,982	< 0.0001
Southwest	24,672	68.0	11,630	32.0	36,302	
East	21,802	75.4	7,126	24.6	28,928	
North	9,037	67.0	4,444	33.0	13,481	
<b>Facility ownership</b>						
Municipal	15,150	69.2	6,739	30.8	21,889	< 0.0001
Non-profit	20,277	71.8	7,980	28.2	28,257	
For-profit	41,859	73.9	14,760	26.1	56,619	
<b>Death within 90 days of assessment</b>						
Yes	66,453	78.1	18,592	21.9	85,045	< 0.0001
No	10,507	49.4	10,746	50.6	21,253	

CHES = Changes in Health, End-stage disease, Signs and Symptoms.

Following the onset of the COVID-19 pandemic, LTC residents who presented with clinical signs of neglect had an 80% (95% CI: 1.70, 1.91) increased risk of death within 90 days compared with individuals who were not neglected, following adjustment for individual- and facility-level characteristics. Risk factors for 90-day mortality included having higher CHES scores, higher frailty scores and advanced age. Protective factors that decreased the odds of mortality for residents during COVID-19 included being female and residing in facilities located in rural areas and the southwestern, eastern or northern regions of Ontario. Individuals residing in for-profit homes had an 18% (95% CI: 1.10, 1.27) increased odds of death compared with residents living in municipal homes, while there were no statistically significant differences between residing in municipal or non-profit homes. Finally, LTC residents who tested positive for COVID-19 had 41% (95% CI: 1.31, 1.53) increased odds of death within 90 days of assessment compared with their counterparts who tested negative

(Table 2). Separate logistic regression analyses were conducted to determine the association between death and each component of the neglect index (i.e., pressure ulcer, dehydration, and UTI), which are reported in Appendix 1 (Tables A1–A3).

**TABLE 2.** Adjusted odds ratios for 90-day mortality for LTC residents living in Ontario, before COVID-19 from January 2019 to February 2020 and during COVID-19 from March 2020 to December 2020

Variable	Mortality			
	Pre-COVID-19		During COVID-19	
	OR	(95% CI)	OR	(95% CI)
<b>Neglect</b>				
Yes (reference = no)	1.55	(1.46, 1.64)	1.80	(1.70, 1.91)
<b>Age group (reference = 65–69)</b>				
70–74	1.22	(1.02, 1.46)	1.27	(1.05, 1.53)
75–79	1.30	(1.10, 1.55)	1.42	(1.19, 1.68)
80–84	1.53	(1.30, 1.80)	1.53	(1.30, 1.80)
85+	1.61	(1.38, 1.88)	1.92	(1.64, 2.24)
<b>Sex (reference = male)</b>				
Female	0.74	(0.70, 0.78)	0.56	(0.53, 0.59)
<b>CHESS score</b>	2.06	(2.01, 2.10)	2.36	(2.31, 2.42)
<b>Frailty (reference = robust)</b>				
Pre-frail	2.41	(2.06, 2.82)	2.03	(1.60, 2.57)
Frail	4.21	(3.63, 4.89)	3.22	(2.57, 4.04)
<b>Location (reference = urban)</b>				
Rural	0.86	(0.80, 0.93)	0.87	(0.80, 0.96)
<b>Facility region (reference = central)</b>				
Southwestern	0.82	(0.77, 0.88)	0.76	(0.71, 0.82)
Eastern	0.78	(0.72, 0.84)	0.86	(0.80, 0.93)
Northern	0.94	(0.86, 1.03)	0.72	(0.66, 0.80)
<b>Ownership (reference = municipal)</b>				
Non-profit	0.85	(0.79, 0.92)	0.92	(0.85, 1.00)
For-profit	0.90	(0.84, 0.96)	1.18	(1.10, 1.27)
<b>COVID-19 test (reference = negative)</b>				
Positive			1.41	(1.31, 1.53)

CI = confidence interval; CHESS = Changes in Health, End-stage disease, Signs and Symptoms; OR = odds ratio.

## Discussion

In this study we investigated the association between indicators of neglect, defined as the presence of decubitus ulcers (pressure ulcers), dehydration and UTIs, and 90-day mortality

for LTC residents in Ontario. We also report on the risk of death due to neglect before the COVID-19 pandemic (January 2019 to February 2020) and in the first 10 months of the pandemic. Findings demonstrate that neglect was a significant risk factor for mortality for residents of LTC homes before and during the pandemic; over one-quarter of residents presented with neglect.

Before the pandemic, individuals who exhibited signs of neglect had 55% increased odds of death within 90 days of the assessment. During the pandemic, the odds of death were 80% higher among residents who presented with signs of neglect compared with those who did not present with signs of neglect. These findings are not unexpected given the severity of conditions found within some of the homes before and during the pandemic (Beattie and Reddekopp 2021; Charpentier and Soulières 2013; Howlett 2021; Russell 2020). In the most severe cases, the Canadian Armed Forces were deployed to assist homes during the first wave and exposed the abysmal conditions. They noted various signs of abuse and neglect such as extreme deprivation, no assistance with eating or drinking and multiple cases of residents with decubitus ulcers (CAF JTFC 2020).

Our analysis revealed that decubitus ulcers and dehydration were both strongly associated with 90-day mortality among LTC residents; however, there was no significant association between UTIs and death (Appendix 1: Tables A1–A3). This may be due to underreporting following the lack of timely diagnosis (LoFaso and Rosen 2014). Previous literature demonstrates that residents who experienced limitations in daily living activities have an increased risk of being neglected (Zhang et al. 2011). This study did not control for the presence of decubitus ulcers, dehydration or UTIs.

Although signs of neglect were identified as a statistically significant risk factor for 90-day mortality in both time periods of the study, the odds of death among residents who presented with neglect compared to those who did not increased during the pandemic. The COVID-19 pandemic may have increased the vulnerability of older adults in LTC to abuse and neglect due to social isolation protocols that eliminated access to networks of informal care through family caregivers and heightened dependency on short-staffed and strained nursing home workers (Gardner et al. 2020; Han and Mosqueda 2020).

