



COVID-19
Long-term Care Review

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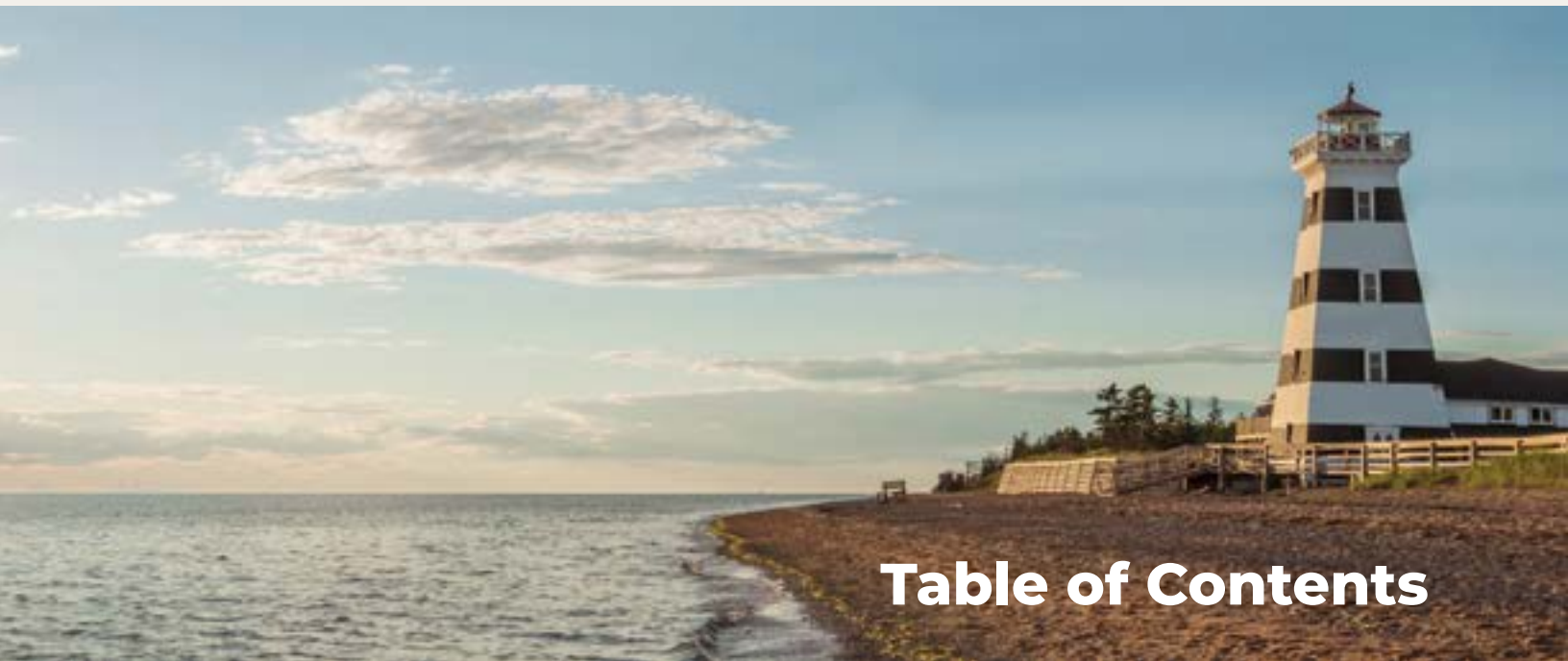


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List of acronyms

| | |
|----------------------|----------------------------------------------------------------|
| CSA | Canadian Standards Association |
| COVID-19 | Coronavirus disease 2019 |
| CPHO | Chief Public Health Office |
| HSO | Health Standards Organization |
| IPAC | Infection Prevention and Control |
| InterRAI LTCF | Inter Resident Assessment Instrument Long-term Care Facilities |
| LTC | Long-term Care |
| PIC | Partners in Care |
| PPE | Personal Protective Equipment |
| PEI | Prince Edward Island |

Recognizing that some readers of this report may not be familiar with certain terminology, we provide Appendix 1 with “key definitions”.

Executive Summary

The Government of Prince Edward Island appointed the Long-term Care COVID-19 External Review Panel to conduct a review and provide a report of findings and recommendations on measures taken to prevent and contain the spread of COVID-19 in long-term care (LTC) homes. We were further directed to comment on the pandemic impact of existing physical infrastructure, staffing approaches, clinical oversight and other features of the LTC system. Specifically, we were asked to assess the impact of these factors on the prevention and spread of COVID-19 in LTC homes.

We acknowledge with thanks the significant contributions made from many to inform us in this work. Recommendations set out herein are designed to prioritize resident quality of life and ensure a more durable capacity to provide high quality resident-centred care during an infectious disease event or a pandemic. Without exception, the overwhelming concern expressed by all parties involved in LTC was resident well-being and quality of life. There was universal recognition that the system's capacity to provide safe and effective care was compromised during the pandemic and was particularly impacted during the first six months when the virus was deadly and there was no vaccine. There was also general concern that the LTC system was deficient in several areas prior to the pandemic, which worsened the impact of COVID-19.

Through surveys, interviews, stakeholder meetings, and document reviews, we identified several challenges and issues that influenced the pandemic

response and the outcomes experienced by residents, partners in care, and staff of LTC homes. Some of these issues are specific to the pandemic while others represent long-standing challenges for LTC homes.

Pre-existing conditions that exacerbated the effects of the pandemic included:

- LTC homes were not sufficiently prepared for a pandemic
- Public and private LTC homes in the Province operate differently, resulting in multiple inconsistencies and inequities, e.g., in resource availability, resident and family access to services, gaps in wages and benefits for staff
- Staffing levels had not kept pace with the increased complexities of today's resident population
- Neither LTC homes nor the system had sufficient data with which to manage the system or a major event such as a pandemic

Pandemic specific challenges:

- Resident-centred care quality deteriorated
- Facility lockdowns intensified resident isolation and had a negative impact on resident health quality of life and that of their family or partners in care
- Staffing was insufficient to balance the demands of the pandemic with resident care
- Restrictions on staff mobility between workplaces negatively affected the ability of operators to adequately staff their homes
- High levels of stress and burnout had a negative effect on workers and resulted in workers leaving LTC.

Implementation of our recommendations will significantly improve care for LTC residents during any future pandemic. We focus on four areas directly related to the pandemic experience:

1. enhancing resident-centred care
2. strengthening infection prevention and control
3. workforce recovery and development
4. improving the long-term resiliency of PEI's LTC system (oversight and accountability).

We support the implementation of the new national standards for LTC. The recommendations in this report complement the national standards, and taken together, offer solutions to addressing challenges facing the LTC sector. We encourage government to establish a process for monitoring the progress on implementing the recommendations in this report, including the national standards.



Recommendations

Below are our main recommendations. The analysis sections of the report include additional actions that support the recommendations. Appendix 2 contains the full list of recommendations, additional actions, and links to relevant national long-term care standards.

I. Resident-centred Care

- 1A Uphold residents' rights and responsibilities.
- 1B Ensure that resident-centred care is always sustained.
- 1C Enhance health care directive/substitute decision-making provisions to ensure resident wishes are known.

II. Workforce Recovery, Recruitment, and Development

- 2A Stabilize LTC health human resources.
- 2B Invest in an evidence-based staff (all levels) recovery plan to support recovery and to promote a positive work environment that supports staff health and well-being.
- 2C Align both public and private sectors to a common care staff model in accordance with resident care requirements and consideration of minimum qualifications, recruitment, retention and financial implications.
- 2D Ensure consistent education and advanced nursing practice resources are available in all LTC homes.
- 2E Increase quality and risk management capacity in the sector (i.e., data collection, care processes, and human resources).

III. Strengthening Infection Prevention and Control

- 3A Strengthen and align infection prevention and control capacity across the LTC sector (public and private homes).
- 3B Update and strengthen business continuity plans to include pandemic protocols that address staffing shortages and resource acquisitions; outline communication channels and key contacts; and include plans to address residents' physical, social, and mental well-being.
- 3C Ensure resident-centred care is maintained despite heightened infection prevention and control measures.

IV. Oversight and Accountability

- 4A Establish a single legislative Act that governs all (both public and private) LTC homes including bringing them under a common accreditation and inspection system.
- 4B Implement both the HSO and CSA national LTC standards in all LTC homes with the necessary supports and funding over the next five years.
- 4C Establish a LTC sector association that includes all homes (public and private) to improve collaboration, e.g.,
- monitor the implementation of national LTC standards
 - guide workforce recovery and development activities
 - oversee the development of organizational capacity on a sector-wide basis, i.e., IPAC, quality and risk data and IT systems.
- 4D Establish equitable government support for private and public LTC homes including base funding, access to capital, and security of ongoing support to develop infrastructure necessary to operate on a comparable basis.
- 4E Implement Inter-Resident Assessment Instrument Long-term Care Facilities (InterRAI LTCF) in all public and private LTC homes.
- 4F Using an independent assessor, collect data that validly assesses partner in care satisfaction.



Introduction

Purpose

Across Canada, the COVID-19 pandemic exposed LTC homes as an area of extreme vulnerability in the health system. LTC homes were disproportionately affected by the SARS-CoV-2 virus, its rapid community spread, and severe staffing shortages. In 2022, the Government of Prince Edward Island appointed an Expert Panel to provide a report and make recommendations to guide the LTC sector in addressing existing challenges, to identify areas for improvement, and to prepare to meet future needs. We were asked to review the following areas:

- a. Measures taken by parties, including the Government of PEI, LTC homes and other parties to prevent, isolate, and contain the spread of COVID-19, including the adequacy of existing legislative and regulatory provisions, policies, practices, and specifications on infection prevention and the control of infectious diseases in LTC homes;
- b. The impact of existing physical infrastructure, staffing approaches, clinical oversight, and other features of the LTC system on the prevention and/or spread of COVID-19 in LTC homes;
- c. The impact and perspectives of pandemic waves on residents, staff, volunteers, and family members;
- d. The current state of the LTC sector compared to the proposed national standards, identifying ideas and recommendations to meet these standards;
- e. Other relevant matters that we considered necessary to review regarding the handling of COVID-19 in LTC homes.

