



# LONG-TERM CARE AND COVID-19

REPORT OF A SPECIAL TASK FORCE PREPARED  
FOR THE CHIEF SCIENCE ADVISOR OF CANADA

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# INTRODUCTION

The COVID-19 pandemic caused by the SARS-CoV-2 virus has disproportionately affected older adults and individuals with pre-existing health conditions who have suffered more severe forms of the disease and poorer outcomes. Those in congregate working or living environments are at higher risk of infection. Consequently, residents of long-term care (LTC) homes have been disproportionately at risk of SARS-CoV2 infection and serious outcomes of COVID-19 including death.

In April 2020, the Chief Science Advisor convened a task force to provide practical advice on limiting infection spread and improving COVID-19 outcomes for residents of LTC homes. The task force included geriatricians, infection prevention and control specialists, and other relevant experts from across the country. Their perspective and findings were informed by the members' practical experience as well as scientific data and analysis. The views of the task force are assembled in this Long-Term Care and COVID-19 report.

The first part of the report was written at the height of the first wave of the COVID-19 pandemic. At the time, the experts identified priority areas for immediate attention together with practical options aimed at ensuring adequate care capacity in LTC homes. They include:

1. *Ensuring sufficient human and physical resources are available for residents care;*
2. *Ensuring staff with the right skills are deployed at the right place and the right time;*
3. *Enhancing support for the LTC sector from local health and hospital systems;*
4. *Enhancing infection prevention training and control for LTC staff.*

Above all, the experts were of the view that LTC facilities are living environments and that a humane and compassionate approach with LTC residents, their families, and the staff who care for them is urgently needed.

While considering short term solutions, the task force recognized that the challenges observed are symptoms of more systemic issues that contribute to the severity and outcomes of the COVID-19 crisis in LTC settings. Experts felt there was a need to better define and ultimately address these systemic LTC issues in order to improve on an ongoing basis the care for vulnerable older adults.

The second part of the report provides the experts' view of the underlying health system factors, which were exacerbated by the COVID-19 crisis but have nonetheless been prevalent for long before the current pandemic. The task force noted that:

1. In the last few decades, little societal priority and strategic attention was put towards LTC in Canada.
2. LTC home residents are highly vulnerable, relatively voiceless, and without strong advocacy.
3. A fragmented continuum of care and heterogeneous operational models make it hard to provide equal and consistent access to necessary services for older adults based on their care needs as they age.
4. LTC sector resources are not at the levels necessary to enable the quality of health and social care required in general, and essential in times of crisis.
5. Built environments often challenge the ability to protect the well-being of older adults, especially those living with dementia.

The experts recognize that their views would benefit from further validation. They welcome the opportunity for a broader national dialogue. The experts also recognize that most of these issues are not new and have been raised in a number of reports and inquiries. It seems that the time is ripe to fundamentally redesign a system that will support a dignified continuum of services to older adults and their families.

By identifying some of the core challenges that older adults face in LTC settings, task force members hope that long-term solutions can be enacted to prevent system failures and enhance the care and well-being of older Canadians.

# TASK FORCE MEMBERSHIP

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## ADDITIONAL MEMBERS THAT HAVE JOINED FOR PART 2

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# PART 1

## ADDRESSING THE UNIQUE CHALLENGES OF COMBATING COVID-19 IN LONG-TERM CARE HOMES

April 19, 2020

*Residents of long-term care homes are disproportionately at risk of SARS-CoV2 infection and serious outcomes of COVID-19 including death. This is due to their underlying health conditions and several health system factors. The Chief Science Advisor convened a task force to provide practical advice on the topic of long-term care homes. The task force, including geriatricians, infection prevention and control specialists, and other relevant experts from across the country, makes a series of proposals which could be implemented in the short term. The task force also recognized that the current challenges are in part the result of systemic issues that should be attentively looked at to increase the resilience of older adults in the face of infections and epidemics. Additional observations on systemic issues are provided in the second part of this report. The first set of conclusions and short term proposals of the task force are provided below.*

## BACKGROUND

- As of April 14, a total of 511 Canadians living in LTC homes have died thus far as a result of COVID-19. Compared to the 903 deaths reported by the Public Health Agency of Canada this corresponds to approximately 57% of all COVID-19 deaths in the country. The vulnerability of LTC residents has been also seen internationally.<sup>1</sup>
- According to the most recent OECD Panorama of Health, Canada has 5.8% of older people in LTC homes.
- LTC residents are vulnerable. The residents are older, frailer, more likely to have complex chronic conditions, and suffer from cognitive decline or dementia. According to 2013 numbers from CIHI – 143,000 residents, 95% require assistance with activities of daily living, 60% have dementia, 70% with heart and circulatory system issues.
- They are at high risk of infection given the unavoidable close contact between staff and residents. In addition, with an aging population and Canada about to be a super-aged society where more than 20% of our population will be aged 65 years of age and older within the next five years, there are capacity issues in the system that is in place to care for them.
- The implementation of infection prevention measures in LTC homes is key to protecting the most vulnerable patients. The task force is very supportive of Public Health Agency of Canada's, Infection Prevention and Control for COVID-19: Interim Guidance

for Long-Term Care Homes<sup>2</sup> (updated April 8 2020). This report provides a complement to implement the guidance in a health system approach.

- From a holistic and health system perspective, infection prevention measures may create systemic challenges or unintended consequences that need to be addressed to ensure their effectiveness in protecting the vulnerable LTC residents.
- A humane and compassionate approach is needed. This report highlights some practical proposals that are part of an overall strategy looking at immediate, and longer-term opportunities to improve the situation and outcome of LTC residents.

## OLDER ADULTS IN LTC HOMES ARE VULNERABLE WHEREVER THEY ARE IN THE SYSTEM

- This document was developed thinking of ways to minimize the impact of COVID-19 outbreaks in LTC homes but should also be considered, as appropriate, for other settings where older people live (e.g. retirement homes). It is well established that the same vulnerabilities affecting older people in LTC exist in other settings.
- LTC residents are vulnerable. We understand that, while smaller LTC homes in urban or in rural and remote areas may present different contexts, similar principles need to be applied throughout to protect LTC residents.