A systematic review conducted by Yon and colleagues (2019) investigated the prevalence of abuse in institutional settings, including neglect, from self-reported data provided by residents and staff. The study revealed that approximately 64% of staff providing care in institutional settings reported perpetrating elder abuse and neglect in the past year (WHO 2021; Yon et al. 2019). Staff are more likely to engage in acts of neglect if they had experienced psychological stressors or had intentions to leave their job following burnout (Botngård et al. 2021). Goodridge and colleagues (1996) surveyed over 100 nursing assistants employed in an LTC home in Winnipeg, Manitoba, to understand the relationship between burnout, conflict with residents and aggression toward staff. The authors found that these direct care workers faced multiple stressors, including aggressive behaviour toward them by residents. Conflict between residents and staff, including situations where either party experienced

abuse, was associated with staff burnout as well as aggression. The pandemic elevated the stressful working conditions in LTC, given staff experienced pressures following inconsistent guidelines from health authorities, limited resources for protection and infection control and severe staffing shortages (Grabowski and Mor 2020; Lysyk 2021; Trabucchi and De Leo 2020). Several studies and news media articles revealed that LTC staff experienced significant psychological distress and work overload during the pandemic in many parts of the world (Mahoney 2021; Martin et al. 2021; Mo and Shi 2020). As such, the turbulent working conditions during COVID-19 and inadequate supports for staff and residents amid social isolation mandates may have led to higher odds of neglect experienced by residents within the first 10 months of the pandemic in Ontario, as revealed by our study.

Furthermore, recent media investigations have found that 85% of homes in Ontario have violated regulations repeatedly in 2019, perpetrating serious offences related to abuse and neglect without facing any consequences (Pederson et al. 2020). Of 623 LTC homes in the province, 200 had repeat offences for “failing to ensure that residents are not neglected by the licensee or staff,” with even more neglect-related incidents filled under other violation codes, such as improper skin care (Pederson et al. 2020). Our findings imply that enhanced accountability measures are needed in Canada to safeguard residents from being placed in situations that compound their vulnerability to neglect. For example, the UK established the Care Quality Commission in 2009, an independent health and social care regulator, to monitor all care organizations, including homes, requiring providers to report incidents of abuse and neglect, including the development of Stage 3 or above decubitus ulcers (Care Quality Commission 2009). It is also within the Care Quality Commission’s discretion to refer incidents of concern to the police or local council to ensure residents’ protection. In 2014, the UK government prioritized the prevention of decubitus ulcers by integrating this goal into their national agenda, placing accountability for improving the health of older adults at the highest level (Department of Health 2014). Research revealed that these accountability measures and reporting mechanisms motivated staff to adhere to recommended pressure ulcer prevention practices (Lavallée et al. 2018). Therefore, establishing accountability protocols through legislative frameworks and independent regulators with the authority to confer punitive measures on perpetrators of elder abuse and neglect may enhance resident safety in institutional care settings.

This study recommends that caregivers are given essential supports, such as training in neglect recognition, where clinical protocols should be carefully assessed to prevent an adverse outcome. Enhanced detection and screening for neglect may reduce unnecessary suffering and death among this vulnerable population. The RAI-MDS is used to collect information on the clinical signs and symptoms of residents upon admission, on a quarterly basis and upon significant changes to their health status. While it can be used to raise concerns related to the deterioration of resident health, a more proactive approach through the implementation of a questionnaire or assessment instrument specific to neglect and abuse may facilitate more accurate and earlier detection. These symptoms are serious and

require an integrated plan of care and neglect prevention that should be formulated upon a resident's admission and informed by a network of caregivers, including nutritionists and family members. Furthermore, improving LTC home conditions, such as addressing chronic understaffing and increasing training and awareness of infection prevention and control protocols for existing staff may reduce the burden of neglect experienced by LTC residents. In particular, psychosocial supports – such as policies that expand access to mental healthcare, including respite or time off work with appropriate remuneration – can address psychological distress resulting from stressful working environments where there are increased experiences of burnout and exposure to traumatic stressors.

The linkage of administrative databases to examine a composite index of signs of neglect is an important strength of our study. Some limitations include the derivation of the neglect index from existing clinical data collected by the assessment items of the RAI-MDS. While the RAI-MDS is completed by trained staff and evidence suggests that it is a reliable and valid instrument overall (Hutchinson et al. 2010), the potential for non-differential misclassification bias may exist. An examination of the criterion validity of the neglect index is proposed for future research. Moreover, given the possibility for simultaneous occurrence of more than one clinical indicator of neglect, the degree or severity of neglect experiences among residents may warrant further investigation. Additional limitations that arise from using administrative databases include the inability to infer causality and the presence of confounding bias from unobserved variables. Confounding of observed variables were controlled for using multivariable logistic regression.

## Conclusion

Neglect of older adults in LTC is associated with an increased risk of death. Clinical signs of neglect such as pressure ulcers and dehydration were significant risk factors for 90-day mortality for residents before and during the pandemic. The odds of death among residents who presented with indicators of neglect, compared with those who did not, increased during the pandemic. Enhanced supports for caregivers, including neglect-detection resources and training, improved working conditions and access to psychosocial benefits, are recommended to address ongoing neglect in residential care homes. The implementation of accountability protocols and reporting mechanisms linked to practical consequences for perpetrators of neglect and abuse is warranted.

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# Inspection Reports: The Canary in the Coal Mine

## Rapports d'inspection : le canari dans la mine



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### Abstract

Neglect in the Ontario long-term care (LTC) sector is defined under section 5 of O. Reg. 79/10 of the *Long-Term Care Homes Act, 2007*. Allegations are monitored and investigated via inspections. Using an exploratory descriptive design, we analyzed reports of neglect in LTC homes from 2019 to 2020. The majority were in response to critical incidents, followed by complaints from family members or staff. Thematic analysis revealed four areas of neglect: (1) failure to provide treatment; (2) failure to provide care; (3) failure to attend to or assist residents; and (4) failure to investigate allegations. Study findings demonstrate that an accountability framework that includes consequences for institutions is needed.

### Résumé

La négligence dans le secteur ontarien des soins de longue durée (SLD) est définie par l'article 5 du Règl. 79/10 de la Loi de 2007 sur les foyers de soins de longue durée. Les allégations de négligence sont surveillées et font l'objet d'enquêtes au moyen d'inspections. À l'aide

d'une conception descriptive exploratoire, nous avons analysé les signalements de négligence dans les foyers de SLD de 2019 à 2020. La majorité portaient sur des incidents critiques, suivis de plaintes de membres de la famille ou du personnel. L'analyse thématique a révélé quatre domaines de négligence : (1) l'absence de traitement; (2) le défaut de fournir des soins; (3) le défaut de s'occuper ou d'aider les résidents; et (4) le défaut d'enquêter sur les allégations. Les conclusions de l'étude démontrent qu'un cadre de responsabilisation qui prévoit des conséquences pour les institutions est nécessaire.

## Background

In Canada, the recent COVID-19 pandemic has exposed significant issues in the long-term care (LTC) sector, including cases of abuse and neglect. LTC homes are mandated under provincial legislation to protect residents from harm. Various approaches to quality improvement and accountability exist across the country. Inspections of LTC homes are used by all provinces. In Ontario, Canada's most populous province, inspections tied to legislation are used as a method of ensuring resident safety.