Approach and scope

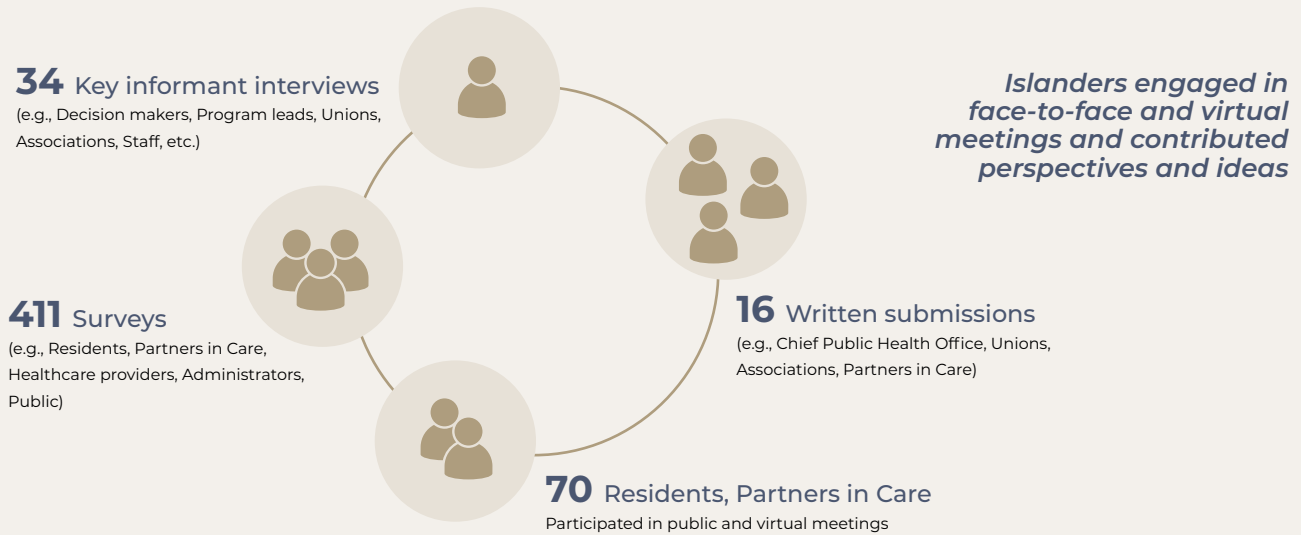
During our work, we heard from many people who were involved in the decision making, as well as in the implementation of measures designed to contain the transmission of COVID-19 and to minimize the harmful effects on residents and staff of the LTC homes. The recommendations in this report focus on how the LTC sector should strengthen its readiness to protect against future threats; specifically, those focusing on resident-centred care, strengthening infection prevention and control, and workforce recovery and development. We also include additional recommendations focused on oversight and accountability that address long-standing issues the effects of which were exacerbated during the pandemic. Implementing these recommendations will require both resources and the cooperation and collaboration of many stakeholders including government, Health PEI, private LTC homeowner/operators, staff, partners in care, and others. The benefits of making these changes will be substantial.

To inform our work, from June to mid-January 2023, we:

- reviewed past documents assessing PEI's LTC sector
- commissioned a review of LTC reports from other jurisdictions
- assessed LTC inspection reports pre-and during the pandemic
- reviewed the Health PEI Accreditation Report in relation to long-term care services
- compiled findings from mailed and emailed written submissions
- conducted a series of key stakeholder interviews
- held in-person and virtual public meetings
- surveyed residents, partners in care, staff, administrators of LTC homes and the public (online and via mail).

Figure 1

Stakeholder Engagement



We used both new national LTC standards (HSO and CSA) during the review process and to inform the development of final recommendations. In 2020 the federal government committed to improving the provision of long-term care and provided funding to the Standards Council of Canada, the Canadian Standards Association (CSA), and the Health Standards Organization (HSO) to develop two new complementary national standards for long-term care. Nationally recognized experts from across Canada, operators, LTC staff, and public representatives (residents, partners in care) used a consensus process to develop standards based on findings from reviews of current research, clinical expertise, evidence informed practices, and the lived experiences of individuals. The draft standards

received an extensive public review through surveys and focus groups. Principles of equity, diversity, and inclusion are integrated within the standards. The standards developed by CSA (December 2022) focus on the design, operation, and infection prevention and control practices in LTC homes. The HSO standards (January 2023) address the delivery of safe, reliable, and high-quality long-term care services. The national standards will be reviewed within five years from the date of publication. We strongly support the implementation of these national standards as an important step for LTC homes and have noted in text boxes, throughout the report, specific national standards which align with the recommendations.

The references in these text boxes are not all-inclusive. The guiding principles are set out in Section 1 (Governing LTC Homes Strategies, Activities, and Outcomes) of the CAN/HSO 21001:2023 Long-Term Care Services.

Section 4 (Organizational commitments) of CSA Z8004:22 Long-term care home operations and infection prevention and control are generally relevant to our recommendations.

Section 1 of the CAN/HSO 21001:2023 standards effectively sets out the governance requirements for each home to ensure it delivers quality of care that is resident-centred, effective, safe and accessible, with appropriate planning, oversight and ongoing feedback to continuing to do so.

Section 4 of the CSA Z8004:22 standards essentially provides the core goals and values guiding the organization and leadership team for providing person-centred care to meet the residents' needs.

Limitations

The scope of the review was limited by several factors including:

- Competing demands. During the survey and interview phases, post-tropical storm Fiona caused widespread damage and power disruptions, which necessitated the immediate attention of many Islanders. Though we made our best efforts to support those who wished to participate in the process, including extended survey and response deadlines, we appreciate that not all Islanders may have had equal opportunity to respond to the invitation to participate.

- The amount, quality and ability to access relevant information. Data collection and monitoring systems differ between private and public LTC homes.
- Recognition that availability of home care services, community care homes, community and caregiver supports are important factors that influence transitions to LTC. These factors are identified in the review where required but an in-depth assessment of these factors was outside the scope of this report.

Our sample sizes and survey responses were relatively small, which may limit the generalizability of the results in some areas. Responses to surveys and attendance at meetings were also relatively small. However, the entire combination of surveys, key informant interviews, written submissions, and personal engagement with residents and partners in care provided us with sufficient information of a consistent nature to produce meaningful results.

Acknowledgement of contributions and submissions

We acknowledge the deep impact of COVID-19 on all Islanders and those in or affected by the LTC system. The LTC sector experienced not only death but suffering, fear, uncertainty, and, at times, hopelessness. We have done our best to honour these experiences.

Background

Long-term care on Prince Edward Island refers to facilities providing 24-hour nursing care, where residents who require day-to-day care, accommodation and personal care services can live safely. LTC services on PEI are delivered by both the public and private sectors. There are approximately 1100 residents living in LTC. Approximately half of the beds are publicly funded and operated by Health PEI while the other half are privately owned and operated. As described in the Nursing Home Project report (2011) by Harper & MacNutt¹, public LTC homes receive 'budget-based funding' whereas access to private LTC beds occurs through 'bed purchase' contract agreements. Private LTC homes receive a per bed payment from government to care for residents. Admissions are managed by three committees (one in each county) comprised of representatives from LTC, acute care, and home care. Each committee is chaired by a Home Care Manager responsible for services in the geographic area and admissions are generally assigned by care requirements and availability.

There are many issues that were brought to our attention relating to the public/private nature of the LTC sector. As described in an internal review report of LTC (2021)², many of these issues are long-standing in nature. Other issues were of lower profile. For example, physical infrastructure was rarely raised during individual interviews and yet from the staff survey responses there was a high degree of agreement on the importance of eliminating shared resident rooms and bathrooms to reduce the impact

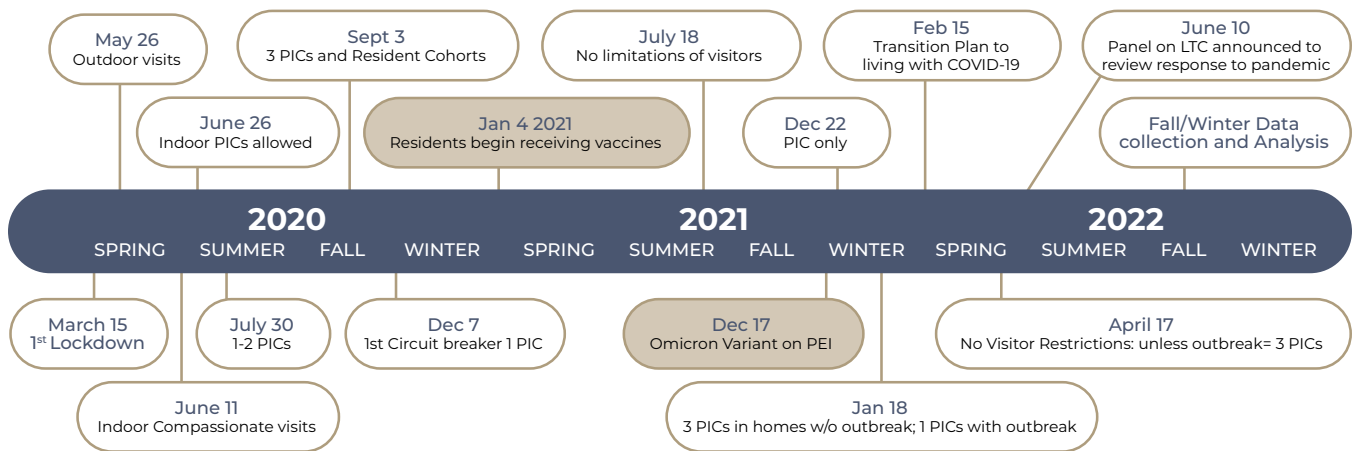
of future virus outbreaks. This may reflect the shift from four bed and shared rooms towards single resident rooms in new LTC builds and remodeling projects. However, there were also new issues that impacted residents' quality of life and care, including their contact with partners in care during the pandemic.

Throughout our work we have focused on the experience of LTC residents and adopted "Home is Home" as the Panel's mantra, meaning that residents should expect to receive a high standard of care wherever they live whether in a public or a private LTC home. This report identifies key areas for change and makes recommendations for a path forward. First, however, we provide a brief overview of the last three years and measures taken to prevent and contain the spread of COVID-19 in LTC homes.