1. <https://ltccovid.org/2020/04/12/mortality-associated-with-covid-19-outbreaks-in-care-homes-early-international-evidence/>

2. <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevent-control-covid-19-long-term-care-homes.html>



## HUMAN RESOURCE SAFETY AND AVAILABILITY

- Human resources in the LTC sector are a critical consideration.
- By nature of the type of their work, staff is at high risk of acquiring COVID-19 infection in the workplace.
- This risk is heightened as LTC homes may not have access to adequate Personal Protective Equipment (PPE) and/or the training to use this equipment properly.
- The number of staff and their skill mix within a LTC home may be insufficient to implement required infection prevention and control measures.
- Employees of LTC homes often work part-time, have low wages and limited sick benefits. This contributes to infection transmission risk in several ways. Staff may feel compelled to work even when they are not well; they may work as part-time employees at multiple care homes; and they may choose not to work if they perceive high personal risk. These factors contribute to ongoing nosocomial infections and outbreaks in multiple care homes, and possibly in the entire health system (e.g. home support workers in the community). They also contribute to staff shortages in times of need.
- Pressure on nursing staff can be alleviated by adding complementary resources such as support for feeding residents, communication facilitators to support communication between residents and their families, or software tools to support virtual care.
- LTC homes often lack access to expertise for making decisions on managing staff and ensuring their safety.

- COVID-19 testing should be performed regularly for all the staff and residents during outbreak situations because symptom-based screening of staff and residents may fail to identify all infections (Kimball et al. 2020). The frequency of testing staff and residents should be guided by local public health recommendations.

## CLINICAL PRACTICE

- Symptoms should not be a sole determinant of testing residents for COVID-19 as atypical symptoms may be present especially in older residents and asymptomatic residents might contribute to COVID-19 transmission.
- Once a home has confirmed a COVID-19 case, all residents should be cared for using recommended personal protective equipment (PPE), with considerations for extended use or reuse of PPE as needed (Kimball et al. 2020).
- If resident isolation is not possible then cohorting should be considered, prudence should be applied in selecting the cohorting arrangements (WHO IPC in LTC 2020).
- Encourage physical distance and social connection as much as feasible, such as by using virtual and technological means. For instance, the World Health Organization suggests to stagger meals to ensure physical distance is maintained between residents. If this is not feasible, it is then suggested to close dining rooms and serve residents individual meals in their rooms. There is anecdotal evidence that eating alone may have adverse effects such as losing weight. Older people, especially in isolation and those with cognitive decline, dementia, and those who are highly care-dependent, may become more anxious, angry, stressed, agitated, and withdrawn during the outbreak or while in isolation (WHO IPC in LTC 2020).

- Infection prevention and control is very different in the context of dementia. The geriatrics community should provide guidance and define how to deal with the ethical issues.
- Medication management must be tailored to address an outbreak. For example, reducing entry into rooms can be accomplished by de-prescribing or reducing the use of unnecessary medications.
- All wandering and impulsive behaviour has meaning. Look for and address underlying causes for the behaviour. LTC residents who wander should be prioritized for behaviour support due to the attendant risk of spread, whether they are tested positive or share space with other residents who may be positive for COVID-19. If possible, consider providing one-to-one support for residents who wander to ensure safety. Consult with the internal and external behaviour support services for additional non-pharmacological and pharmacological supports, e.g. geriatric psychiatry, geriatric medicine. (Reference: COVID-19-BSO-RGP-Wandering-Guidelines-2020-04-14)
- Maintaining essential care (e.g. chronic condition management) will limit the need to transfer residents out of the home.
- It is necessary to update discussions on goals or level of care and advanced directives.
- It is necessary to ensure effective palliative care within all LTC homes.
- Where possible, medical assessments, diagnostic procedures and treatments should occur at the LTC home, rather than transferring to an emergency department or acute care. This reduces exposure of the resident to infection risk and reduces the public health risk if the resident lives in a LTC home with an active outbreak.

## CLINICAL SUPPORT AND LEADERSHIP

- Regional health authorities ensure implementation of cohort planning and separation, staff deployment, setting rules for entry into the facilities, and information flow.
- Medical directors share clinical guidelines and update staff. There is evidence that institutions with a medical director show improved outcomes.
- Within each centre there should be support and troubleshooting functions for clinical care, health care worker safety, and family engagement via virtual means.
- Mental health support should also be considered. For instance, the impact on long-term care workers being exposed to personal risk of infection, having to deal with a high number of deaths, and at the same time being unable to connect with the families of residents is taking a significant toll on their mental health.

## ACCOUNTABILITY

- LTC homes are highly variable in size and management capabilities. There are varying degrees of oversight and application of regulatory standards.
- Care of older adults may occur in other types of facilities (for example, retirement homes) and in private homes with the support of primary care and home care. There are inconsistent processes for ensuring patient needs are matched with capacity. There is inconsistent oversight of these processes. As a result, many of the issues identified for LTC residents apply to older adults in other settings.

- Short-term actions (and recommendations) may be more relevant for the jurisdictional level. Longer-term actions could benefit from attention at the national level, in close collaboration with jurisdictions.

## CONCLUSION AND PROPOSALS

Residents of LTC are disproportionately at risk of infection and serious outcomes including death. This is due to their underlying health conditions and several health system factors. LTC homes are not the only care location with a high proportion of older adults. While we have focused this report on LTC homes, older adults in other living situations should also be considered at risk.

There is an urgent need to address the health system factors in order to improve our ability to provide humane care and to ensure protection of residents. We have identified a series of time-sensitive actions, which could be implemented now.

### Proposals for immediate implementation

Although focused on LTC homes, these proposals could also apply to residential homes that provide similar services to their residents, and to some extent to home care services caring for vulnerable older adults with special care needs.