Neglect is defined under *O. Reg. 79/10*, section 5 of the *Long-Term Care Homes Act, 2007*, as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents” (Government of Ontario 2011: 70). There are limited data available on the prevalence of neglect in LTC homes. Most studies focus on elder abuse and include neglect as a sub-type of abuse found in institutional settings (Myhre et al. 2020; Pérez-Rojo et al. 2021). A meta-analysis by Yon et al. (2019) on the prevalence of abuse in LTC homes found that estimated prevalence reported by older residents was 11% for neglect, double the prevalence of neglect in the community (4.6%).

The Ontario government created the Long-Term Care Home Quality Inspection Program (LQIP) to “safeguard residents' well-being by continuously inspecting complaints and critical incidents” (Ontario Ministry of Health and Ministry of Long-Term Care 2019). Within the LQIP there are three ways an inspection occurs: (1) complaints reported by staff, family members or other visitors; (2) critical incidents identified through mandatory reporting; and (3) resident quality inspections conducted annually to ensure homes are meeting specific requirements of the *Long-Term Care Homes Act, 2007*. As part of the inspection process, inspectors use protocols to investigate issues and determine if a home is compliant with the *Long-Term Care Homes Act, 2007*, and its regulations.

We conducted a study to better understand the inspection process by analyzing reports on LTC homes in Ontario. The analysis focused on a two-year period (2019 to 2020), one year before COVID-19 and the first year of the pandemic. The study objectives were to (1) describe the inspection process; (2) describe the types of inspections conducted and the issues reported; and (3) describe and analyze reports specific to neglect. A better

understanding of reported cases of neglect can help inform policy changes needed to improve the quality of care for LTC residents across Canada.

## Research Design and Methods

An exploratory descriptive design was used to examine the inspection process in Ontario and analyze selected inspection reports over a two-year period. A review of grey literature, including government publications and the public reporting website,<sup>1</sup> was conducted to identify the stages involved in the inspection process. A Google search was conducted to identify relevant websites that included information about the LQIP. The findings were documented and reviewed for face and content validity by experts, including researchers and government officials working in the LTC sector. A database was created that categorized all inspections completed in LTC homes in Ontario between January 1, 2019, and December 31, 2020. The variables recorded included type of home (profit, not-for-profit or municipal), type of inspection (critical incident, internal or external complaints and resident quality inspection) and the relevant section or sub-section of legislation cited in the report. The reports varied in length and could include one incident or multiple incidents and outcomes.

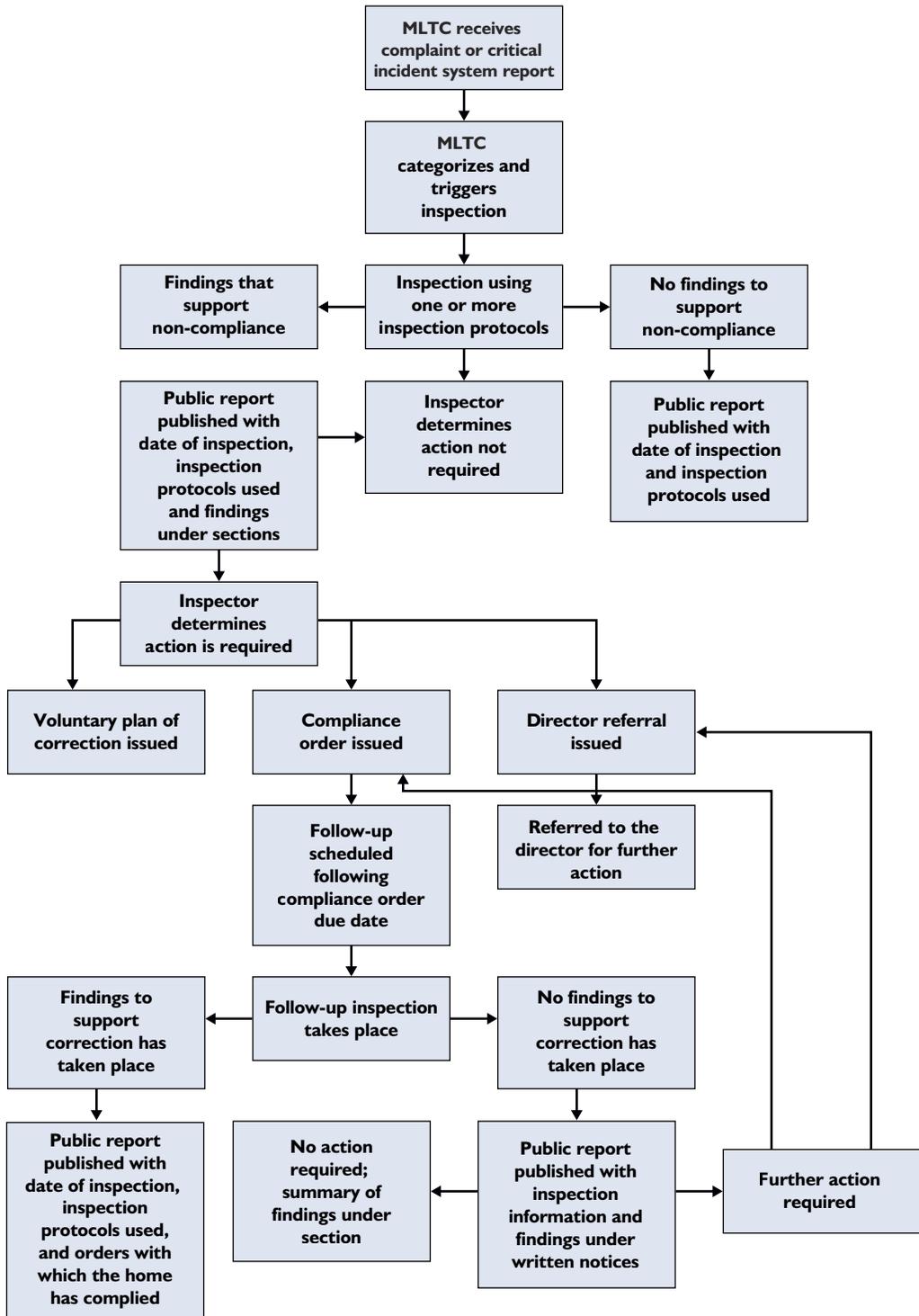
Descriptive analyses were conducted to identify the number and types of inspections reported and the recorded findings for each inspection. Count data were extracted from the reports to identify the characteristics of homes and incidences of neglect. Section 19, titled “Duty to Protect,” and section 20, titled “Policy to Promote Zero Tolerance,” of the *Long-Term Care Homes Act, 2007*, specifically address the prevention of abuse and neglect. Reports that included a finding of neglect under one of these sections were further analyzed. Texts were interpreted through thematic analysis and categories were developed using the *Long-Term Care Homes Act, 2007*, definition of neglect (Boyatzis 1998). During the preliminary coding, two members of the research team coded several texts independently. Team members then collaborated to develop a refined scheme to code the texts. Additional codes were assigned as new themes emerged. Major themes were highlighted and key findings were categorized under each thematic heading. Examples of cases of neglect with serious clinical consequences are reported in this paper.