COVID-19 Reaches PEI's Shores

We received a tremendous amount of detailed information, and, through the analytical phase of this work, we considered PEI's pandemic experience in two time periods. The first, 'pre-vaccine', occurred between March 2020 to January 2021. The second time period, 'post-vaccine', began in February 2021 when COVID vaccines became widely available to LTC residents and the general public. While initial and booster doses of COVID vaccines were available during the second time period, variants of the initial virus emerged, including the highly infectious Omicron variant.

Figure 2: Timeline of Key Pandemic Events/Policies Affecting PEI Long-term Care (Spring 2020 to Winter 2022)



Pre-vaccine

The early months of the pandemic had multiple waves and were marked by dramatic developments world-wide. Islanders were living in “unprecedented times” of fear and anxiety and it is important to remember that everyone, including key decision makers, were experiencing high levels of uncertainty and extraordinary changes to daily life as the virus spread rapidly. In interviews with us, many people spoke of the traumatic impact of attempting to work safely amidst the threat of mass mortality in the long-term care system. This fear was well-founded and not exaggerated, as LTC homes in other provinces reported critical conditions, resident deaths, and staff infections. We heard accounts of health care providers working with little sleep, stricken with concern that residents and coworkers might die if the virus infiltrated the homes’ defenses and afraid for their own and their family’s safety.

Post-vaccine

Community transmission of COVID-19 did not become an issue on Prince Edward Island until arrival of the Omicron variant in December of 2021. All prior cases of COVID-19 were linked to out of province travel, verified by contact tracing. By the time

Omicron arrived in Island communities, widespread vaccination efforts were underway and protective protocols were in place.

As health officials prepared the LTC system for the potential harms during 2020 and 2021, it is important to recall that other jurisdictions were experiencing significant death rates. Until the development of effective vaccines, people operated under the very real risk that failure to prevent transmission could be catastrophic. It is difficult to overstate the extraordinary stress this risk created for those responsible for operating within the system. With few exceptions - residents, partners in care, family and friends, staff, administration, and health care providers acknowledged their fear of bringing COVID into LTC homes. They understood and accepted that isolation was necessary to protect lives. However, the same measures that isolated residents from contact with partners in care, sometimes for excessive periods, also negatively impacted residents’ physical, social, and mental well-being.

Residents, partners in care, and staff reported that the focus of “home” was lost during the efforts to contain the virus. Staff efforts were redirected to escalated infection control procedures, and resident-centred care became a lower priority.

Analysis

1. Resident-Centred Care

Key issues:

- Resident-centred care deteriorated during the pandemic
- Residents were negatively affected by the restrictions placed on their family/friends to have access to LTC homes
- Facility lockdowns intensified resident isolation and negatively affected physical, mental and social well-being.

Deteriorating care

Canada's new national LTC standards are built around resident-centred care as a philosophy and an approach to providing care that prioritizes residents' goals, needs and preferences. The pandemic response demonstrated how gains made in resident-centred care can be quickly lost unless resident quality of life is prioritized. An important finding was the degree to which the pandemic affected residents' quality of life; physical, mental and social well-being; and the care received in LTC homes.

Quality of life is the essential goal for every person; however, achieving quality of life for a long-term care resident is dependent on their caregivers. Quality of care is fundamental to quality of life, such as clinical and personal assistance received from LTC staff and partners in care. However it is only one part of a comprehensive suite of considerations. Quality of life must also consider other factors, such as:

- Physical comforts and protections i.e., appropriate beds, chairs, and transitioning equipment
- Quality of food, including taste, variety, cultural considerations, and nutritional value

- Regular health monitoring, especially for pain and infections, medication reviews, appropriate dosing and supervised administration
- Meeting daily needs, especially assistance with toileting and bathing as needed, providing dignity and respect
- Symptom management
- Availability of recreation considering individual physical and mental abilities, including appropriate socialization for dementia patients in appropriate settings
- Appropriate communication with residents, including respect, avoiding ageism and use of dementia appropriate techniques when needed
- Access as required to allied health workers
- Introduction of new technologies as developed for both protection and socialization benefits
- Inclusion of partners in care in decision-making related to residents because of their familiarity with, and ability to identify, changes in the mental and physical health of the resident
- Recognize that quality of work life affects quality of care.
- Quality end of life care.

Resident quality of life should consider:

- Social connectedness, cultural respect, and psychological safety
- A sense of meaning in one's life
- A sense of purpose, pleasure, and joy.

Quality of life is a multifaceted goal requiring healthcare providers to have appropriate training and a compassionate aptitude; it can be complex to achieve. It can also be easily sidelined during a pandemic, especially for residents with more

advanced dementia or other cognitive disabilities who cannot speak for themselves.

We heard repeatedly from staff, residents, and partners in care that “resident-centred care” (and, hence, quality of life) was lost during the pandemic. When considering these concerns, we examined the differing systems of oversight for public and private homes. Private homes are subject to annual inspections, and are rated as “compliant”, “partially compliant”, “non-compliant” or “not applicable” on approximately 130 factors, covering a wide range of administrative and resident care issues. Where deficiencies are identified, remedial action is recommended, and follow-up inspections are done. Where issues are significant, a home’s license may be changed to “provisional” with admission restrictions and follow-up to ensure appropriate remediation. Public homes are not annually inspected but are included as part of Health PEI’s review by Accreditation Canada, an independent, not-for-profit, non-governmental organization. The national LTC standards will be incorporated within Accreditation Canada’s quality review processes and inform the inspection of health care services across Canada. The most recent Health PEI accreditation was received in August 2022.

Appendix 4 provides our review and analysis of private LTC home inspection reports published between 2019 (pre-pandemic) and 2022. We observed an increase in the number of provisional licenses granted to LTC homes in 2022 and an increase in the number of documented “partially

compliant” and “non-compliant” standards. While there was an increase in “partially compliant” standards in the area of resident care, the “non-compliant” standards were in the areas of management and administration, physical environment and security, and human resource management.

Because of the use of an accreditation process for public homes, instead of annual inspections, similar information for comparison is not available from public LTC homes. The 2022 Accreditation Report Executive Summary, Accreditation Decision: Service Excellence Standard Results for Long-term Care Services – Direct Service Provisions are set out in Appendix 5. The level of detail is not available as with inspection reports for the private homes. However, we collected additional information through the surveys and interviews. In these surveys and interviews, respondents shared examples of ways in which infection prevention and control measures displaced care activities and routines, making daily life for residents sub-standard.

We heard multiple concerns expressed about differences between public and private long-term care homes with respect to resident care. The data collected through our surveys and interviews were not sufficient to make specific comments on this.

Findings

Based on these experiences and reports, we conclude that measures taken to respond to COVID-19 had unintended significant and negative consequences on the well-being and quality of care of residents in LTC.

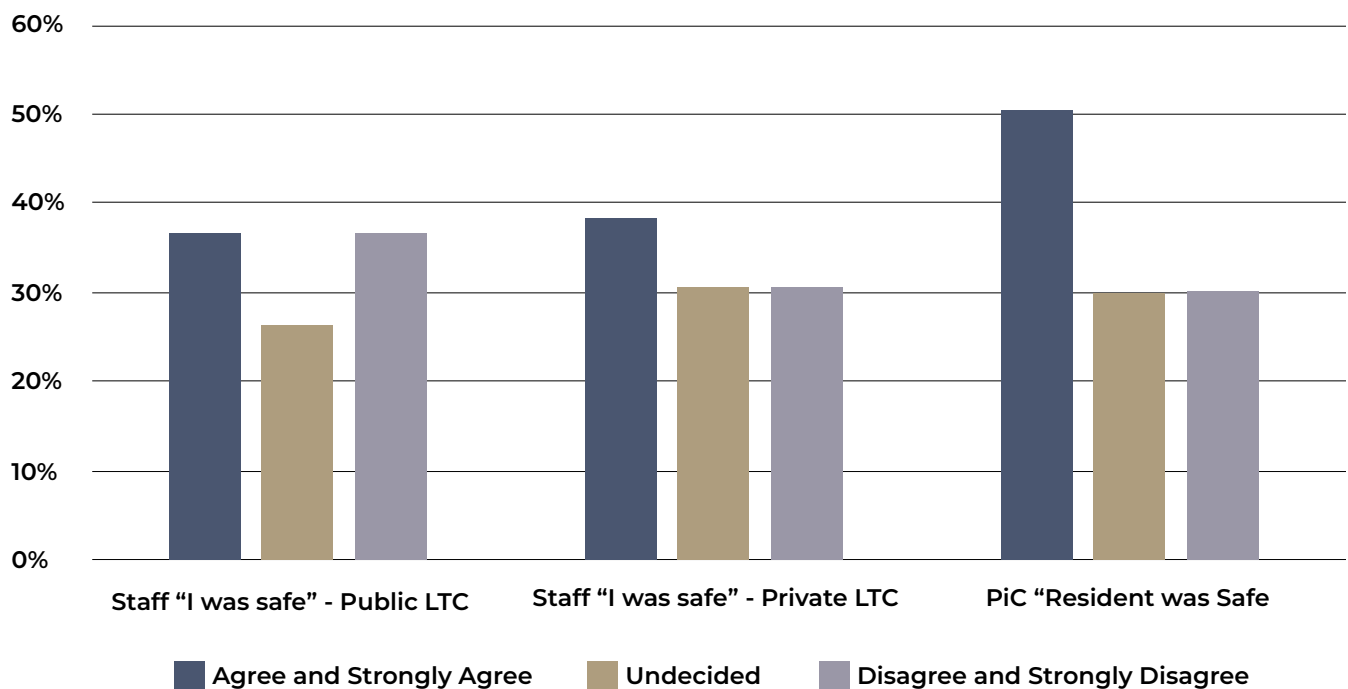
Negative impact of restriction



“...family and visitors can’t take meals together; masks mandatory at mass; lost 2 years opportunity to educate young people; robbed residents of home-like environment; loss of essential activities (choir)...”

One important change in residents’ lives was the isolation experienced during lockdowns as a result of visitor restrictions. During the pre-vaccines phase, these restrictions were enacted to reduce residents’ risk of COVID-19 exposure and were re-activated during outbreak conditions to reduce the spread of COVID within homes. The surveys of residents, partners in care, and staff described the impact of these restrictions. The survey results also showed a belief that the restrictions provided a sense of protection and safety. Surveys of partners in care revealed a perceived greater value of visitor restrictions than the surveys from staff at either private or public LTC homes.