- 1. Adopt a humane and compassionate approach with LTC residents, their families, and the staff who care for them.** This requires regular communication with families, especially when residents are infected or after they succumb to their illness. It also requires supporting staff who may struggle mentally with the burden of caring for residents and when their own health is at risk.

### Implementation proposals:

- a) Health system leaders must set the tone by emphasizing compassion for LTC residents, families, and healthcare workers.
- b) Regular communication with families must take place to provide current updates on the residents' condition, preferably via virtual means, and credible educational resources on COVID-19 and older adult health should be provided to families (e.g. UBC's Pathways Magazine).<sup>3</sup>
- c) Non-essential visits to LTC homes must be restricted. Social engagement of LTC residents must continue via virtual and technological means.
- d) Programmatic support must be provided for healthcare workers to support mental health.
- e) Resident dignity must be ensured and maintained during life (through symptom management) and after death (by ensuring clear procedures for handling of the deceased).

- 2. Ensure adequate availability of staff to support immediate care needs, including: the right skills mix in the right place at the right time.** This includes staff to accomplish the following:

- a. Basic care – ranging from administrative clerical support, housekeeping, kitchen staff;
- b. Health care – ranging from personal support workers, nurses, advanced practice nurses, primary care physicians, pharmacists, and specialist physicians;

3. [https://view.joomag.com/pathways-issue-4-covid-19-edition/0283338001587141762?short&fbclid=IwAR0sCwuMi0706XD7pZQDv7XxrgSuM5F6LdgJkCQVqgRdoUKgq0jpFIP1\\_LE](https://view.joomag.com/pathways-issue-4-covid-19-edition/0283338001587141762?short&fbclid=IwAR0sCwuMi0706XD7pZQDv7XxrgSuM5F6LdgJkCQVqgRdoUKgq0jpFIP1_LE)

- c. Leadership, advice, and staff to ensure application and oversight of resident care and infection prevention and control practices.

#### **Implementation proposals:**

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- a) Regional health systems should consider taking over staffing for all LTC homes during the outbreak, if possible.
- b) Staff should be restricted to working in a single LTC home whenever feasible to reduce the risk of cross-infection. The issue of staff wages and benefits during COVID-19, especially those who used to work on a part-time basis, should be addressed.
- c) Regional health authorities should adopt measures to move health workers from hospitals to LTC as part of an overall strategy of crisis management during COVID-19.
- d) Hospital-based infection prevention and control programs and Public Health Departments should take a consolidated approach to ensure consistent support of LTC homes.
- e) The credentialing of personal support workers, and on-boarding of eligible and qualified nursing or other health professionals should be fast tracked so that they can become available to LTC homes.

### **3. Ensure sufficient resources required to safely care for residents within LTC homes, including:**

- a. Personal protective equipment and training on how to make effective use of it;

- b. Diagnostic tests:

- i. COVID-19 testing for LTC staff and residents at a frequency defined by the particular conditions in a LTC home. Outbreak situations must be managed with mandatory frequent testing, including asymptomatic staff and residents;
- ii. Laboratory and diagnostic imaging with rapid turnaround (e.g. same day testing and results) to reduce the need for transfer to emergency department or acute care.

- c. Therapies:

- i. Medications (for instance, ensure adequate access to appropriate medications for end of life care, and consider de-prescribing unnecessary medications);
- ii. Oxygen;
- iii. Subcutaneous and IV rehydration;
- iv. Parenteral route of medication administration.

#### **Implementation proposals:**

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- a) There should be a regional approach to resource distribution (including personal protective equipment) with inclusion of LTC homes as a critical consideration.
- b) Training (including refresher courses) of the safe and effective use of personal protective equipment should be made available to LTC staff, such as via open-access, online modular courses.

- c) There should be a regional approach to COVID-19 testing with clear accountability for testing and reporting.
- d) At the regional level, partnerships with emergency departments should be established to provide consultative support to LTC physicians (e.g. goals of care discussion) via telephone or tele-health.
- e) Reporting of data on cases and deaths by sex, age, and LTC setting.

**4. Enhance support and back-up to the LTC sector from health system leaders and hospital providers via:**

- a. Open communication channels with medical directors to identify specific LTC home needs;
- b. Direct connections and access to hospital based providers to support decision making at the LTC home (e.g. goals of care) and to assist with care delivery;
- c. Virtual care technologies to support care in place;
- d. Connect each LTC home to a specific acute care hospitals to create special access within these designated hospitals for consultations and diagnostics to ensure care can be provided in the home where possible and avoid facilitating needed care for these vulnerable patients when interventions are required in the acute care setting;
- e. Ensure access to effective palliative care.

**Implementation proposals:**

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- a) Existing communities of practice, medical associations, or formal agreements should be deployed to ensure the knowledge and experience of medical directors is meaningfully utilized to maximise impact.
- b) An on-call group from hospitals should be created to provide consultation advice to providers in the LTC sector, leveraging expertise of geriatric medicine and geriatric psychiatry where possible. Ensure access to specific expertise to manage goals of care discussions, behavioural issues, and palliative care. This could be supported by new virtual care technologies to facilitate timely advice.
- c) Diagnostic centres specifically for LTC residents within a region should be created, and diagnostic testing should be performed in the LTC homes where possible (e.g. by working with private sector partners).

**5. Ensure appropriate training for LTC staff and support in order to implement the enforcement of relevant COVID-19 pandemic infection prevention and control.** The principles include:

- a. Cohorting of diagnosed residents and residents under investigation;
- b. Staff screening and PPE donning and doffing practices;
- c. Outbreak management;
- d. Documentation of advanced care planning conversations including access to Severe Illness Conversation Guide;
- e. Guidance for supporting residents who wander and require physical isolation (Reference: COVID-19-BSO-RGP-Wandering-Guidelines-2020-04-14).