## Results

### *Inspection process*

It demonstrates the outcomes of an inspection, such as voluntary plan of correction, compliance order or director referral (Figure 1). The latter two result in a follow-up inspection that potentially leads to further consequences. Inspection reports are publicly available from the Ministry of Health and the Ministry of Long-Term Care.<sup>1</sup>

FIGURE 1. LTC home inspection process



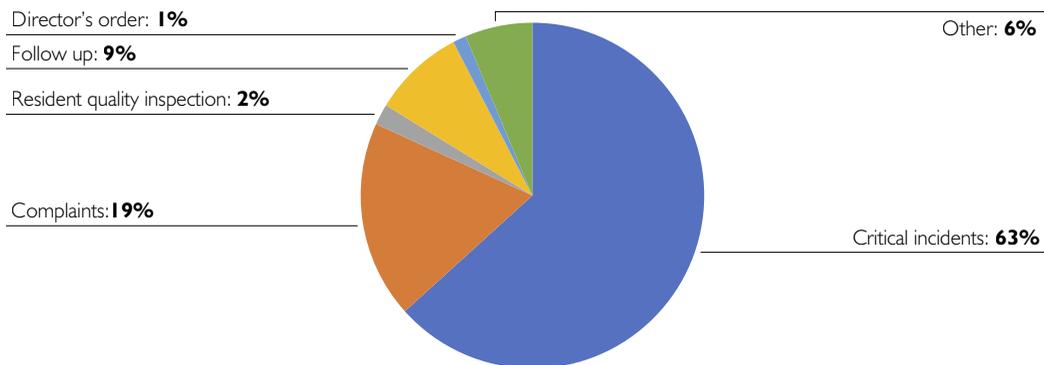
MLTC = Ministry of Long-Term Care.

### Inspection reports: Types and outcomes

At the time of the study, there were 626 LTC homes in Ontario. Between January 1, 2019, and December 31, 2020, there were 5,101 inspection reports across these homes. The majority of inspections were critical incidents, followed by complaints (see Figure 2). Reports ranged from three to 125 pages and included an average of 3.7 issues per report.

Of 626 homes, 538 (86%) had violations under the *Long-Term Care Homes Act, 2007*, which comprises 10 parts and 399 sections and sub-sections. Over the two-year period, 18,240 violations were identified. Table 1 shows the most frequent violations identified in the inspection reports.

**FIGURE 2.** Types of inspections completed in Ontario LTC homes, 2019–2020



**TABLE 1.** Ontario LTC home inspection reports, 2019–2020

LTCHA, 2007, sub-sections	Section	Number	Percent
Plan of care	2007, c.8, s.6	3,661	20%
Policies and records	O. Reg. 79/10, s.8	1,207	7%
Reporting certain matters to the director	2007, c.8, s.24	830	5%
Prevention of abuse and neglect	2007, c.8, s.19	873	5%
Policy to promote zero tolerance	2007, c.8, s.20	655	4%
Administration of drugs	O. Reg. 79/10, s.131	659	4%
Skin and wound care	O. Reg. 79/10, s.50	573	3%
Transferring and positioning techniques	O. Reg. 79/10, s.36	539	3%
Report regarding critical incidents	O. Reg. 79/10, s.107	455	2%
General requirement programs	O. Reg. 79/10, s.30	349	2%
Infection prevention and control program	O. Reg. 79/10, s.229	328	2%
Other*		8,309	46%
<b>Total</b>		<b>18,240</b>	<b>100%</b>

\*Includes a combination of other sections of the *LTCHA, 2007*, cited in reports.  
 LTCHA, 2007 = *Long-Term Care Homes Act, 2007*.

### *Selected reports of abuse and neglect*

There were 628 reports of abuse and neglect. Of these, 438 identified incidents of abuse and 190 identified incidents of neglect. We focused our analysis on the latter, which included 231 separate incidents of neglect that were categorized into four thematic areas (see Table 2). These areas are not necessarily mutually exclusive, and they were chosen for the purposes of discussion and illustration.

**TABLE 2.** Thematic areas of neglect in LTC homes in Ontario in 2019 and 2020\*

Thematic area	Sum	Percentage (%)
Failure to provide treatment	90	39
Failure to provide care	73	32
Failure to attend or assist	36	15
Failure to investigate allegations	32	14
<b>Total</b>	<b>231</b>	<b>100</b>

\*Some reports included only a single incident, while others included multiple incidents.

#### FAILURE TO PROVIDE TREATMENT

This theme reflected the failure of the home to provide specialized medical care or assessment required for treatment of illness or injury. Thirty-eight percent ( $n = 90$ ) of neglect incidents involved failure to provide treatment, which includes medications and specialized care. In one case, a home had failed to provide a resident with necessary care that included nutrition and hydration, wound care and medications. The inspector noted that on multiple occasions the resident was not given appropriate hydration and was often left unattended for 12 to 14 hours with no documented care. The inspector also noted that upon admission, the initial assessment failed to identify skin integrity issues; consequently, the plan of care did not include wound care for altered skin integrity. Furthermore, it was observed that “[d]rugs were not administered to residents in accordance with the directions for use prescribed by the prescriber” (Inspection Report A: August 25, 2020).

In another case, a complaint was issued against a home for failing to provide skin and wound care. According to the inspection report, a resident with “significant alteration in skin integrity” had been neglected by direct care staff for an extended period. The inspector interviewed the wound care lead, a registered staff member, who indicated they relied on direct care staff to assess residents during their regular weekly bathing. Yet the care worker had not alerted anyone regarding the resident’s skin issues. By the time “the wounds were assessed ... [it was evident that] they had been present for some time.” The inspector documented that the physician had made a note in the resident’s chart that read: “THIS IS NOT ACCEPTABLE ... THIS WAS PREVENTABLE AND SHOULD NOT HAPPEN” (Inspection Report B: August 13, 2020; physician’s emphasis).

In another instance of neglect, a resident fell onto the floor while under the supervision of a registered staff member. The resident was not assessed or provided treatment at the time

of the fall. They were later transferred to hospital where the injury was identified and the resident eventually died. The inspector interviewed the registered staff involved and commented, “They were not sure if they were required to report and document this incident, and therefore, they search[ed] the internet and decided not to report and document the incident” (Inspection Report C: October 21, 2020).