Figure 3: Staff (private/public) and Partners in Care (PIC) responses re: whether visitor restrictions kept staff and/or residents safe from COVID -19



During interviews and in survey responses, residents, key informants, partners in care and staff members described the effects of the pandemic on the physical, mental and social well-being of residents in LTC homes. Partners in care and staff members reported that restrictions that limited movement within LTC homes affected their ability to support residents' mobility. Time taken with other activities and staffing constraints meant that some residents had less support to be active. At the same time, visiting restrictions and the absence of partners in care increased the demands on staff to assist with resident mobility. Moving around within the LTC home, outdoors, and on visits outside the home were opportunities for mobility that were reduced during periods of visiting restrictions. Reduced activity resulted in worsening frailty, and also increased time in bed that contributed to reduced mobility, changes in skin integrity, and increased falls.

Partners in care of residents with dementia observed an increased rate of decline that they attributed, in part, to isolation and the lack of stimulating activities.

“Lack of stimulation through limited volunteer music groups and ability to come out of home to visit family and friends have worsened condition of dementia.”

Those who knew residents best commented on the impact of the pandemic and related restrictions on residents' emotional and mental health. Some residents became withdrawn while others were more irritated and agitated compared to before the pandemic. Visiting restrictions were implemented to protect residents from exposure to COVID. However, some partners in care observed that the restrictions were confusing for residents who felt “abandoned by others” and had difficulty understanding the need for restrictions. These experiences were also very distressing for partners in care who were unable to visit LTC homes according to their wishes and preferences.

“My grandmother became very anxious when our family was not able to go and visit with her in person. She would call us in a panic, just wanting to hear our voices. She would get more confused when she didn't have us to orient her to her surroundings and provide a frame of reference.”

~

“I looked through a window and saw first-hand the sad, forlorn look on not only my [husband's] face but many others.”

Residents experienced fragmented and fewer social connections with staff, other residents, family, friends and the community in general. The world of the residents became smaller with the application of more restrictions, loss of congregate meals, and reduced activities. Residents, who previously exercised their autonomy to leave LTC homes and attend events, were required to stay in the facility. However, access to outside services, entertainment and activities within the LTC home was also disrupted.

Figure 4: Staff perceptions of pandemic caused changes in resident experiences by private vs public LTC homes

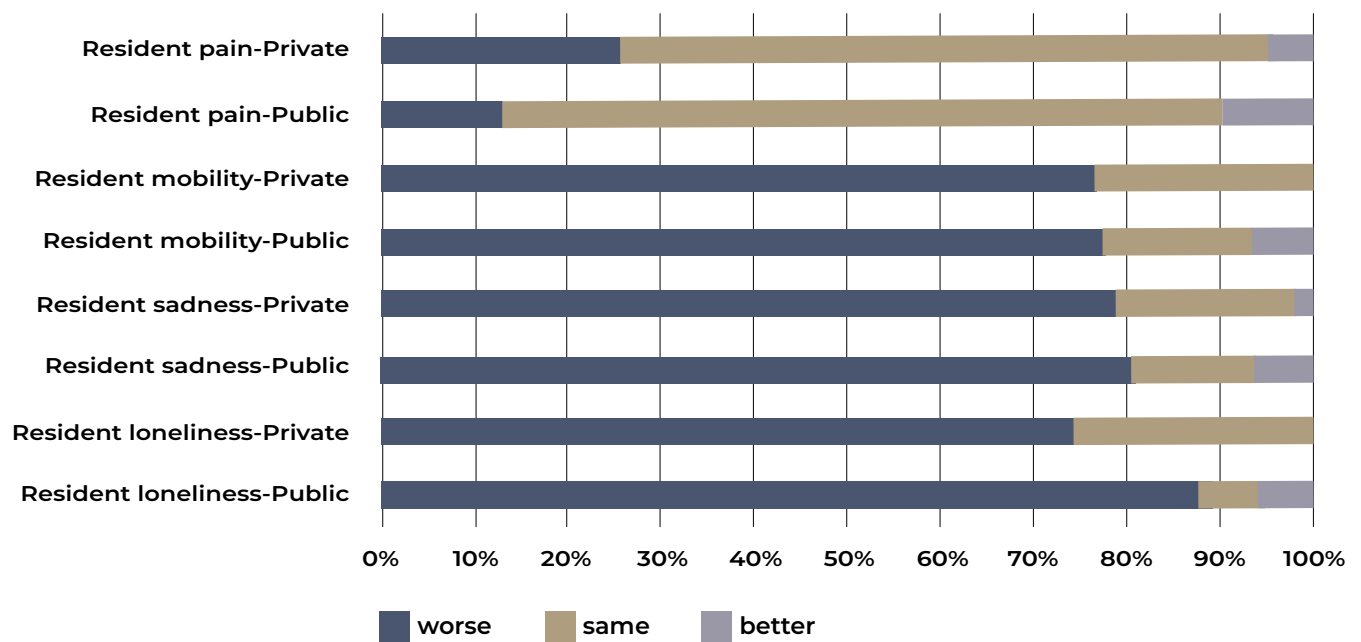


Figure 4 depicts little difference between private versus public LTC staff regarding their perspective of changes in residents during the pandemic. What is significant is the high proportion of staff (80%-90%) who report that the resident experiences of sadness, loneliness, and mobility worsened during the pandemic. Given the restrictions on visitation and movement, together with the emphasis of staff time on infection control, it is not unexpected that the social and mobility experiences of the residents worsened. Pain was the only area where staff reported that residents' experiences were less likely to change.

Care provided to residents was affected by extra infection prevention measures and cleaning, staffing challenges, and outbreaks. Changes to bathing routines, decreased charting of care, reduced allied health services, and reduced activities with residents were cited as examples of the ways in which the pandemic affected care. Staff members and partners in care expressed distress at these changes in care.

We heard from partners in care who were upset and frustrated with seeing residents receiving inadequate care resulting in progressive health complications. In some cases, they expressed concern to staff but also recognized there was little that could be done because of staff shortages. In other cases, they were concerned about speaking up, until the health of their loved one had significantly deteriorated, for fear of reprisals from staff. In at least one case, a resident told the partner in care not to say anything for fear of upsetting the staff.

Whether or not there is a pandemic, a formal complaint or reporting process should be available to residents and partners in care that is both free of fear of reprisal and free of actual reprisal. An independent process, external to the LTC home, similar to a whistleblowing policy with appropriate privacy and confidentiality protections, should be implemented and available to all residents and their partners in care.

Canada's new national LTC standards (CAN/HSO 21001:2023 Long-Term Care Services, section 2) support the recognition of partners in care and the important role that they play in residents' lives. As identified by a resident, their partners in care offer emotional, social, and physical support and, as such, should understand their rights and responsibilities as well as receive ongoing communications from LTC homes to support their role in resident care.

“...urinary tract infection and yeast from being left dehydrated and setting in his soiled depends.”
~
“I would turn up 3-4 times a week to feed him, he would still have dried food all over his face and clothes from dinner. I have witnessed one more than a few occasions workers attempting to ‘shovel’ food into residents.”

Amid these challenges, we also heard positive achievements of how nurse practitioners worked in LTC homes to update resident goals of care. The importance of recreation services, occupational therapy and physiotherapy for LTC residents was recognized and access increased during the pandemic in some LTC homes despite the challenges.

Findings

Based on these experiences and reports, we conclude that the physical, mental and social well-being of residents were negatively affected by the restrictions placed on their family/friends to have access to LTC homes.

Text box 1

Connection to Canada's National Long-term Care Standards^{4,5}

CSA Z8004 Long-term Care Operations and Infection Control

Section 4: Organizational commitments – accessibility, activities, collaboration, complaints

Section 5: Operations – person-centred operations, visiting

CAN/HSO 21001:2023 Long-Term Care Services

Section 2: Upholding resident-centred care – respect of residents' rights and responsibilities; capacity to make care decisions; consent to treatment; interactions with substitute decision makers.

Section 3: Enabling a meaningful quality of life for residents – providing a welcoming, home-like environment and purposeful daily activities.

Section 4: Ensuring high-quality and safe care – comprehensive needs assessments – basic needs, physical, mental health, social needs (on admission and on-going); individualized resident care plan; procedures to support quality, safe care.

Facility lockdowns

Residents, partners in care, staff, and administrators identified that facility lockdowns, with visitor restrictions, had negative effects on the residents in LTC homes.

The most intense period during which residents and families were separated was from March 15, 2020 until June 24, 2020. This period is believed to be the time when people were most significantly affected. We heard critical comments that there was no community spread of COVID-19 at this time and perhaps the measure was too severe. However, we recognize that, during this period, the trajectory of the virus was not yet known. Infection prevention and control procedures were just ramping up and the supply and distribution of PPE was not yet stable. The world was working on a vaccine, but nothing was in sight. Given the inability to manage the risks if the virus entered LTC, we understand the aggressive approach taken by CPHO during this initial time period.

The “Partners in Care” initiative was established within 3.5 months of declaring COVID-19 as a pandemic. This initiative recognized the critical role that family and friends play in the well-being of LTC residents and provided a pathway for PIC to safely visit with residents. Further periods of restriction on visits occurred during “circuit breakers” when outbreaks emerged, and threatened community spread.

As an alternative to full facility lockdowns, we heard stakeholders recommend that the right of residents to live with risk should be considered. Much has been written about the restriction of residents’ rights during the pandemic. These works focus primarily on balancing of personal and collective safety against the rights of the individual to live with autonomy and

risk. Health professionals often embed this thinking into ethical decision-making processes to ensure that this balance is kept in mind. During the pandemic, residents in LTC homes were offered few options and limited choices on meeting their social and care needs.

We heard from LTC owner/operators that, given the opportunity, they would have been able to modify operational procedures to minimize transmission while still allowing visitors for residents under most circumstances.

Residents were required to isolate in their rooms upon admission, as well as when they were identified as a close contact and/or tested positive for COVID-19. Stakeholders expressed acceptance for the isolation requirement upon testing positive. However, we heard from many about the concern of isolation requirements for new residents upon admission and upon close contact identification. The concern centred on the even more difficult move-in transition that new residents, unfamiliar with their surroundings face. Participants told us that this practice was even more difficult for residents with dementia, who might not understand what was occurring.