## Implementation proposals:

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- a) Regional swat teams should be developed to address specific issues based on risk identification. Risk measures should consider specific LTC homes situations, including: number of vacancies, number of COVID-19 infections, and engagement of medical director. High risk LTC homes should be targeted by regional leadership and swat teams should be sent to the LTC home with input from geriatric medicine and geriatric psychiatry where possible to work with local leadership to address gaps.
- b) Provincial and/or regional associations should disseminate advice on practice issues pertinent to COVID-19 – in particular on supporting residents who wander and advanced care planning.
- c) Online modular courses that are open access should be developed in a central repository and made available to LTC staff.

## Longer-term actions

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The factors contributing to inconsistent quality of care and staff safety are not specifically related to the COVID-19 pandemic. Nor are these challenges limited only to LTC settings. There are underlying health system factors, which, though highly visible now, have been prevalent for long before the current outbreak situation. As it is unlikely the pandemic will be resolved in the short-term and to avoid a recurrence of these undesirable outcomes, the task force presents additional observations on these larger systemic factors in part 2 of this report.



## PART 2

### SYSTEMIC LONG-TERM CARE ISSUES REVEALED BY THE COVID-19 PANDEMIC

May 17, 2020

*In the first part of this report, the Long-Term Care (LTC) task force outlined proposals for immediate actions in fighting the COVID-19 pandemic. As part of that first effort, the task force recognized that systemic issues contribute to the severity and outcomes of the COVID-19 crisis. The task force felt there was a need to better define these systemic LTC issues in preparation for a post-crisis national dialogue on LTC within the broader system of care for vulnerable older adults.*

*In this second part, the group of experts from across the country described systemic issues underlying the current challenges. The perspective of these experts is informed by their work in the field, which includes practical experience and academic study. We recognize these views would benefit from further validation; and, we welcome the opportunity for a broader national dialogue.*

## WHY IS IT IMPORTANT TO DEFINE SYSTEMIC ISSUES?

1. Concern that immediate response will have limited impact on the future well-being of LTC home residents.
2. Recognition that there have been challenges facing residents of LTC for decades.
3. A failure to learn from this crisis does a disservice to those currently suffering as a result of systemic issues.

## WHO IS AFFECTED BY THE SYSTEMIC ISSUES OUTLINED IN THE REPORT?

The task force's role was to address the effect of the pandemic on LTC. However, it was noted in our deliberations that a fundamental challenge exists in supporting Canadians in the latter stages of their life irrespective of whether they live in LTC. Specifically, there are similar challenges faced by aging Canadians in settings other than LTC, including care at home and in retirement residences.

The pandemic crisis has exposed major health system inequities, which disproportionately impact older people, and women. Given the aging of the Canadian population, this makes it critical to prioritize improving the system of care provided to older people in their homes, in the community, in other settings, or in long-term care homes.

People with disabilities, irrespective of their age, face similar challenges in LTC homes and assisted living homes. Although this report does not focus on that population, the observed systemic issues may also be relevant to look at from their perspective.

## SYSTEMIC ISSUES

Some of the failures observed during the first wave of the COVID-19 pandemic are symptoms of more systemic issues. Fixing symptoms will not stop the failures from recurring.

Most of these issues are not new and have been raised in a number of reports and inquiries.<sup>4</sup> A key issue facing us is *“why” has so much been examined and reported on and so little done to fundamentally redesign the system or clarify the continuum of services to support older adults and their families?*

Outlining how these systemic issues played in the context of the COVID-19 crisis adds another layer to the problem.

### **1. *In the last few decades, little societal priority and strategic attention was put towards long-term care in Canada.***

In recent years, long-term care did not seem to be a priority for Canadians. Is it ageism? Maybe Canadians are looking away, not wanting to face their own future as older adults. Canada is about to be a super-aged society. More than 20% of our population will be aged 65 years of age and older within the next five years. Yet, very little priority has been given to this sector of our health and social systems, making it vulnerable to the crisis.

There is an important need to consider the way gendered roles, due to their social circumstances, may have contributed to this crisis and how this lens could help inform the solution. The gendered implications relate to both the residents of LTC homes and those who provide the care. For instance, in Ontario where LTC homes are home to more than 73,000 older adults, more than 70% of these residents are women, the average age is 85, and they have multiple medical conditions,

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4. For instance, the recent National Institute on Ageing White paper (2019) *Enabling the Future Provision of Long-Term Care in Canada*.



cognitive and functional impairments, making them a very vulnerable group. The care provided in LTC homes is delivered primarily by personal support workers. This group is almost all women, who do not have full-time positions and receive low pay. Supplementing this care by personal support workers are unpaid family and friend caregivers.

### **In the COVID-19 crisis this resulted in:**

- A disproportionate burden born by vulnerable groups (including older adults) who are characterized by inequities and inequalities due to their social circumstances.
- COVID-19 disproportionately affected and damaged the weakest points of our health and social systems, including long-term care.<sup>5</sup>
  - o Provincial data from around May 1, indicate the number of COVID-19 LTC home deaths (% of total COVID-19 death for the province): B.C. 70 (63%), Alta. 64 (70%), Ont. 590<sup>6</sup> (49%), Que. 1,469 (79%), N.S. 33 (89%). There is concern that these numbers substantially underestimate both the LTC and total deaths associated with COVID-19.
  - o Canada shows the highest proportion of COVID-19 LTC home deaths as a proportion of total number of deaths among 14 compared countries such as Australia, Denmark, France, Germany, Israel, etc. Range goes between Singapore (11%) and Canada (62%).<sup>7</sup>

## **2. Long-term care home residents are highly vulnerable, relatively voiceless, and without strong advocacy.**

LTC home residents need extra safeguards because they are highly vulnerable. This can include enhanced assurances of service quality, including effective responses to crises. There is currently a predominant focus on processes and structures of care rather than outcomes relevant to quality of life (including experience at the end of life). This leads to a regulatory approach that, at times, can be perceived as bureaucratic rather than aligned with the health needs of residents and their families.