#### FAILURE TO PROVIDE CARE

This theme included cases where a home failed to provide adequate care to residents in order to maintain good health and well-being. There were 73 reports of neglect in this category. They covered various aspects of care, such as continence care, mobility and nutrition. It was documented in one critical incident that a resident had been left without proper continence care for a protracted amount of time. During a changeover in shift, staff discovered the resident was “saturated in urine” and upon assessment “determined that [they] had specified alterations in skin integrity to identified areas of the body” (Inspection Report D: November 8, 2019). The inspector’s findings indicated that the home failed to ensure the resident received immediate care to promote healing as required.

A different case involved residents missing meals on multiple occasions. In one example, the inspector noted that residents who required extra assistance or a higher level of care remained in bed during meal times because the personal support worker did not have time to get the residents up. The home was short-staffed and it was reported that staff did not wake the residents for their morning meals. Additional documentation reflected a lack of clarity regarding whether residents were given nutritional supplements in place of missing meals.

In another incident, a resident who had been identified as a nutritional risk was not being fed sufficiently. The resident required total assistance during meals and was to be provided with “high energy, high protein meals.” Upon investigation, it was found that the resident had experienced significant weight loss over five months because they had not been receiving their meals regularly (Inspection Report E: November 21, 2019).

#### FAILURE TO ATTEND OR ASSIST

This theme reflected the failure of the home to ensure residents were provided with adequate assistance and supervision to maintain safety and well-being. It includes failing to respond to calls for assistance (by call bells) or conducting regular safety checks. In 36 cases of neglect, residents were left unattended or without assistance for extended periods. In one example, a staff member had transferred a resident to a new room but did not apprise other staff. It was not until the next shift that the home was searched and the resident was found. It was noted that this incident led to the resident “not receiving care or repositioning for an identified period of time and very late medications and meal” (Inspection Report F: July 29, 2020).

Other examples involved staff failing to check on residents as required. In one case, a resident was left unattended and without care, despite documentation indicating care had been provided. Video footage revealed the resident had been left alone for five hours and

was found unresponsive. The resident was later pronounced dead (Inspection Report G: October 16, 2020). Another report described residents suffering serious injuries due to being left unattended and in one such case the resident passed away unexpectedly (Inspection Report H: February 11, 2020). In one of the more severe cases, a resident “was found with their sweater sleeves tied in knots and was sitting in the wheelchair [with their body] tilted” (Inspection Report I: July 2, 2020). The report indicated that the resident was left for approximately five hours before being found by housekeeping.

#### FAILURE TO INVESTIGATE ALLEGATIONS

This theme included cases where the home failed to investigate allegations of neglect including failure of the home to conduct internal investigations and failure of the home to report neglect cases to the ministry. Thirty-two reports described a lack of attention to incidents that subsequently led to inspections. In one example, staff at all levels advised management over a five-year period (2016–2020) that a registered staff member was abusing narcotics and provided residents with medication “when they did not need it” (Inspection Report J: December 21, 2020). A family member had complained that their loved one was being given narcotics without cause and asked that it be discontinued immediately. The report indicated, “There were multiple allegations of narcotic diversion by the same staff member and the allegations were ongoing since 2016” (Inspection Report J: December 21, 2020).

Residents in a different case did not receive their medications. Nine unopened pouches of medications were found in the waste disposal. However, staff had documented that the medications had been administered. The staff member who failed to provide the medication continued to work at the home after this incident. It was later identified that another 28 residents were not given their medications (Inspection Report K: June 25, 2020).

In another case, management failed to investigate or act after receiving numerous reports of abuse and neglect of residents from staff, family members and visitors. The inspector indicated, “Despite the multiple allegations of abuse and neglect ... the DOC [director of care] denied taking any management actions to correct their lack of reporting, such as education or discipline as outlined in the home’s Zero Tolerance of Abuse and Neglect policy” (Inspection Report L: September 1, 2020).

## Discussion

Researchers have identified neglect of LTC residents as a critical policy issue that requires immediate reform to improve care (Jolly 2020; Storey 2020). Reader and Gillespie (2013) provided a comprehensive description of the incidence and nature of neglect in their concept analysis. Neglect causes significant deterioration in health status that leads to deleterious outcomes such as decubitus ulcers, dehydration, urinary tract infections and increased prevalence of falls (Bunn et al. 2019; Clarysse et al. 2018). All of these were identified in the inspection reports we reviewed, highlighting the need for accountability measures that enforce corrective action on the part of LTC homes.

The inspection process in LTC has changed over time. Historically, the government of Ontario conducted mandatory annual Resident Quality Inspections using methodology adapted from a Quality Indicator Survey. The inspections were amended in 2018 to occur only in response to specific complaints or incidents as required under the *Long-Term Care Homes Act, 2007*. The complaint process for LTC homes includes non-urgent and urgent complaints. The first are considered “less serious ... [and] are related to diet, activities or care,” while the second “include cases of harm, neglect or danger to residents” (Government of Ontario 2021a). Although our analysis focused on neglect, the inspection reports also included issues that the provincial government considers less serious. It is important to recognize that these issues can compound neglect and increase the potential for adverse outcomes for LTC residents.

The Ontario government recently made a significant investment over three years to increase the number of inspectors and reintroduce the annual proactive inspections program (Government of Ontario 2021b). The new funding will result in a ratio of one inspector for every two homes. The government is also introducing new legislation that will provide “stronger enforcement and compliance tools to hold poor performing long-term care homes to account” (Government of Ontario 2021b). Provincial legislation should be supplemented with mandatory accreditation that would incorporate the National Standards of Care for Long-Term Care (HSO 2021). This would close the loop on a continuous quality improvement model that includes mandatory accreditation that builds on the national standards in long-term care.

COVID-19 exposed the decades-old crisis in the LTC sector. Public response to the lack of answers and accountability has given rise to class action lawsuits. The allegations are numerous: disregard for the health and safety of residents; lack of infection prevention and control, resources and personnel; and failure to respond properly, comply with public health guidance, communicate with family members or report deaths (Katawazi 2020a, 2020b; Morris 2021; Perkel 2021).

Findings from our study provide additional evidence of the need to improve accountability, enforcement and transparency in the LTC sector. The persistent cycle of “Neglect, Abuse, Crisis, Review, Repeat” in LTC must be broken (Lantz 2020). As long as the situation remains unchanged, the consequences will continue to be borne by the vulnerable residents of LTC homes and their families rather than by the homes and their operators.

### *Limitations*

The variation in inspection reports was a significant limitation in the study. Lack of standardized reporting made it difficult to identify and extract relevant data. Additionally, the COVID-19 pandemic introduced disruptions to the inspection process. First, inspections were suspended in March and April 2020, resulting in a significant drop in the number of reports during this time. Second, visitor restrictions were imposed in LTC homes for a four-month period. This may have reduced the number of complaints issued by family members or other visitors.