In the context of balancing residents’ rights and risks, standard form healthcare directives/substitute decision-maker documents typically obtained upon admission could be designed to anticipate future health crises. In these documents, individuals could set out their preferences and wishes for protection of themselves and their family in the event they are living in a LTC home with an outbreak. In conjunction with these stated wishes, further decisions could be made at the time of a future outbreak. Perhaps, for example, if the partners in care wish to remove their masks during their visit with a resident in a private room, there could be a formal approval process to do so.



With appropriate signed waivers by all immediate family members, and with appropriate infection control procedures, including masking outside of the private room, protection of other residents could be maintained. Such a formal approval process could be studied for implementation for future outbreaks.

Findings

Based on these reports we conclude that full facility lockdowns resulted in unintended negative consequences for residents and partners in care.

Recommendations for improvement

With respect to resident-centred care, we have the following recommendations. Under some key recommendations, we have included specific examples of the types of actions that could be taken to achieve the recommendation. In addition, we are recommending adoption of Canada's National Long-term Care Standards, and for this portion of the Panel's report, see particularly relevant those standards in the accompanying text box 1 titled, 'Connection to Canada's National Long-term Care Standards'.

1A Uphold residents' rights and responsibilities.

The following action supports this recommendation:

- Introduce a confidential, independent complaint reporting process

1B Ensure that resident-centred care is always sustained. The following are actions that support this recommendation:

- Establish a common approach to ensure oversight and resident-centred care regardless of whether residents are in a public or privately operated LTC home (i.e., inspection and accreditation process)
- Include partners in care as full team members in resident care.

1C Enhance health care directive/substitute decision-making provisions to ensure resident wishes are known. The following are actions that support this recommendation:

- Ensure individual LTC home documentation is used to provide residents the option to set out personal value statements and other directions, as currently provided for in the standard form Health Care Directive published by Health PEI (Form 14HPE15-40623)
- Enhance documentation to set out the wishes of residents for application of personal protective measures in the event of infection outbreaks
- Develop risk management policies to balance residents' right to live at risk with the rights of others to live in safety.

2. Workforce Recovery, Recruitment, and Development

Key issues:

- Staffing was insufficient to balance the demands of the pandemic with resident care
- Restrictions on staff mobility between workplaces had serious effects on staffing in LTC homes
- Health human resource stability was impacted, e.g., through stress, burnout, and other health effects; inadequate access to risk management support; and other issues with resulting increased departures from LTC

Impact of the pandemic on LTC workers

We heard many suggestions from stakeholders about ways to address long-standing issues and strengthen health human resources in LTC. An important first step is recognizing the mental, physical, and psychological effects of the pandemic on LTC personnel (staff, managers, and leaders) and supporting them in their recovery.

“Working during the pandemic was a learning experience but a terrible one at that. Every minute of it, wore my mental and physically health so much that now my husband checks to make sure I ate and slept because I haven’t been, working has been very stressful...”

“In 41 years of management I had not experienced this level of crisis; I was at the end of the rope and didn’t know what to do”

Developing and implementing a recovery plan for all staff (nursing, ancillary, allied and managers) to restore physical, mental and social well-being moving forward is foundational. It is essential to strengthening the workforce and embedding a culture within LTC homes that values the health and wellness of residents, partners in care, staff, and leaders. Survey results from staff in LTC homes provided insights into areas for focus when strengthening the culture of wellness in the workplace. These included::

- Increased attention to staff physical, mental and psychological wellness
- Rebuilding relationships strained during the pandemic – between staff and families; among co-workers; and between staff and management

- Recognition of staff burnout and stress and its consequences for both staff and resident quality of care
- Increasing respect in the workplace.

Achieving a positive workforce culture is a concept that requires long-term commitment, with willing participation by all levels of workers, including senior leadership. Collaboration is required with constructive input to make work life better for everyone, combined with a commitment to maintain a positive working environment. A strong culture of staff well-being promotes a healthy team, supports resident-centred care, and recognizes the value of each team member's contributions.


“Staff are fed up, burned out, stressed out and very saddened by the lack of support. Employees work above and beyond at the LTC facilities doing many extra duties to make the residents feel better and give companionship when families couldn't visit. Many, many extras and not really appreciated.

This recommendation aligns with national LTC standards (CAN/HSO 21001:2023 Long-Term Care Services 6.1.4) that promote quality improvement activities for a healthy and competent workforce. Actions, such as increasing access to virtual and in-person employee supports across the sector, and creating and supporting positive work environments, will provide greater options for staff to choose approaches that best meet their needs. Tracking and monitoring data on staff well-being provides a basis for evaluating the effectiveness of well-being programs and developing strategic actions for workforce recovery and development. Recognizing the importance of staff well-being, we recommend that achieving certain goals in this area be incorporated within government funding agreements with LTC homes to ensure that meaningful progress is made in this area.

Partners in care observations on staff shortages and the impact on resident care:
“Staff felt the impact, stress and sadness sketched on their faces. Staff shortages became an accepted thing.”


As with infection prevention and control resources, staffing issues differed between public and private LTC

homes during the pandemic. The disproportionate impact on private LTC homes arising from staff mobility restrictions is an example of these differences. On June 25, 2020, CPHO issued a public health directive restricting staff from working in more than one LTC facility. The intention was to minimize the risk of transmission of the virus between homes. Private LTC owner/operators, Health PEI, and unions reported that this measure had an uneven impact in the public and the private sectors. Part-time and casual staff who worked in more than one facility tended to migrate to their public sector place of employment leaving the private homes with increased staffing shortages.



“The last three years have been harder than the last 30 years I’ve worked in health; what we were directed to do vs what we knew we should do was different..... I had to step away from it for a while”

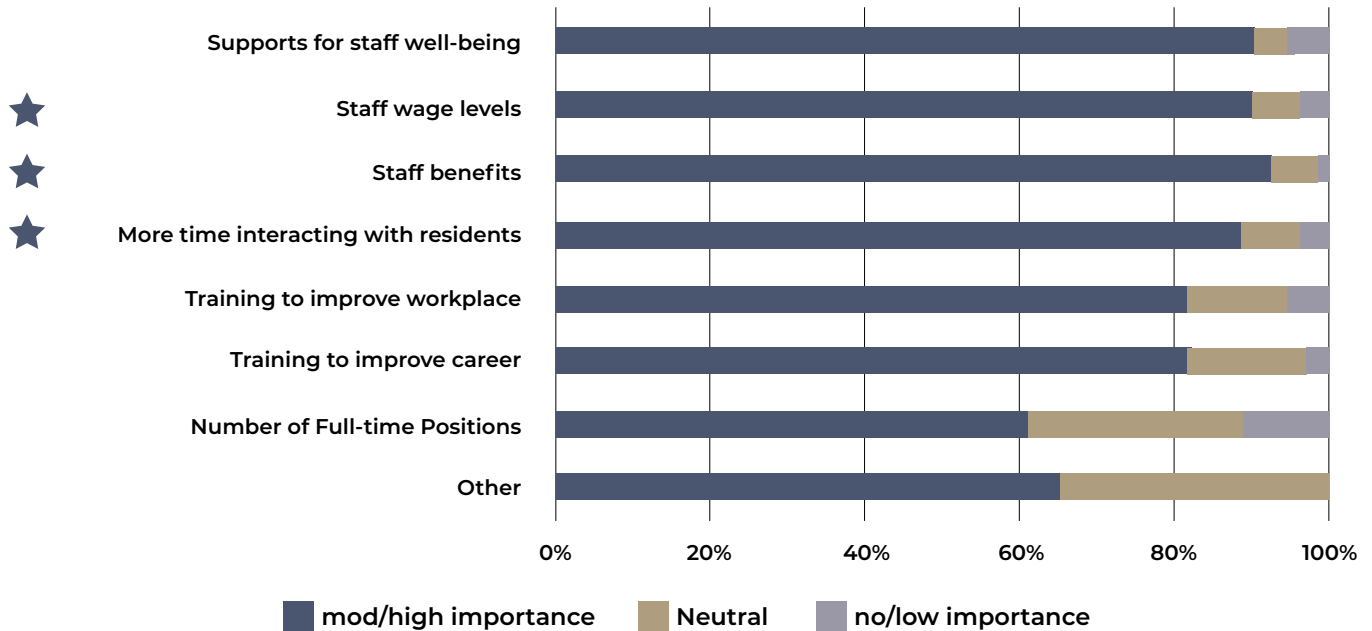
We heard reports of staffing shortages from staff, unions, owner/operators and partners in care. However, PEI lacks sector-wide data with which to confirm these reports. Unions and Health PEI Human Resources reported that staff vacancy rates during the pandemic were regularly 30% or higher. This means that on any given shift, 30% of the positions may have been vacant. This was a serious issue. COVID-19 outbreaks among staff resulted in further absenteeism that destabilized operations. We heard stories of workers unable to leave after a shift as there were no staff members coming in to replace them.



“Shortage of staff a chronic issue at best of times throughout all LTC facilities, but worse during COVID. How could patient care and services NOT be affected by this?”

The ongoing health human resource challenges facing the LTC sector worsened during the pandemic. While

Figure 5: Staff perspective on the level of importance of workplace improvements in LTC



★ This symbol represents workplace improvements identified as priorities by staff in LTC homes

efforts were made to encourage staff reassignment to fill LTC home staffing shortages, reports from stakeholders indicated that the reassignments were few and insufficient to bridge the staffing gaps regularly occurring in the homes. In seeking to determine the human resources available to support LTC during this period, we sought to understand the redirection of health human resources to other areas in the health care system. COVID testing sites, cough and cold clinics, vaccination rollouts and clinics, and many other important functions required immediate and urgent human resources to contain the transmission of the virus and inoculate the population. The focus centred on public health functions and preserving hospital patient capacity to respond to anticipated COVID admissions, sometimes to the detriment of LTC. To better respond to the staffing shortages and reduce the risk of the disproportionate impact on any one

area of the health system, we recommend that a health human resource response strategy be developed. This strategy should include a plan for setting priorities and for finding staff resources when critical needs arise. An inventory of cross trained staff may be an option to respond to staffing shortages during outbreaks or other conditions.

Sufficiency of health human resources in the LTC sector remains fragile as the system recovers from the pandemic. We recommend that both short-term and longer-term recruitment and retention strategies be urgently pursued. Staff shortages are a common issue across the LTC sector (public and private homes) and solutions must be developed and tested in collaboration by government, LTC leaders, and staff. The following actions were suggested by stakeholders and document reviews as steps towards achieving greater workforce stability:

- Strengthening health human resource recruitment and retention across the sector, including addressing wage and benefit differences between private and public homes
- Reviewing and updating the model of care for LTC homes considering resident care requirements, staffing ratios, and best practices
- In keeping with national LTC standards, improve workforce data collection, monitoring, analysis, and reporting across the sector
- Explore collaboration with other jurisdictions to create a single Atlantic Canada license and credentialing system for health human resources.