This crisis demonstrated a failure to ensure a person-centered, gender sensitive, humane and holistic approach to address physical, psychosocial and spiritual needs of residents. Radically shielding the older adults from contagion may offer increased safety, security and order; but it is not enough. It does not foster dignity, spiritual and social care, and can have unintended undesirable consequences, such as social isolation and loneliness, resulting in negative physical and mental health impact.

### **In the COVID-19 crisis this resulted in:**

- In the LTC homes with a reduced workforce there were difficulties meeting the daily care needs of residents. In the context of an outbreak and reduced workforce, some residents were not fed, toileted, moved or interacted with. They were not cared for physically, psychologically, socially or medically –

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5. Data source: <https://ltccovid.org/wp-content/uploads/2020/05/Mortality-associated-with-COVID-3-May-final-2.pdf>

6. The Ontario number is questioned in the report. There are arguments to the fact that it should be almost double that value.

7. Disclaimer: Due to differences in testing availabilities and policies, and to different approaches to recording deaths, international comparisons are difficult.

some died of dehydration, not socially or cognitively stimulated, alone and afraid.

- Family caregivers could not safely access facilities to support the needs of their loved ones, contribute to their care and well-being as they do in normal times or to be with them even in death (acknowledging that there were variations across jurisdictions).
- People died alone, in many cases no measures were available to give families proper grief rituals.

**3. *A fragmented continuum of care and heterogeneous operational models make it hard to provide equal and consistent access to necessary services for older adults based on their care needs as they age.***

Older adults and their families can struggle to find the formal caregiving support they need to meet their evolving needs. As older adults transition from independence to dependence, their needs may be best met in a variety of settings. Canadians could benefit from a clearer continuum of service aligned with needs. This includes support for their families and other informal caregivers and would address the financial barriers inhibiting certain decisions. Clarifying this continuum with input from residents, families and care partners can foster a more coherent, effective and sustainable system, help set standards of residential, social and health care, and establish appropriate goals, incentives, and regulatory oversight mechanisms for the sector. Publicly available data helps better understand and assess this continuum as well as identify and better support the most vulnerable.

**In the COVID-19 crisis this resulted in:**

- Long-term care homes showed varied degrees of preparedness to face the COVID-19 crisis in terms of both infection prevention and control and clinical management.
- In some homes surveillance to identify and respond to early signs of nosocomial transmission were lacking until the situation was dire and in many instances beyond recovery.
- Some LTC homes found it challenging to obtain information, guidance, and support to quickly react to the threat of the pandemic and to put preventive measures in place including active screening of healthcare workers and visitors, active surveillance and testing of residents, and implementation of masking of all healthcare workers as a means of source control to protect residents.

**4. *Long-term care sector resources are not at the levels necessary to enable the quality of health and social care required in general, and essential in times of crisis.***

The LTC sector does not seem to have the appropriate and sustainable resources to ensure an engaged, appropriately trained, well compensated and resilient workforce consistently throughout the industry. The care provided in LTC homes is delivered primarily by personal support workers who do not have full-time positions and receive low pay. This care is supplemented by personal support workers from unpaid family and friend caregivers. Having the right people with the right skills and the right tools at the right place, can ensure a better integration of social, nursing and medical care on a day-to-day basis. Appropriate staff,

including ancillary staff, is critical to ensure adequate care for people with dementia (~80% in LTC have dementia), frailty, chronic diseases and recurrent medical problems – as well as, to meet their complex emotional and social needs. This capacity becomes essential to ensure quality of care and quality of life in normal times and to prevent tragic, often fatal outcomes in times of crisis.

LTC homes do not all have the same connection to the broader health care system that can enable a more direct access to the IPC expertise, needed staff, availability of testing and PPE required to create a safe environment to deal with a novel and complex threat. SARS-CoV2 is not like other viruses: there was absolutely zero immunity, a long incubation period, asymptomatic transmission, etc.

#### **In the COVID-19 crisis this resulted in:**

- Infection prevention and control was implemented poorly in some homes due to deficits in leadership, proper training and resources compared to acute care hospitals.
- Widespread transmission of COVID-19 among both residents and healthcare workers due to gaps in basic infection prevention practices including hand hygiene, proper use of personal protective equipment and environmental cleaning.
- Employees unwittingly propagated COVID-19 across organizations due to poor infection prevention and control practices, and incentives (necessity and remuneration practices) to work for multiple organizations.
- Employees inadvertently became a source of transmission within homes in a number of ways: poorly followed healthy

workplace policy, no active screening and testing was available while many COVID-19-positive employees were working and transmitting to residents in the context of poor hand hygiene and misuse of personal protective equipment.

- Homes in outbreak had large numbers of staff also at home either due to positive COVID-19 or isolating due to exposure to contain further spread – once you lose a certain % of staff it becomes difficult to fill the shifts.
- Movement of residents in and out of LTC homes to access medical services in hospitals and clinics created additional risks and confusion.
- Scarcity of supplies including swabs for testing, personal protective equipment, other medical equipment and some medications.
- Several provinces or regional health authorities had to centralize HR and personal protection equipment administration. In some jurisdictions, acute care hospitals were asked to support LTC homes to provide testing, equipment, and outbreak management.

#### **5. *Built environment often challenges the ability to protect the well-being of older adults, especially those living with dementia***

In architecture, the form of the built environment is selected to fit certain functions. In LTC homes, the form of the built environment proved challenging to protecting residents from the propagation of infections. Facility structural guidelines and regulations about shared rooms, bathrooms, etc. can have a significant impact on the ability to fight transmittable diseases.

### In the COVID-19 crisis this resulted in:

- Multiple people per room and shared washrooms made mitigating spread and cohorting of infected LTC residents more difficult.
- Lack of spaces to segregate wandering LTC residents and coordinated approaches to provide care for residents with dementia and wandering behaviours even when symptomatic

with COVID-19 leading to increased exposures between residents.