## Conclusion

There are systemic issues in LTC that must be addressed at the provincial level. Inspections have been perceived as punitive but they do provide useful information about issues in the sector as a whole. In order to be effective, inspections should be related to continuous quality improvement. We reviewed inspection reports one year before and during the first year of the COVID-19 pandemic. The number and severity of neglect cases within the two-year period suggest that the current accountability measures in LTC are not enough. Cases should be analyzed and synthesized annually within an accountability framework with clear consequences for individuals and organizations. A shorter timeline with explicit expectations for quality improvement is also required. Although policy goals are clear, there are definite signs of longstanding inaction in the LTC sector. National standards have been developed by a committee of Canadian experts to guide quality improvement in LTC. The standards are a useful framework for LTC institutions but they require a plan for monitoring and evaluation. In order to improve the quality of care provided to LTC residents, standards should be implemented provincially and integrated into legislation across jurisdictions. Accountability mechanisms must be strengthened and investments should include staffing, improved training and comprehensive documentation and reporting.

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## Note

1. Reports on Long-Term Care Homes can be found here: <http://publicreporting.ltchomes.net/en-ca/default.aspx>.

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# Rights versus Risks: The Impact of Isolation on Residents and Families in Long-Term Care

## Les droits contre les risques : l'impact de l'isolement sur les résidents et les familles dans les établissements de soins de longue durée



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### Abstract

Early in the COVID-19 pandemic, the Ontario government created directives for long-term care (LTC) homes. As a result, residents were isolated in their rooms and visitors were banned. This commentary examines these practices and their impact on LTC residents and their families. A review of relevant documents showed the practices were unnecessary and physically and psychologically detrimental. Moving forward, family should be recognized as essential members of residents' care teams and allowed in LTC homes during outbreaks. This would entail providing them with the necessary protective equipment and adequate training to ensure infection prevention protocols are maintained.

### Résumé

Au début de la pandémie de COVID-19, le gouvernement de l'Ontario a élaboré des directives pour les foyers de soins de longue durée (SLD). En conséquence, les résidents ont été isolés dans leurs chambres et les visites ont été interdites. Le présent commentaire examine

ces pratiques et leur impact sur les résidents des SLD et leurs familles. Un examen des documents pertinents a montré que ces pratiques étaient inutiles et préjudiciables tant sur le plan physique que psychologique. Dorénavant, la famille devrait être reconnue comme un membre essentiel des équipes de soins et elle devrait être autorisée dans les foyers de SLD pendant les éclosions. Cela impliquerait de leur fournir l'équipement de protection nécessaire et une formation adéquate pour garantir le maintien des protocoles de prévention des infections.

## Background

The long-term care (LTC) sector in Canada was ravaged by COVID-19. As of January 15, 2021, residents of LTC homes accounted for almost 60% of pandemic-related deaths in Ontario (Government of Ontario 2021). The Long-Term Care COVID-19 Commission found the province had “no comprehensive plan to address a pandemic. Worse yet, there was no plan to protect residents in long-term care” (Marrocco et al. 2021: 2). A convergence of evidence shows the provincial government was warned regarding “the looming dangers lurking in long-term care homes ... [but] failed to deliver what was desperately needed” (Russell et al. 2021: 6).

Ontario has the largest population nationwide, followed by Quebec and British Columbia. In comparing the three provinces, Quebec was the first to restrict LTC home visitation to essential visitors and Ontario was the last (Lysyk 2021). British Columbia was the first to mandate home staff wear masks and refrain from working in more than one LTC home. Ontario did not implement these measures until more than a month later (Lysyk 2021).

British Columbia led the country in demonstrating “best practices around health communication” pertaining to COVID-19 (Zussman 2020). In Ontario, however, LTC homes and the public received mixed messages from the Ministry of Long-Term Care and the Chief Medical Officer of Health (Lysyk 2021). This lack of comprehensive, consistent communication created significant confusion, which exacerbated the impact of Ontario government directives that prohibited visitors from entering LTC homes, restricted residents' movements and led to extended periods of isolation. This article is a commentary that examines one province's social isolation policies and practices and their effect on LTC residents and their families. Relevant documents were reviewed and included legislation, directives, newspaper reports and policies.

## *What relevant legislation was invoked during COVID-19?*

On March 17, 2020, the Government of Ontario (O. Reg 50/20) declared a state of emergency in response to COVID-19. The *Emergency Management and Civil Protection Act (EMPCA)* (1990) allowed the Lieutenant Governor in Council to issue orders, under section 7.0.1(1) of the EMPCA, believed “necessary and essential in the circumstances to prevent, reduce or mitigate serious harm to persons or substantial damage to property” (EMPCA 1990).

The *Health Promotions and Protection Act (HPPA)* (1990) establishes the framework under which directives may be issued to LTC homes. Under section 77.7(1) of the *HPPA*, Ontario's Chief Medical Officer of Health is empowered with discretion to issue orders to healthcare providers, including LTC homes, with respect to precautions and procedures to protect the health of persons in Ontario if they are of the opinion that there is, or may be, an immediate risk (*HPPA* 1990). Directive #3, specific to LTC, was issued under the *HPPA* to govern visitor restrictions, isolation requirements and short-stay absences; define non-essential visitors; and cohort staff and residents (MLTC 2020). Eleven versions of Directive #3 were released between March 22, 2020, and December 7, 2020 (AdvantAge Ontario 2022).<sup>1</sup>

#### DIRECTIVE #3

The first version focused on limiting short-stay absences for LTC residents but allowed outdoor visits with family to continue. As per the second version, LTC homes continued to bar short-stay absences and outdoor visits with family were removed. Additionally, no visitors were allowed to enter the home with the exception of an essential visitor defined as “a person performing essential support services (e.g., food delivery, maintenance and other healthcare) or a person visiting a very ill or palliative resident” (MLTC 2020: 4). Resident and staff cohorting measures were issued and included isolating residents to their rooms if there was an outbreak or if the resident was a new admission. There was a stipulation included that “in smaller long-term care homes or in homes where it is not possible to maintain physical distancing of staff or residents from each other, all residents or staff should be managed as if they are potentially infected” (MLTC 2020: 4). The third version continued the restriction on visitation but further modified the definition of essential visitors to include support services such as laboratory and food. It was not until the fourth version that family members were included under the definition of essential visitors. No changes were made to resident and staff cohorting in the third, fourth, fifth or sixth versions.