As the LTC workforce moves towards greater stability, staff should be provided with educational opportunities for initial and ongoing training to obtain and refresh skills to build relationships with team members, and to grow as care providers. The inclusion of orientation and continuing education modules on person-centred care and dementia care are examples of actions to better prepare all employees to offer quality care. Special communication and interaction skills are required for individuals with dementia and training in such proficiencies with regular updates are important. In 2022, the Implementation Council for the *Promoting Wellness, Preserving Health Action Plan for Seniors, Near Seniors, and Caregivers*⁶ provided a recommendation to government to enhance specialized geriatric and dementia training for health care workers who support seniors and their caregivers. The recommendation stated: “Given the objectives and principles as set out in the National Dementia Strategy, the Council recommends that dementia care training programs be mandatory for all care workers in all long-term care homes (including support staff such as housekeeping, dietary, direct care providers), as well as health care workers (acute, emergency and primary care) who interact with dementia patients.” We support this recommendation.

Further changes in the workforce should be explored to stabilize the system. Care providers, such as Resident Care Workers, may achieve greater recognition and enhanced opportunities by becoming a regulated profession. A robust LTC system includes a quality and risk management system where competent professionals are continually monitoring LTC homes to minimize the risks to residents and staff while identifying opportunities to improve quality. It was not apparent to the Panel that the current levels of quality and risk capacity was sufficient across the sector to support the activities required by the new national LTC standards.

Findings

We found that long-standing health human resource challenges facing LTC homes worsened during the pandemic. LTC workers require support to recover from the mental and physical impacts of the pandemic and ongoing support throughout their careers. Urgent action is needed in the short-term to address LTC health human resource shortages and longer-term planning for recruitment and retention.

Text box 2

Connection to Canada’s National Long-term Care Standards^{4,5}

CAN/HSO 21001:2023 Long-Term Care Services

Section 5: Enabling a healthy and competent workforce: staffing mix and ratio; workforce training; effective strategies for recruitment and retention; mitigating understaffing.

Recommendations for improvement

With respect to workforce recovery, recruitment, and development, we have the following recommendations. Under some key recommendations, we have included specific examples of the types of actions that could be taken to achieve the recommendation. In addition, we are recommending adoption of Canada's National Long-term Care Standards, and for this portion of the Panel's report, see particularly those standards in the accompanying text box 2 titled, Connection to Canada's National Long-term Care Standards.

2A Stabilize LTC health human resources. The following are actions that support this recommendation:

- Ensure regular capture of high-quality health human resource recruitment and retention data
- Increase access by the workforce to clinical educators, quality and risk professionals and allied health care providers
- Review and update the model of care for LTC homes considering resident care requirements, staffing ratios and best practices
- Explore enhancing recognition and opportunities for staff by making Resident Care Workers a regulated profession.

2B Invest in an evidence-based staff (all levels) recovery plan to support recovery and to promote a positive work environment that supports staff health and well-being. The following are actions that support this recommendation:

- Ensure collection of data that validly assesses staff health and well-being using external resources to ensure objectivity and privacy
- Develop and include performance measurements of employee well-being as a component of LTC home funding agreements
- Increase employee access to virtual and in-person well-being supports
- Research/establish an approach to promote a culture supporting the importance of staff

well-being and to create a cohesive workforce team focused on delivering resident quality of care, incorporating participation by both workers and leadership.

2C Align both public and private sectors to a common care staff model in accordance with resident care requirements and considerate of minimum qualifications, recruitment, retention and financial implications. The following are actions that support this recommendation:

- Strengthen health human resource recruitment and retention across the sector, including addressing wage and benefit differences between private and public homes
- Review and update the model of care for LTC homes considering resident care requirements, staffing ratios and best practices
- In keeping with national LTC standards, improve workforce data collection, monitoring, analysis, and reporting across the sector
- Explore collaboration with other jurisdictions to create a single Atlantic Canada license and credentialing system for health human resources.

2D Ensure consistent education and advanced nursing practice resources are available in all LTC homes. The following are actions that support this recommendation:

- Provide initial and ongoing training to the workforce to obtain and refresh skills to build relationships with team members and to assist staff to grow as care providers
- Provide specialized training on communication and interaction skills to individuals who interact with dementia residents.

2E Increase quality and risk management capacity in the sector (i.e., data collection, care processes, and human resources).

3. Strengthening Infection Prevention and Control

Key issues:

- LTC homes were not sufficiently prepared for the pandemic

Unprepared for the pandemic

Infection prevention and control is everyone's responsibility in a LTC home. However, the pandemic revealed that not all homes nor all people were equally prepared and protected. This was one of the key areas where differences between the public and the private system were observed. Health PEI employs a team of IPAC nurses to provide support to the whole public health system, including LTC, whereas private LTC homes did not have access to dedicated IPAC providers. It was not until February 2022 that a registered nurse with extensive IPAC experience was hired by the Department of Health and Wellness to offer in-person assessments of privately owned/operated LTC homes³. This process provided private homes with practical information on hand hygiene products, personal protective equipment, cleaning, laundry, isolation set up, COVID-19 testing procedures, and IPAC advice for dementia units. Health PEI assigned IPAC professionals early in the pandemic to work with public LTC homes to increase preparedness. Throughout the early months of the pandemic, the Chief Public Health Officer provided guidance to public and private LTC homes to reduce the risk of outbreaks. Masking, handwashing, sterilizing, contact tracing, testing/swabbing, enhanced cleaning, isolation protocols, and many other procedures were put in place to contain the virus.

During the review, we heard many ideas from staff, system leaders, and partners in care to strengthen

and improve access to infection prevention and control resources in the LTC sector including:

- Continue funding IPAC positions to work with private LTC homes to collaborate with colleagues at Health PEI
- Develop and implement a formal IPAC training program for partners in care, visitors, and volunteers

The pandemic response in LTC homes required staff to undertake COVID screening activities and manage PPE and other supplies, perform infection prevention and control activities, and enhance cleaning. However, pre-pandemic staffing shortages left little resilience in the system to accommodate additional work and staff new positions. Based on this experience, the Province should consider options to coordinate the allocation of health human resources to work in LTC homes experiencing outbreaks and developing a rapid response team to support homes in managing outbreaks.

Personal protective equipment was an important tool for risk reduction. It was required because of residents' increased vulnerability to serious infection, for staff protection, and to reduce the risk of resident to resident transmission. However, securing PPE was challenging with all areas of the health system seeking supplies at the same time. While the provincial PPE repository appeared to work well from the perspective of some stakeholders, others commented on ill-fitting PPE, and that PPE was rationed to LTC homes. To maintain an equitable supply of PPE for the sector and to leverage purchasing power, a provincially-managed stockpile of PPE may be the most effective approach to protect residents and staff in LTC homes. This provincial stockpile would be managed to ensure maintenance of supplies, monitor expiry dates, and update equipment as knowledge and technology changes.



“Staff were put at risk with lack of PPE and reusing PPE, and I believe using PPE that is substandard continues to put staff at risk in LTC.”

Before the pandemic, LTC homes on PEI maintained a degree of preparation to respond to adverse situations. LTC standards required site-specific business continuity plans. Such plans were designed to respond to external disasters with loss of essential services such as a power or heating failure, isolation due to weather conditions, fire and evacuation situations. These plans are inadequate to address the staffing, service, and IPAC challenges that a pandemic poses. Therefore, these plans must be reviewed and updated to reflect the lessons learned during the pandemic. For example, they need to include steps for a perceived or real outbreak of an infectious agent, plans to address staff shortages due to infection, and measures to ensure the social and mental health of residents is maintained.

Future planning for LTC must be informed by conducting a sector-wide assessment of LTC infrastructure against IPAC best practices and the designs identified in the national LTC standards (see text box 3). This will assist owner/operators and administrators to set priorities as they plan new builds and renovate existing homes. Monitoring the development of IPAC technology and investing in this technology will also help to ensure essential measures to ensure optimal air quality and cleanliness in homes.

Findings

Based on these reports, we concluded that, in the early months of the pandemic, LTC homes struggled and, in many cases, failed to meet infection control standards designed to protect residents, visitors, and staff against the virus.

Text box 3

Connection to Canada's National Long-term Care Standards ^{4,5}

CSA Z8004 Long-term Care Operations and Infection Control

Section 5: Operations – contingency planning

Section 6: Quality improvement – IPAC auditing and quality improvement indicators

Section 7: Infection prevention and control – IPAC program development, PPE inspection

Section 8: Design – guidance on resident household design for new or renovations to existing homes

Section 11: Catastrophic event management – planning

Recommendations for improvement

With respect to strengthening infection prevention and control, we developed the following recommendations. Under some key recommendations, we have included specific examples of the types of actions that could be taken to achieve the recommendation. In addition, we are recommending adoption of Canada's National Long-term Care Standards, and for this portion of the Panel's report, see particularly those standards in the accompanying text box 3 titled, Connection to Canada's LTC Standards.

3A Strengthen and align infection prevention and control capacity across the LTC sector (public and private homes). The following are actions that support this recommendation:

- Establish a provincial coordination plan for allocation of health human resources work in LTC homes during outbreaks
- Develop a rapid response team to support individual LTC homes in managing outbreaks
- Establish a consistent process for sharing information on a timely basis between the Chief Public Health Office and long-term care homes to provide consistent guidance on management and science of emerging viruses and infections, and timely information in the case of outbreaks.

3B Update and strengthen business continuity plans to include pandemic protocols that address staffing shortages and resource acquisition; outline communication channels; identify key contacts; and include plans to address residents' physical, social, and mental well-being. The following are actions that support this recommendation:

- Conduct a sector-wide assessment of LTC infrastructure against the national standards
- Regularly monitor the development of IPAC technology and invest to maintain the best practices.

3C Ensure resident-centred care is maintained despite heightened infection prevention and control measures. The following are actions that support this recommendation:

- Continue funding IPAC positions to work with private LTC homes to collaborate with colleagues at Health PEI
- Develop and implement a formal IPAC training program for partners in care, visitors, and volunteers upon a resident's initial admission, with enhanced training upon outbreaks
- Perform a provincewide review of LTC home physical infrastructure regarding appropriateness for infection control in accordance with the national standards.