- Presence of wood railings, carpets and cluttered spaces that are challenging to clean and conducive to contamination of the high-touch surfaces, particularly when many residents have dementia and behavioral and psychological symptoms of dementia (e.g. wandering) that may contribute to contamination.

## USEFUL LINKS

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- o National Institute on Ageing. (2019). Enabling the Future Provision of Long-Term Care in Canada. Toronto, ON: National Institute on Ageing White Paper. <https://static1.squarespace.com/static/5c2fa7b03917eed9b5a436d8/t/5d9de15a38dca21e46009548/1570627931078/Enabling+the+Future+Provision+of+Long-Term+Care+in+Canada.pdf>
- o Public Health Agency of Canada, Infection Prevention and Control for COVID-19: Interim Guidance for Long-Term Care Homes (updated April 8 2020). <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevent-control-covid-19-long-term-care-homes.html>
- o Regional geriatric program of Toronto (RGPT), Guidance for supporting clients who wander and require physical isolation, <https://www.rgptoronto.ca/wp-content/uploads/2020/04/FINAL-COVID-19-BSO-RGP-Wandering-Guidelines-2020-04-14-1.pdf>
- o World Health Organization. Infection prevention and control guidance for long-term care facilities in the context of COVID-19: interim guidance. Full document available from: [https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC\\_long\\_term\\_care-2020.1-eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf)

# APPENDIX A – OPTIONS OF ACTIONS TO DEAL WITH SYSTEMIC ISSUES

The task force mandate was to identify systemic issues, not to formulate specific recommendations on how to address them. These issues are complex, often interrelated, and addressing them would require national dialogue and context-specific solutions. Through the first report, discussions, and written exchanges some ideas have been raised that are summarized below for consideration.

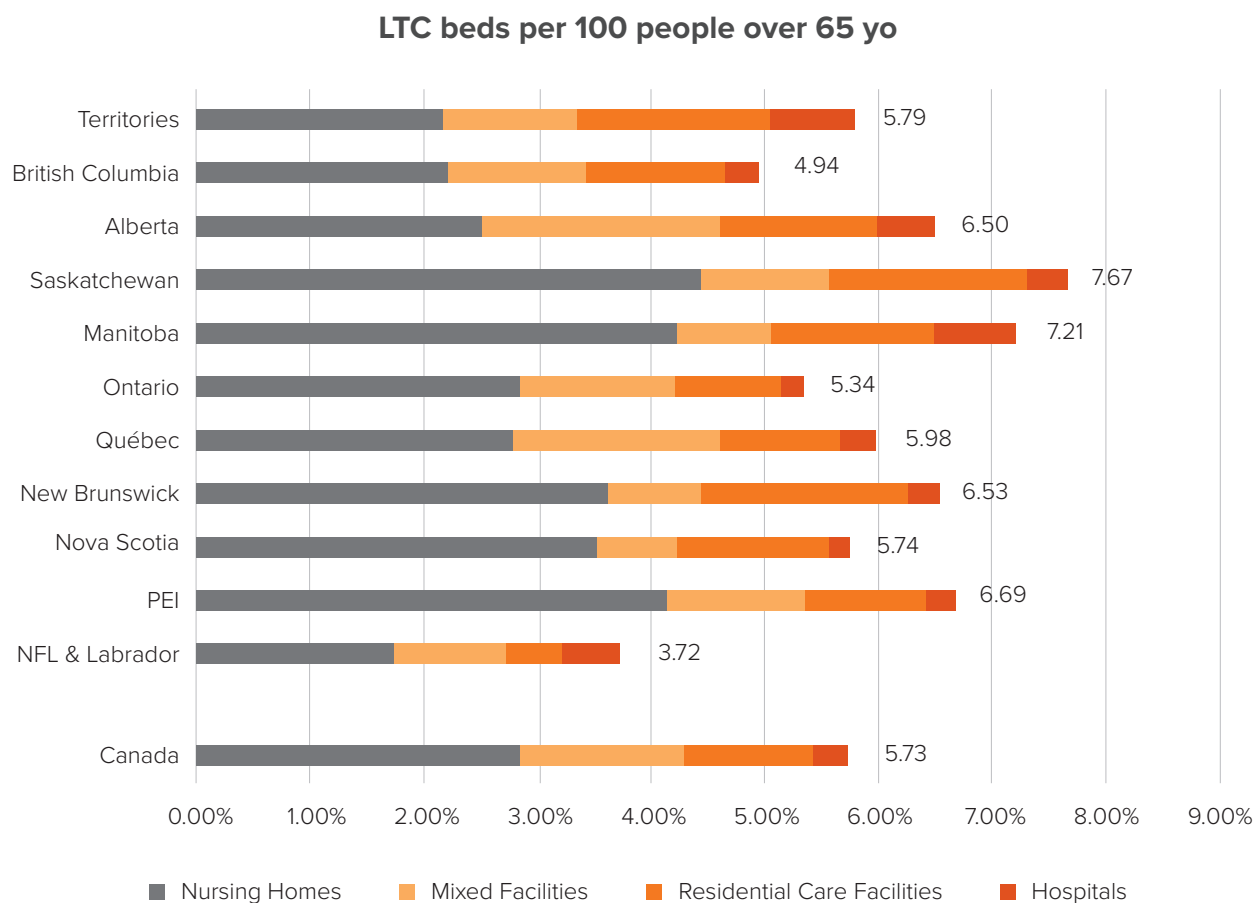
SYSTEMIC ISSUE	OPTIONS
<p>1- In the last few decades, little societal priority and strategic attention was put towards long-term care in Canada.</p>	<ul style="list-style-type: none"> <li>• Use this crisis to make the point: Policy development could be supported by an “inquiry” into the health system gaps identified during the COVID-19 pandemic.</li> <li>• Create a national agenda (long-term plan) for older adults care, including long-term care, with tracking mechanisms. Report data by setting of care (separating out LTC) sex and age to help us better understand who are most vulnerable, to understand the role that gender related social circumstances may play, and use this information to inform interventions and resource allocation.</li> </ul> <p><u>Outside the box:</u></p> <ul style="list-style-type: none"> <li>• Launch a national campaign to fight ageism (perceived and non-perceived) and foster collaborative discussions about healthy ageing.</li> <li>• Deal with the psychological blockage that limits us from looking this issue straight in the eyes.</li> </ul>
<p>2- Long-term care home residents are highly vulnerable, relatively voiceless, and without strong advocacy.</p>	<ul style="list-style-type: none"> <li>• Create a national long-term care strategy that emphasizes person-centered, humane and holistic care to address the physical, psychosocial and spiritual needs of older adults.</li> </ul> <p><u>Outside the box:</u></p> <ul style="list-style-type: none"> <li>• Develop an older adults bill of rights (e.g. <a href="https://policyoptions.irpp.org/magazines/march-2017/protecting-the-rights-of-older-persons/">https://policyoptions.irpp.org/magazines/march-2017/protecting-the-rights-of-older-persons/</a>)</li> <li>• Create older adults protection services.</li> </ul>