It was not until the seventh version (June 11, 2020) that homes were instructed to develop the gradual resumption of visitor policies that included family members, beginning with one visitor at a time. The eighth version allowed residents temporary absences for personal reasons with 14 days of self-isolation upon their return. The ninth version made no changes to cohorting or isolation practices but allowed residents to receive a maximum of two visitors at a time. Homes had discretion to impose additional rules such as requiring visits to be scheduled in advance and limiting the duration of visits. The 10th and 11th versions maintained the same precautions and procedures as the ninth version in relation to cohorting, isolation and visitation.

#### *How did isolation and visitor restrictions affect residents and families?*

Isolation of LTC residents in Ontario and restrictions on their movements persisted from April 1, 2020, to June 11, 2020, despite scientific evidence demonstrating that “extreme isolation is physically and mentally damaging” and it was known that COVID-19 would be “far

less likely to spread outdoors than indoors” (Perkel 2021). Evidence also demonstrates that a lack of physical activity exacerbates existing medical conditions, including diabetes and osteoporosis, and adversely affects mental health (McPhee et al. 2016). In addition, factors such as lack of sunlight and movement contribute to vitamin D deficiency, muscle atrophy and reduced strength, which can increase the threat of falls and fractures for older persons (DiPietro et al. 2018; Leonard 2020).

Due to rigid adherence to the broad and continual application of these isolation measures, many residents lost vital connections with their family caregivers and the world outside the LTC home. In some cases, residents lost their substitute decision makers. It is common practice for residents to appoint someone to act as their advocate and help them to understand their situation and make appropriate decisions. Directive #3 prevented residents from having in-person consultations with their substitute decision makers, which severely hampered their ability to provide informed consent, diminished their agency and increased their vulnerability. It also hampered the ability of substitute decision makers to fulfill their duties as outlined in the *Substitute Decisions Act, 1992* (Ontario Ministry of the Attorney General 2020) and the *Health Care Consent Act (1996)*. The use of tablets and smartphones facilitated communication but excluded those residents who lacked the necessary understanding, aptitude and senses (hearing and vision).

A review of newspaper reports shows how prolonged isolation affected LTC residents and their family members (see Table 1).

**TABLE 1.** Newspaper reports of the impact of isolation on residents and their family members

Outcome	Source	Comments
Depression and immobility	<i>Toronto Star</i> – July 2020	"In isolation [my dad] got tired of being told to go back into his room so he decided to just stay there. When they tried to get him on his feet again, he would roll over in bed and refuse to speak." <sup>a</sup>
Severe weight loss and unresponsiveness	<i>CBC News</i> – October 2020	"When we first saw her [during a window visit], she was in such terrible condition. She had lost 30 pounds. She was unresponsive." <sup>b</sup>
Distress	<i>Toronto Star</i> – October 2020	"Being alone in one room every day almost made me crazy." <sup>c</sup>
Loss of function and overall strength	<i>The Globe and Mail</i> – August 3, 2020	"After a series of medical crises and isolation stemming from the COVID-19 pandemic, the Toronto-area couple's health has deteriorated so dramatically [that] they need round-the-clock care." <sup>d</sup>

<sup>a</sup> Welsh 2020a.

<sup>b</sup> Roumeliotis and Mancini 2020.

<sup>c</sup> Welsh 2020b.

<sup>d</sup> Mahoney 2020.

These findings were corroborated by the review of key policy documents, specifically the Canadian Armed Forces Joint Task Force (Central) report (CAF JTFC 2020), Ontario's Long-Term Care COVID-19 Commission report (Marrocco et al. 2021) and the Royal Society of Canada policy briefing (Estabrooks et al. 2020). The Joint Task Force recounted egregious incidents of residents "crying for help with staff not responding for 30 minutes to over 2 hours," feeling fearful and abandoned "like they're in jail," being denied adequate nutrition and not receiving "psychosocial support ... [after having] their families taken away" (CAF JTFC 2020: 5, 9, 12). The Long-Term Care Commission noted the "isolation, fear ... [and] sorrow" experienced by LTC residents and the "deteriorating levels of ... care and quality of life visited upon residents" and their families (Marrocco et al. 2021: 239, 312). The Royal Society likewise acknowledged the "high levels of physical, mental and emotional suffering" endured by LTC residents (Estabrooks et al. 2020: 30).

### *Whose rights were violated?*

LTC residents' rights are enshrined in legislation under the Residents' Bill of Rights, *Long-Term Care Homes Act, 2007*. The legislation is clear that the 27 enumerated rights are to be fully respected and promoted. This includes the right to be cared for, the right to fully participate in decision making regarding care, the right to receive visitors and the right to consult with any person without interference.

Directive #3, which excluded family caregivers from homes for lengthy periods and resulted in residents isolated to their rooms even when they were not symptomatic or at risk, was a breach of residents' rights under this legislation. Residents could argue it violated their right to life based on evidence that the loss of supplementary caregiving resulted in a deterioration of their health that was sufficiently connected to an increased risk of death. Residents may further be able to argue that the inability to access their substitute decision maker in person or obtain the support of family caregivers in understanding medical decisions was a deprivation of their right to liberty and security of person. They may also be able to assert that preventing their access to essential caregivers resulted in physical and psychological suffering and harm and permanent damage to their level of independence and functioning.

### *What could have been done differently?*

Studies, newspaper reports and policy documents highlight the consequences of isolation and visitor restrictions. Internationally, researchers have found "lockdown causes risks of cognitive decline, depression, anxiety, frailty and disabilities" for nursing home residents (Pitkälä 2020: 889), while barred "visitors experienced low psychosocial and emotional well-being" (O'Caomh et al. 2020: 2). Researchers in Australia determined "there are risks for those families living with chronic stress and social isolation" due to COVID-19 (Deakin University 2020).

An ethical analysis conducted in the US showed how "the risk of harm secondary to isolation increased over the time that the restrictions remained in effect" (Purvis Lively 2021: 1).

This harm included the heightened potential for adverse events and outcomes such as functional, cognitive and physical decline (National Academies of Sciences, Engineering, and Medicine et al. 2022). In addition to supplementing care, family members monitor for signs of abuse and neglect. An integrative review of the effects of visiting restrictions in various countries concluded:

From a caring perspective, family members can be seen as external partners or an essential and internal part of a patient’s care team. (Hugelius et al. 2021: 8).

According to Coulter and Richards, a “humane approach to visiting policies in hospitals and care homes need not be incompatible with an effective pandemic response” (2020: 1). We contend that such an approach is not only humane but also progressive as it supports collaboration between family members and healthcare staff. Drury et al. (2020) have observed:

In our rush to contain COVID-19, we have both minimized and mischaracterized the essential role family and caregivers of patients with complex needs serve as the backbone of the health system. Without them playing an active role in care, the fact is there will be an unmanageable additional burden on healthcare providers tackling COVID-19.