4. Oversight and Accountability

Key issue:

- Public and private LTC homes in the province have different operating systems. The result is multiple inconsistencies and inequities in resources, access to services by residents and families, and gaps in wages and benefits for staff.

Achieving greater equity in LTC

During the review, we learned of several long-standing issues that affected the degree to which the sector was able to effectively respond to the pandemic. Addressing these issues will take time, investment, and effort by all parties to work collaboratively. However, changes in these areas are essential to ensure that LTC homes – their residents, staff, partners in care, and administrators can continue recovery from the pandemic towards a stronger more resilient future.

As noted in the *Internal Review of Long-term Care report (2021)*², as well as the *Nursing Home Project Report (2011)*¹, public and private LTC homes operate in different ways with different access to resources, staffing, and standards. The public and private LTC sectors will continue to remain separate and distinct until they are brought under a single piece of legislation. We recommend this legislative change be implemented to achieve more equitable access to care and services for residents. An updated Act bringing both public and private LTC homes under a common system will ensure greater accountability and transparency in public reporting. The updated legislation and regulations must also outline the options that can be applied to address gaps in compliance with standards.

We also recommend that the sector move to a single quality assessment system that applies a common framework towards implementing the new national standards in order to strengthen public confidence and trust in the system. Given that the national LTC standards will become part of the accreditation process and that there appears to be value in both inspection and accreditation, it makes sense that the whole sector participates in accreditation. This will likely require developing new inspection, licensing, and accountability systems.

These recommendations represent large scale changes to the sector with investments required to expand the capacity to conduct inspections, implement the national LTC standards, and level quality and service standards between the public and private sector where inequity currently exists. While these ideas have been proposed in other reports about PEI's LTC sector, the challenges emerging during the pandemic have lessened some barriers to change within the sector and demonstrate the importance of making improvements. Planning and guiding the transition towards meaningful change will require significant collaboration among Health PEI, private LTC owner/operators, and the Department of Health and Wellness.

We recommend that consideration be given to forming a steering committee, consisting of representatives from these groups, to guide the workforce stabilization process, and that a new LTC Association be formed.

Formation of an association, for which mandatory membership would be required for all LTC homes, would provide a single body to improve collaboration, oversee the implementation of national standards, and guide workforce recovery and development

activities. LTC operators would have a single source of resources (or information about where to find resources) to ensure consistency and quality delivery of services. Rewards to members could include the financial benefits of economies of scale related to certain purchasing requirements. They could also rely on the Association for guidance in the area of governance best practices with help to establish and update policies, standards, human resource development and worker education. The Association would also be a common advocacy body for both public and private homes in dealing with government for new issues that arise, including planning and funding requirements to meet LTC national standards. The Association may also explore the continuum of LTC further by including community care facilities in its planning.

Harmonized information systems available to private and public LTC homes are necessary to:

- Assess quality of care
- Monitor quality of life and end of life care
- Assess quality of staff work life and physical, mental and social well-being
- Measure satisfaction and well-being of family and other partners in care, and
- Monitor implementation of and adherence to national LTC standards.

Examples of these systems include the InterRAI LTCF system for routine collection of resident quality of care data and a system for collecting staff indicators of well-being. For staff, this may take the form of routine staff surveys every 1 to 2 years by a trusted source (such as a credible, arm's length research team), measurement of quality of life of residents living with dementia, and regular surveys of partners in care. The implementation of these systems are large scale initiatives but we recommend that the sector moves without delay in this direction to enhance quality and safety and restore public confidence.

Findings

Interviews with stakeholders confirmed that inequities (e.g. access to resources, allied health care, staffing, wages, etc.) exist between public and private LTC homes.

Text box 4

Connection to Canada's National Long-term Care Standards^{4,5}

CAN/HSO 21001:2023 Long-Term Care Services:

Section 1: Governing LTC Home's Strategies, Activities, and Outcomes: requirement for a strategic plan; addressing systemic challenges; human resource planning

Section 6: Promoting Quality Improvement: dedicated resources and a plan for quality improvement activities



Recommendations for improvement

With respect to oversight and accountability, we have the following recommendations:

- 4A Establish a single legislative Act that governs all (both public and private) LTC homes including bringing them under a common accreditation and inspection system.
- 4B Implement both the HSO and CSA national LTC standards in all LTC homes with the necessary supports and funding over the next five years.
- 4C Establish a LTC sector association that includes all homes (public and private) to improve collaboration, e.g.,
 - monitor the implementation of national LTC standards
 - guide workforce recovery and development activities
 - oversee the development of organizational capacity on a sector-wide basis, i.e. IPAC, quality and risk data and IT systems.
- 4D Establish equitable government support for private and public LTC homes including base funding, access to capital, and security of ongoing support to develop infrastructure necessary to operate on a comparable basis.
- 4E Implement Inter-Resident Assessment Instrument Long-term Care Facilities (InterRAI LTCF) in all public and private LTC homes.
- 4F Using an independent assessor, collect data that validly assesses partner in care satisfaction.

Conclusions

We have concluded that significant improvements in measures taken by the parties in dealing with the pandemic are required, but these are based on hindsight. Given the environment at the time the pandemic started, the measures that were implemented, including isolation, were reasonable given the available information and resources at the time. However, measures taken, including full facility lockdowns, had negative consequences on the well-being and care of residents, as well as for partners in care. Long-standing health human resource challenges facing LTC homes worsened during the pandemic. LTC homes struggled and in many cases failed to meet infection control standards designed to protect residents, visitors and staff against the virus.

The pandemic experience has taught us that significant improvements are required to existing legislative and regulatory provisions, policies and practices to prepare for similar future events. Action is also needed for workforce recovery, recruitment and development. This action is unlikely to occur without attention and we encourage government to establish a process for monitoring the progress on implementing the recommendations in this report and the national LTC standards.

We have recommended improvements to existing physical infrastructure, staffing approaches, clinical oversight and other features of the LTC system to prevent and/or minimize the spread of virus outbreaks within homes. After reviewing the impact and perspectives of the pandemic on residents, staff, volunteers, family members and others, we have

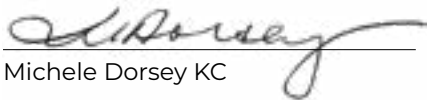
offered recommendations to assist with recovery from the ongoing effects, especially on staff, and to avoid such issues in the future.

The current state of our LTC sector requires substantial improvements, and the new national standard for LTC services (CAN/HSO 21001:2003 Long-term Care Services) provides criteria and guidelines for delivering resident-centred, high-quality care, enabled by a healthy and confident workforce. New national standards for infection control (CSA Z8004:22 Long-term care home operations and infection control) sets out infection prevention and control policies and procedures for LTC homes. These are standards that will need to be operationalized by taking into account the specific nature of PEI long-term care homes. Such factors include considering the size of the home, the physical infrastructure, the number of residents and their health issues, whether the LTC home is privately or publicly owned with consideration of the related governance and oversight models employed, specific human resource complement, and other such factors.

Consequently, a steering committee or other organizational approach to planning for the implementation of the standards will be essential. Regardless, it is important to begin immediately so that the national LTC standards are incorporated into the necessary steps to implement our recommendations related to resident-centred care, workforce recovery, recruitment, and development, strengthening infection prevention and control, and improving oversight and accountability.

We recognize the extraordinary efforts people made to respond to the COVID pandemic, and are optimistic that acceptance of these recommendations will provide a roadmap to a strengthened long-term care system. This is truly a situation of “everyone is responsible, yet no one is to blame”. With a renewed focus, it is our hope that Islanders who need long-term care in the future will find themselves in a home of quality care where they can truly live a quality life. Like any reflective exercise, there may be areas of concern or pride that have not been highlighted in this report.

We urge all stakeholders, government, operators, care providers, staff, community members, partners in care and most importantly residents to accept the work of the Panel with hope and commitment towards implementing these recommendations to achieve a stronger system.



Michele Dorsey KC



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Blair Corkum



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APPENDICES

Appendix 1: Key Definitions

Appendix 2: Recommendations Cross Referenced to National LTC Standards

Appendix 3: Summary: Nursing Home Project Report (2011)

Appendix 4: Summary: Private long-term care inspection report analysis

Appendix 5: Health PEI Accreditation Report Executive Summary and Accreditation Decision (2022)

Appendix 6: Consultation Summary

Appendix 7: References

Appendix 8: Bibliography

Appendix 1: Key Definitions

Acute care: For the purposes of this report, this refers to in-patient hospital care.

Allied health services: For the purposes of this report, this refers to prevention, treatment, and care services provided to residents by trained health care professionals, including but not limited to, services provided by physiotherapists and physiotherapy assistants, occupational therapists and occupational therapy assistants, pharmacists, registered dietitians, social workers, recreational therapists, speech language pathologists, respiratory therapists, audiologists, pastoral care clinicians, prosthetists/orthotists, and others.

Circuit breaker: Introduction of tight restrictions for a period of time that are designed to reduce the number of cases of an illness.

Compassionate visit: A visit with someone with a life-threatening illness or at end of life.

COVID-19: The name of the disease caused by the SARS-CoV2 virus.

Health care directive: A legal document that explains an individual's wishes for health care and treatment. A directive may appoint another person(s), called a Proxy, to make health care decisions if an individual is unable or incapable of communicating their own wishes⁷.

Infection Prevention and Control (IPAC): Evidence-based practices and procedures that, when used consistently in health care settings, can reduce the risk or prevent the transmission of disease to residents, staff, and visitors⁸.

Inter Resident Assessment Instrument Long term care facilities (InterRAI LTCF): The InterRAI Resident Assessment instrument assesses needs and strengths of persons living in LTC and provides information on key domains of function, mental, and physical health, social support, and service use.

Long-term care homes: On Prince Edward Island, LTC homes provide personal care and nursing services for people who can no longer live on their own or with assistance from Home Care and partners in care. The homes provide room and board, personal care, 24-hour nursing care and medical services. LTC homes may be publicly or privately owned⁹.

Model of care: For the purposes of this report, this term refers to the way that services are delivered to residents of long-term care homes. This includes what services are delivered, by whom, and how.

Morbidity: A word meaning illness, disease, or adverse effect.

Mortality: A word meaning death.

