EXECUTIVE SUMMARY

Restoring Trust:

COVID-19 and The Future of Long-Term Care

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An RSC Policy Briefing

RSC SRC

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Executive Summary

Why do we need urgent action to reform and redesign long-term care in Canada?

For 50 years, Canada and many other countries have generated inquiries, panels, task forces, commissioned reports, media reporting and clarion calls for action to reform conditions in nursing homes and create a higher standard of care. We have ample sound evidence produced by social and health scientists globally on how to achieve this.

But Canada is experiencing a far higher proportion of total country COVID-19 deaths in nursing homes than other comparable countries—81% in Canada, compared to 28% in Australia, 31% in the US and 66% in Spain, based on current reports.[1] Many of those older Canadians in nursing homes are dying without family, anxious and afraid, surrounded by people in frightening protective equipment. Why?

Our long-term care sector, particularly nursing homes, is in crisis now from far more than COVID-19. The pandemic just exposed long-standing, wide-spread and pervasive deficiencies in the sector. These deep operational cracks arise from *failures in:*

- addressing the consequences of well-known population trends in aging, dementia and caregiving by family members
- listening to the voices of our older adults, especially those living with dementia and their families
- acknowledging profound inequities faced by older Canadians, foremost among them poverty
- maintaining adequate levels of properly oriented dietary, laundry and housekeeping staff, and recognizing their roles in creating a quality environment
- developing and supporting management and leadership on the ground
- building and supporting resilience of the long-term care workforce
- listening to the voices of the workers at the point of direct care
- establishing standards for appropriate levels of regulated health workers
- adequately educating, regulating and supporting the unregulated care workers who provide upwards of 90% of direct care

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[1] Canadian Institute for Health Information. "New analysis paints international picture of COVID-19's long-term care impacts": CIHI; June 25, 2020. Available from: http://emktg.cihi.ca/ViewEmail.aspx?em_key=08jafBPP2lXCQzTRLz6rSCxyfUk+dfkDpRY-QwdGchCoOfLXGIWW6Y6UWEMHRnIQqp03BjiwW7pQ5bqfdhCmHXL3vARe3YTEE&em_source=html

- regulating the sector in a balanced, whole systems way
- using data to act on improving the sector and evaluating results
- collecting, verifying and analyzing crucial data to manage the sector
- financing a sturdy long-term care sector

Canada's long-term care (LTC) sector, pre-pandemic

Canada's LTC sector has its roots in the Elizabethan Poor Law of 1601, not in the healthcare system. Provincial and territorial plans are disparate and piece-meal. The Canada Health Act does not protect or ensure universal LTC. Today, the characteristics *before* the pandemic of the people living in nursing homes, the workforce that looks after them, and the physical environment that surrounds them are all key contributors to Canada's long-term care crisis.

Canada's older adults are entering nursing homes later in life. As Canada ages and older adults live longer, we have worked toward more capacity for those people to age in community. At the same time, prevalence of chronic diseases—foremost dementia—and the social challenges of living into one's 80s, 90s and 100's have increased. The consequence is that residents enter nursing homes—commonly their final home—with much more complex and higher social and medical needs. This has dramatically raised the complexity of care that nursing homes are faced with providing, even compared to the care required a decade ago.

The workforce mix in Canada's nursing homes has changed, but has not evolved to align with the needs of older adults who need complex health and social care. Hands-on care is now almost entirely given by unregulated workers—care aides and personal support workers. They receive the lowest wages in the healthcare sector, are given variable and minimal formal training in LTC, and are rarely part of decision-making about care for residents. Studies have shown that they often have insufficient time to complete essential care and are at high risk for burnout and injury. Despite these severe challenges, most report feeling that their work has meaning.

Over the past two decades, ratios of regulated nurses to care aides have dropped steadily to contain costs and in the belief that richer staffing mixes were not required. Canadians in nursing homes may also have little access to comprehensive care including medical, health and social services and therapies. Such comprehensive care requires staffing and resources such as physicians, mental health care, palliative resources, physical therapists, occupational therapists, speech/language therapists, recreation therapists, dieticians, pharmacists, pastoral care, psychologists, and social workers.

Canadians in nursing homes may also have little access to uninsured services such as podiatry, dental, hearing and vision care. In some cases residents must pay for specific medications. Residents with family and friends close at hand may be able to rely on them to help fill some of these gaps in services. However, fewer and fewer of these unpaid caregivers are available due to continuing changes in family size and geographic distance.

Finally, ***many nursing homes in Canada are old and not designed for the complex needs of today's residents***—or for containing or preventing the communicable disease now sweeping through them. When infections such as COVID-19 arrive, too often quality of life and quality of care must take second place to handle the surge. Today's paradigm of nursing homes as a public social place, inviting in the community, has clashed sharply with nursing homes as a safe space for residents and staff under COVID-19.