SYSTEMIC ISSUE	OPTIONS
<p>3- A fragmented continuum of care and heterogeneous operational models make it hard to provide equal and consistent access to necessary services for older adults based on their care needs as they age.</p>	<ul style="list-style-type: none"> <li>• Create a policy framework to guide the development of standards for the structures, processes, and outcomes of care for older adults in a variety of settings including in community homes, in retirement homes, and in LTC homes. <ul style="list-style-type: none"> <li>◦ This policy framework should focus on fostering the conditions for aging in place, that is, having people in the right care setting for their needs.</li> </ul> </li> <li>• Promote healthy aging at the national level ensuring the Government's investments in home care, palliative care and community care are well coordinated and are having the intended impact.</li> <li>• Cover LTC and related components in the care continuum, including home care and support for informal caregivers, in the Canada Health Act.</li> <li>• Develop and implement new national care standards which align service providers and sectors at a local and regional level with the needs of older adults.</li> <li>• Adopt a national standard nomenclature describing care locations and services.</li> <li>• Establish local governance structures that oversee implementation of national recommendations using a quality improvement approach.</li> <li>• Align with broader sector including acute care, primary care, home care, and public health.</li> <li>• Define a national approach to ensure alignment and consistency between private and public sector providers.</li> <li>• Conduct a comprehensive assessment of support for family/friend caregivers.</li> <li>• Establish a national process to support transitions from independent living without support to in home support with home care, to other forms of congregant living such as retirement homes, to LTC. In addition to defining clear criteria to guide decision-making during such transitions, it is necessary to look at the financial barriers inhibiting decisions to remain at home. This includes lost wages for informal care givers and lack of access to underfunded programs (i.e. in which demand outstrips capacity).</li> </ul> <p><u>Outside the box:</u></p> <ul style="list-style-type: none"> <li>• Hold a dialogue on the future of getting old (e.g. <a href="https://www.wired.com/brandlab/2018/04/the-future-of-getting-old/">https://www.wired.com/brandlab/2018/04/the-future-of-getting-old/</a>)</li> <li>• Launch a technology development moonshot effort to support older adults care.</li> </ul>

SYSTEMIC ISSUE	OPTIONS
<p>4- Long-term care sector resources are not at the levels necessary to enable the quality of health and social care required in general, and essential in times of crisis.</p>	<p><b>Funding</b></p> <ul style="list-style-type: none"> <li>• Develop and implement new ways of funding LTC like the LTC Public Insurance Schemes implemented in many European and Asian countries.</li> <li>• Separate budget envelop from hospitals.</li> </ul> <p><b>Human and material resources</b></p> <ul style="list-style-type: none"> <li>• Consider coordinated or centralized model of health human resource management at a regional level.</li> <li>• Develop policies to address compensation and benefits inequity with other organizations within health sector.</li> <li>• Consider models to enable coordinated or central distribution of PPE.</li> <li>• Align needs with centralized healthcare supply chain management.</li> </ul> <p><b>Care</b></p> <ul style="list-style-type: none"> <li>• Clarify role of medical director in LTC and train/accredit accordingly.</li> <li>• Develop best practices for medication management, advanced care planning, hydration and nutrition oversight with associated compliance tests.</li> <li>• Determine optimal methods to support care providers and families through the use of virtual care capabilities.</li> <li>• Improve person-centered care by improving access to appropriate support (e.g., family medicine, internal medicine, psychiatry, palliative care, etc.).</li> </ul>
<p>5- Built environment often challenges the ability to protect the well-being of older adults, especially those living with dementia.</p>	<ul style="list-style-type: none"> <li>• Develop and implement restrictions on maximum number of residents per room, moving to a single resident per room model.</li> <li>• Develop and implement standards for shared spaces.</li> <li>• Reflect older adults' housing needs in the National Housing Strategy.</li> </ul> <p><b><u>Outside of the box:</u></b></p> <ul style="list-style-type: none"> <li>• Hold an architecture competition.</li> </ul>

# APPENDIX B – BACKGROUND

(source : Réjean Hébert, École de santé publique, Université de Montréal – Special compilation of Statistics Canada 2016 Survey data)



Where the four categories are defined as:

**Hospitals:** facilities providing active medical treatment (general and specialized).

The following three are residential care facilities: Stats Can definition – They include all residential facilities in Canada with four or more beds providing counselling, custodial, supervisory, personal, basic nursing and/or full nursing care to at least one resident. Excluded are those facilities providing active medical treatment (general and allied special hospitals).

**Nursing homes:** where residents have access to 24-hour nursing care.

**Mixed facilities:** basic nursing and/or full nursing care to at least one resident.

**Other residential care facilities:** residential facilities excluding facilities providing basic nursing and/or full nursing care to at least one resident.