When family members participate in the provision of care, it frees up staff to focus on other residents. This is particularly important in sectors with understaffing and low surge capacity such as LTC (Andrew-Gee and Stone 2020; Baumann et al. 2006).

It is reasonable to assume that family members understand that care includes various practices to safeguard their loved ones and are used to taking the necessary precautions such as not visiting when feeling ill and appropriately using personal protective equipment. Rather than applying and adhering to blanket policies restricting their access, LTC homes could have provided them with infection prevention and control (IPAC) education and training specific to COVID-19 and permitted visits to continue. The International Long Term Care Policy Network found that allowing “family caregivers [who are] using safe visiting practices does not lead to COVID-19 infections when community transmission levels are low” (Low et al. 2021: 3). In Ontario, it was only late in Wave 1 of the pandemic that one family member per LTC resident was allowed to enter a home under the essential visitor category. One home reportedly counted a paid personal support worker as an essential caregiver thereby reducing the number of family members to visit. Consequently, many homes neglected to tap an important resource early on – one that could have improved outcomes for residents and kept vital connections intact.

### *Cross-provincial approaches*

In contrast to Ontario, LTC homes in other provinces developed and implemented various

successful strategies to maintain in-person family visits. In New Brunswick and Manitoba, multiple homes used family members as volunteers and provided them with advanced IPAC training. In a national webinar on November 29, 2020, it was noted that there was no increase in COVID-19 due to this strategy (Healthcare Excellence Canada 2021). To contain the spread of infection and reduce social isolation, a home in Nova Scotia capitalized on its unique physical design and used a phased approach for on-site family visits. The home features “10 self-contained households with separate entrances and private resident rooms” (Fancey et al. 2021: 15). Family members were provided with information about IPAC and had to demonstrate their understanding of safety protocols and processes related to entering residents’ households. In British Columbia, one home designated physical space as a family visitation centre. Another home hired family caregivers as cleaners to offset a shortage of personnel. Although controversial, this strategy provided family members with access to the home and allowed for family visits at designated times.

## Discussion

This commentary demonstrates that decisions made during the pandemic to isolate LTC residents and restrict visitors not only infringed on residents’ legal rights but also negatively affected individuals and their families. Reports, anecdotal evidence and media coverage confirm that family members were denied access to LTC homes even though they met the definition of *essential* as stipulated in government directives. Visitor restrictions severed critical family ties for residents and invalidated the valuable role that families play, while isolation created unnecessary trauma and despair for residents and their families. Various lawsuits filed by family members focus on the conditions in LTC homes and their responses to COVID-19. The lawsuits allege the homes violated the “charter rights to life, liberty and security of person” (Ontario Health Coalition 2020: 4).

If the overall goal of LTC is “to create long-term care home environments where residents feel at home, are treated with respect, and have the supports and services they need for health and well-being” (Government of Ontario 2011: 1), how does a care home reconcile the risk of virus transmission and the consequences of social isolation? Early in the pandemic, many LTC homes in Ontario had no outbreak yet they still banned all non-essential visitors, including family caregivers. According to news reports, care homes asserted they did what was mandated and what was right given the circumstances and government directives. This underscores a significant issue: Just because something is “legal” does not make it ethical.

Several groups, including the Patient Ombudsman, argued for the continuation of visits with the proviso that the number of caregivers should be limited and essential IPAC measures and necessary oversights should be in place. This perspective was ignored. Furthermore, the decision to create an essential visitor category resulted in confusion and frustration due to the ever-shifting definition of essential visitor through various versions of Directive #3. Overall, it was clear that LTC homes had difficulty understanding and developing policies that met residents’ essential caregiving needs.

The subsequent loss of caregiving conducted by family members included critical interventions such as regular bathing, feeding, mobilization, socialization and emotional support. Documents revealed that isolation led to deprivation, decreased function and deterioration of overall health for many LTC residents. Recognizing the unique role of family caregivers and providing them with IPAC training and education would have allowed them to continue visiting and caring for their loved ones and lessened the demands on LTC staff. Moreover, it would have reduced the dramatic and in some cases irreversible effects of isolation. However, this approach was not considered and family members were not given the option.

The decision to isolate LTC residents was an attempt to protect them from infection, but it was made without regard for the significant toll. As early as the 1950s, psychologist Harry Harlow demonstrated the consequences of prolonged social isolation via a series of controversial experiments using animals (Harlow et al. 1965). At the same time, developmental psychologist John Bowlby was interested in understanding the effect of institutional care on orphaned children. Bowlby identified that separation and deprivation were extremely detrimental to young children and their development (van der Horst and van der Veer 2008). His early works revealed that humans require social and physical interventions and interactions to thrive (Bowlby 1952).

Throughout the 20th century, researchers continued to investigate the effects of isolation on the psychological and physical health of individuals. A more recent application of this research can be found in studies that examined the practice of solitary confinement as a form of extreme punishment. Findings from this literature confirm that isolation “can be as clinically distressing as physical torture” (Metzner and Fellner 2010: 104) and secluded inmates endure a range of “harmful effects that vary in severity as they become progressively more anxious, depressed, irritable, confused, aggressive, and suicidal over time” (Luigi et al. 2020: 2).

Similar effects were observed among LTC residents during the pandemic. As per IPAC measures, they were no longer permitted to walk around the hallways, gather in common areas or dine together. They were also forced to isolate in their rooms. Family visits, which were initially allowed by appointment and only for short periods, were eventually barred altogether. Much like segregated inmates, LTC residents had to “live with extensive surveillance and ... the absence of ordinary social interaction ... or other purposeful activities” (Metzner and Fellner 2010: 104). As of March 2021, many LTC residents had been confined to their rooms or floors and denied the companionship of family members and each other for more than a year (Perkel 2021). As the restrictions not only remained but also became even more oppressive, critics began to question the impact of isolation on residents and if their legal rights were being violated.

It took more than 30 years for residents and patients to obtain rights and only weeks to lose them during the pandemic. Moving forward, caregivers should be recognized as essential members of residents’ care teams and allowed in LTC homes during outbreaks. This would entail providing them with the necessary protective equipment and adequate training to ensure IPAC protocols are maintained. The use of private paid caregivers should also be

included, but they should not replace essential caregivers. There has been much said about COVID-19 creating a “new normal.” However, the abrogation of rights in the LTC sector and the restriction of family visitors should never be accepted as normal.

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### *Note*

1. A comprehensive list of all iterations of Directive #3, with links to each version, can be found here: [http://www.advantageontario.ca/AAO/Content/Resources/Advantage\\_Ontario/COVID-19/Ministry\\_Documents.aspx](http://www.advantageontario.ca/AAO/Content/Resources/Advantage_Ontario/COVID-19/Ministry_Documents.aspx).

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