A preferred future for the LTC sector in Canada

In this Policy Briefing Report commissioned by the Royal Society of Canada, we describe a preferred future for the LTC sector in Canada, with a specific focus on COVID-19 and the LTC workforce. Nursing homes are an essential part of our social and health system. *For the many older Canadians who will need this high level of care, a nursing home is a good choice* ***if we do it right***. However, in nursing homes we must be able to consistently deliver high-quality and holistic care and support a good quality of life, a good end of life and a good death. Canadians expect no less. Canada certainly has the capacity and knowledge to achieve this goal.

Our key message looking ahead: Solve the workforce crisis in LTC

As a first step, and *if we do nothing else right now, we must solve the workforce crisis in LTC*. It is *the* pivotal challenge. Workforce reform and redesign will result in immediate benefit to older Canadians living in nursing homes and is necessary for sustained change. It will also improve, at a minimum, quality of care so that nursing homes are able to reduce unnecessary transfers to hospitals, reduce workforce injury claims, and interface more effectively with home and community care.

Solving the LTC workforce crisis is intimately linked with securing robust and sustainable funding and strong governance for LTC going forward. New federal and provincial dollars are urgently needed to tackle the LTC workforce crisis so that we can face and manage COVID-19 pandemic conditions and improve quality of care, quality of life and quality of end of life for people living in nursing homes.

We recommend 9 steps to solving the workforce crisis in nursing homes, all of which require strong and coordinated leadership at the federal and provincial/territorial levels to implement.

1. The federal government must immediately commission and act on a comprehensive, pan-Canadian, data-based assessment of national standards for necessary staffing and staffing mix in nursing homes. National standards must encompass the care team that is needed to deliver quality care and should be achieved by tying new federal dollars to those national standards.
2. The federal government must establish and implement national standards for nursing homes that ensure (a) training and resources for infectious disease control, including optimal use of personal protective equipment and (b) protocols for expanding staff and restricting visitors during outbreaks.
3. The provincial and territorial governments, with the support of new funding from the federal government, must immediately implement appropriate pay and benefits, including sick leave, for the large and critical unregulated workforce of direct care aides and personal support workers. Appropriate pay and benefits must be permanent and not limited to the timespan of COVID-19. Pay and benefits must be equitable across the country and equitable both across the LTC sector and between the LTC and acute care sectors for regulated and unregulated staff.
4. Provincial and territorial governments must make available full-time employment with benefits to all unregulated staff and regulated nursing staff. They should also evaluate the impact on nursing homes of "one workplace" policies now in effect in many nursing

homes and the further impact on adequate care in other LTC setting such as retirement homes, hospitals and home care. Provincial and territorial governments must assess the mechanisms of infection spread from multi-site work practices and implement a robust tracking system.

5. Provincial and territorial governments must establish and implement (a) minimum education standards for the unregulated direct care workforce in nursing homes, (b) continuing education for both the unregulated and regulated direct care workforce in nursing homes and (c) proper training and orientation for anyone assigned to work at nursing homes through external, private staffing agencies.
6. To achieve these education and training objectives, provincial and territorial governments must support educational reforms for specializations in LTC for all providers of direct care in nursing homes, care aides, health and social care professionals, managers and directors of care.
7. Provincial and territorial governments, with the support of federal funds, must provide mental health supports for all nursing home staff. In addition to extraordinarily stressful pandemic working conditions, these staff are experiencing significant deaths among the older adults they have known for months and years, and among colleagues. They are grieving now, and this will continue.
8. Federal support of the LTC sector must be tied to requirements for data collection in all appropriate spheres that are needed to effectively manage and support nursing homes and their staff. Data collected must include resident quality of care, resident quality of life, resident and family experiences, and quality of work life for staff. Data must be collected using validated, appropriate tools, such as tools suitable for residents with moderate to severe dementia. Captured data must address disparities and compounding vulnerabilities among both residents and staff, such as race, ethnicity, language, gender identity, guardianship status, socioeconomic status, religion, physical or intellectual disability status, and trauma history screening.
9. Data collection must be transparent and at arm's length from the LTC sector and governments. Provincial and territorial governments must evaluate and use data to appropriately revisit regulation and accreditation in nursing homes. They must take an evidence-based and balanced approach to mandatory accreditation, as well as to regulation and inspection of nursing homes. They must engage the LTC sector in this process, particularly the people receiving care, their families, managers and care providers.

Canada's choice

Canadian nursing homes have generally been able to "just manage." However, just managing is not adequate. Then came COVID-19, a shock wave that cracked wide all the fractures in our nursing home system. It precipitated, in the worst circumstances, high levels of physical, mental and emotional suffering for our older adults. Those lives lost unnecessarily had value. Those older adults deserved a good closing phase of their lives and a good death. We failed them. We have a ***duty to care*** and to fix this—not just to fix the current communicable disease crisis, but to fix the sector that enabled that crisis to wreak such avoidable and tragic havoc. We have the capacity, the knowledge and the resources to take immediate steps toward restoring the trust we have broken.

This is our choice.