# LTC IN CANADA – A PRE-PANDEMIC STATUS FACT SHEET (CARE PROVIDERS & CARE RECIPIENTS)

(for Health Canada Expert Panel)

Source: Carole Estabrooks, Faculty of Nursing,  
University of Alberta

COVID-19 did not cause the crisis in long-term care (LTC) in Canada. It revealed deep fault lines that already existed. This fact sheet highlights some of what Translating Research in Elder Care (TREC) has learned over the past 14 years on **Care Providers and Care Recipients** in LTC. Each fact has a supporting body of research and literature, however for brevity references are not included. TREC has routinely collected data from over 90 nursing homes in B.C., Alberta, Saskatchewan and Manitoba. Its knowledge base has also been informed by research collaborations in Ontario, the Atlantic region and internationally.

## Care Providers

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Care provision is primarily provided by a vulnerable group consisting of mostly older, racialized women who have little formal training and manage high workloads with frequent interruptions.

### *Regulated*

- There are significant jurisdictional differences regarding the number and mix of regulated care professionals required in nursing homes.
- Family physician care models vary widely by jurisdiction and owner, from a resident's prior family physician, to a single or small group of physicians per site, to almost no physician involvement ("medical care by fax") or combination of same. In some provinces NP's play a larger role.
- Registered Nurses (RN's) are required through legislation in most provinces but not all, and the number is not based on resident needs. In some cases, only one

per facility is required, regardless of the facility size. In some jurisdictions they do not have to be on site 24/7, rather may be on call particularly on shift (evenings, nights).

- Licensed Practical Nurses often supervise the Care Aides/Personal Support Workers, however again there is significant variability across the country. Some regions have moved as an efficiency strategy to almost all LPN models.

### *Unregulated Care Aides*

- Also called personal support workers, health care aides, nurse aides, nursing assistants, continuing care assistants.
- No national training standard.
  - o Limited formal education required ranging from; high school diploma plus a range of 6 week to 6-month to 8-month certificate training. Some include placements.
- With nobody to monitor the labour supply, solid data is unavailable on the national supply (e.g., difficult to tease out of StatsCan reporting).
  - o Some provinces have registries (B.C. – mandatory for region owned and operated sites, N.S. – voluntary with limited take-up).
  - o Pay range approximately \$13 to \$24 per hour and can be lower in non-unionized settings; often part-time without benefits. In Atlantic Canada the pay range is \$13-18.
  - o Upwards of 30% in some provinces work in more than one facility (to create a full-time job) (pre-pandemic).

- Over 90% are women (or 9 out of 10).
- In the Canadian western provinces.
  - Majority (67%) are over 40 years of age.
  - 61% speak English as a second language in urban areas.
  - Most have worked more than 10 years as a care aide.
  - They experience a higher level of burnout and mental health issues than the general population or regulated RNs and LPNs.
  - They experience high injury rates due to the physical demands of the job.
  - 57% report being unable to complete necessary work on a shift, leaving at least one essential undone at the end of their shift.
  - Most frequent missed care – walking, talking, oral care.
- Have poorer mental and physical health than non-care providing counterparts.
  - Higher rates of cardiovascular disease.
  - Higher rates of depression and stress disorders.

### Care Recipients (Residents)

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Residents living in LTC can be characterized as an invisible, voiceless population whose multiple and intersecting vulnerabilities are rarely if ever accounted for and currently not measured or assessed.

- Over ~250,000 people are living in LTC in Canada, over 225,000 of them are over 65.
  - In western Canada most residents are over 85 years of age.
- Average length of stay is 18 months, shorter in provinces with aggressive aging in place policies (although home and community supports lag behind need significantly).
  - Calgary 15 months; Edmonton 12 month, Winnipeg 2.4 years, N.S. 30 months (LOS measured at different points in time in locations over last 4 years), e.g. Calgary 2015, N.S. 2019.
  - Over 90% die in a nursing home, remainder die in hospital after transfer from LTC.
- Over two thirds are women.
- As many as 80% or more have some degree of cognitive impairment (under detected in routinely collected data – that is collected in most but not all provinces and territories).
- Experience increasingly complex needs as they approach end of life (EoL).
  - 80% require assistance with most if not all *activities of daily living*.

### Unpaid Family Caregivers

- Over 75% are women globally.
- 28% of Canadian provided care to persons needing assistance - about 60% of these caregivers are women.
- Provide approximately 70-80% of direct home and community care services, an unpaid contribution valued at \$375 billion US dollars annually. In 2007 in Canada this was estimated to be between \$17-31 billion.
- Women provide more personal care (bathing, toileting, feeding) that is time consuming and more stressful.
- Moving a close family member to LTC does not reduce family caregiver burden, especially for women.
- Experience under-employment, precarious employment, lower incomes; may withdraw from workforce.

- o 30% meet criteria for marked frailty.
- o High levels of severe co-morbidities and dependency (both medical and social).
- o ~70% are in wheelchairs (most are ambulatory on admission); this is in comparison, for example, to some Scandinavian and European NH settings with much lower rates of immobility even closer to death.
- o End of life symptoms often inadequately managed.
- Over 4% are "unbefriended" (no friend or family support of any kind) and are placed under public guardianship.
  - o Tend to be clustered in larger urban, public not-for-profit facilities.
  - o Have no family living, able or willing, some family live at great distances or may be estranged.
  - o Histories of homelessness, mental illness and substance abuse.
    - are highly vulnerable to poorer quality of care and lower quality of life;
    - suffer higher levels of loneliness and social isolation;
    - at higher risk of hospitalization especially nearing EoL.
- Quality of Life (QoL) is residents' primary goal.
  - o Quality of care is a necessary, but highly insufficient condition for quality of life.
  - o No jurisdiction in the world (of which we are aware) routinely measures QoL with a tool validated for persons with dementia.
  - o Alberta is planning (stalled by pandemic) implementation of a dementia specific QoL.
  - o A review of regulatory policy in four provinces identified safety and security as the most common aspect of QoL discussed despite a strong emphasis on person-centred care.