Partners in care (PIC): A person, identified by a resident, who may provide help with communication, personal hygiene, moving around, feeding, decision making, and/or emotional support¹⁰.

Resident cohort: An infection prevention and control practice where groups of 10-12 residents consistently have meals, activities, and participate in recreational events together. This supports social engagement while ensuring quick recognition of close contacts among residents in the event of an outbreak.

Substitute decision maker: An individual who makes health care and treatment decisions on behalf of someone who is not able to do so. An individual may appoint their substitute decision maker or if none has been formally appointed then the *Consent to Treatment and Health Care Directives Act* offers a list of individuals that are authorized to act as substitute decision makers⁷.



Appendix 2: Recommendations Cross Referenced to National LTC Standards

In the listing below, we reference certain national standards supporting our recommendations, although not a comprehensive list, and in no way minimizes the importance of implementing all of the national standards. References prefixed with HSO refer to the CAN/HSO 21001:2023 Long-Term Care Services national standards. Those beginning with CSA are from the CSA Z8004:22 Long-Term Care Home Operations and Infection Prevention and Control national standards.

I. Resident-centred Care

- 1A Uphold residents' rights and responsibilities. The following action supports this recommendation:
- Introduce a confidential, independent complaint reporting process (HSO 2.1.3, 2.4.4 and CSA 4.1.8)
- 1B Ensure that resident-centred care is always sustained. The following are actions that support this recommendation:
- Establish a common approach to ensure oversight and resident-centred care regardless of whether residents are in a public or privately operated LTC home (i.e., inspection and accreditation process) (HSO Standard 1)
 - Include partners in care as full team members in resident care (HSO 2.3.1, 2.3.2, 2.3.3, 2.3.4, 2.3.5).
- 1C Enhance health care directive/substitute decision making provisions to ensure resident wishes are known. The following are actions that support this recommendation:
- Ensure individual LTC home documentation is used to provide residents the option to set out personal value statements and other directions, as currently provided for in the standard form Health Care Directive published by Health PEI (Form 14HPE15-40623) (HSO 2.1.6, 2.2.6, 2.2.7)
 - Enhance documentation to set out the wishes of residents for application of personal protective measures in the event of infection outbreaks (HSO 2.1.1, 4.2.12)
 - Develop risk management policies to balance residents' right to live at risk with the rights of others to live in safety (HSO 2.1.4).

II. Workforce Recovery, Recruitment, and Development

- 2A Stabilize LTC health human resources. The following are actions that support this recommendation:
- Ensure regular capture of high-quality health human resource recruitment and retention data (HSO 5.1.5 and 5.3.3)
 - Increase access by the workforce to clinical educators, quality and risk professionals and allied health care providers (HSO 5.1.2, 5.1.3, 5.1.4, CSA 4.4.3, 5.1.3)
 - Review and update the model of care for LTC homes considering resident care requirements, staffing ratios and best practices (HSO 5.1.1)
 - Explore enhancing recognition and opportunities for staff by making Resident Care Workers a regulated profession.
- 2B Invest in an evidence-based staff (all levels) recovery plan to support recovery and to promote a positive work environment that supports staff health and well-being. The following are actions that support this recommendation:
- Ensure collection of data that validly assesses staff health and well-being using external resources to ensure objectivity and privacy (HSO 5.3.1, 5.3.2, 5.3.3, 5.3.4)
 - Develop and include performance measurements of employee well-being as a component of LTC home funding agreements (HSO 5.3.1, 5.3.2, 5.3.3, 5.3.4)
 - Increase employee access to virtual and in-person well-being supports (HSO 5.1.8)
 - Research/establish an approach to promote a culture supporting the importance of staff well-being and to create a cohesive workforce team-focused on delivering resident quality of care, incorporating participation by both workers and leadership (HSO 6.1.1, 6.1.2, 6.1.3, 6.1.4, 6.1.5).
- 2C Align both public and private sectors to a common care staff model in accordance with resident care requirements and considerate of minimum qualifications, recruitment, retention and financial implications. The following are actions that support this recommendation:
- Strengthen health human resource recruitment and retention across the sector, including addressing wage and benefit differences between private and public homes (HSO 5.1.1, 5.1.5)
 - Review and update the model of care for LTC homes considering resident care requirements, staffing ratios, and best practices (HSO 5.1.1)
 - In keeping with national LTC standards, improve workforce data collection, monitoring, analysis, and reporting across the sector (HSO 5.3)
 - Explore collaboration with other jurisdictions to create a single Atlantic Canada license and credentialing system for health human resources (HSO 5.1.1, 5.1.5).
- 2D Ensure consistent education and advanced nursing practice resources are available in all LTC homes. The following are actions that support this recommendation:
- Provide initial and ongoing training to the workforce to obtain and refresh skills to build relationships with team members and to assist staff to grow as care providers (HSO 1.1.14, 1.1.15, 5.1.3, 5.1.4, CSA 12)
 - Provide specialized training on communication and interaction skills to individuals who interact with dementia residents (HSO 2.4.1, 5.1.2, 5.1.3, 5.1.4, 2.4.3).
- 2E Increase quality and risk management capacity in the sector (i.e., data collection, care processes, and human resources) (HSO 6.1.1, 6.1.2, 6.1.3, 6.1.4, 6.1.5).

III. Strengthening Infection Prevention and Control

3A Strengthen and align infection prevention and control capacity across the LTC sector (public and private homes) (CSA Section 11). The following are actions that support this recommendation:

- Establish a provincial coordination plan for allocation of health human resources in LTC homes during outbreaks (HSO 1.1.7)
- Develop a rapid response team to support individual LTC homes in managing outbreaks
- Establish a consistent process for sharing information on a timely basis between the Chief Public Health Office and long-term care homes to provide consistent guidance on management and science of emerging viruses and infections, and timely information in the case of outbreaks (HSO 4.2.12, 4.2.14).

3B Update and strengthen business continuity plans to include pandemic protocols that address staffing shortages and resource acquisitions; outline communication channels and key contacts; and include plans to address residents'

physical, social, and mental well-being. The following are actions that support this recommendation:

- Regularly monitor the development of IPAC technology and invest to maintain the best practices (HSO 1.1.7, CSA 7.1.2, 8.1.1).

3C Ensure resident-centred care is maintained despite heightened infection prevention and control measures. The following are actions that support this recommendation:

- Continue funding IPAC positions to work with private LTC homes to collaborate with colleagues at Health PEI (CSA 5.7.4, 7.3.6)
- Develop and implement a formal IPAC training program for partners in care, visitors, and volunteers upon a resident's initial admission, with enhanced training upon outbreaks (CSA 5.3.2)
- Perform a provincewide review of LTC home physical infrastructure regarding appropriateness for infection control in accordance with the national standards (HSO 3.1.1, CSA 10.1.2).

IV. Oversight and Accountability

From our analysis of past reports and information collected during this review, governance and the importance of leadership in LTC was apparent. The issue of governance also arises in CAN/HSO 21001:2023 Long-Term Care Services national standards (HSO 1) which emphasizes the responsibility of those in leadership positions in the LTC system. We recommend that system administrators, owner/operators, and clinical leaders review these national LTC standards to ensure that their actions support achieving the overall goals of quality care. We include the following overarching recommendations around oversight and accountability to improve the strength of the sector.

- 4A Establish a single legislative Act that governs all (both public and private) LTC homes including bringing them under a common accreditation and inspection system (HSO 1).
- 4B Implement both the HSO and CSA national LTC standards in all LTC homes with the necessary supports and funding over the next five years (HSO, CSA).
- 4C Establish a LTC sector association that includes all homes (public and private) to improve collaboration, e.g.,
 - monitor the implementation of national LTC standards
 - guide workforce recovery and development activities
 - oversee the development of organizational capacity on a sector-wide basis, i.e., IPAC, quality and risk data and IT systems (HSO 1).
- 4D Establish equitable government support for private and public LTC homes including base funding, access to capital, and security of ongoing support to develop infrastructure necessary to operate on a comparable basis (HSO 1).
- 4E Implement Inter-Resident Assessment Instrument Long-term Care Facilities (InterRAI LTCF) in all public and private LTC homes (HSO 4.1).
- 4F Using an independent assessor, collect data that validly assesses partner in care satisfaction (HSO 2.3 and 6).

Appendix 3: Nursing Home Project Report (2011)

MacNutt MG and Harper WG¹

Background

In October 2009, the Department of Health initiated a Nursing Home Project to:

- Develop and negotiate a multi-year service agreement with private LTC homes
- Develop operational and care service standards for private and public LTC homes
- Identify new and existing issues, to be considered during negotiations, related to the 2007 LTC agreement with private homes
- Identify other policy and/or administrative issues related to LTC to be addressed by authorities or within the standards.

The project was guided by an interdepartmental steering committee and supported by consultants (Gail MacNutt and William Harper) provided by HRA. The project completed its mandate and compiled a list of recommendations that provide background information and insights into long-standing sector issues also observed by the COVID-19 LTC Review Panel during its work. We include the process and recommendations of the 2011 report because we wanted to highlight that over a decade ago this report identified some of the similar issues that we have outlined.

Key findings and recommendations

- **Recommendation 1:** Outstanding issues – a LTC Sector Joint Working Group, composed of representatives from the Department, Health PEI and private owner/operators, was recommended in

2011 as a forum to proactively address the important issues facing the sector.

- **Recommendation 2:** Nursing home standards – the 2011 report recommended that the Department of Health and Health PEI take steps to approve and implement standards for both private and public LTC homes.
- **Recommendation 3:** Maintaining a viable partnership – Maintaining a resilient LTC sector requires collaboration between the Department of Health and Wellness, Health PEI and private LTC owner/operators.
- **Recommendation 4:** Legislative review for LTC service
- **Recommendation 5:** Policy review for long-term care subsidization – since the 2011 report, policy changes have increased the comfort allowances for residents, changed accommodation rates, and updated the subsidy assessment process to enable spouses of LTC residents to retain a larger proportion of their family income.
- **Recommendation 6:** Drug programs, medication management
- **Recommendation 7:** Resource utilization and management for nursing home inspection and licensing
- **Recommendation 8:** Resident care staffing in nursing homes - resident care staffing, including access to allied health care providers and direct care hours continue to vary between public and private LTC homes on PEI.
- **Recommendation 9:** Process for assessing and approving bed allocation

Appendix 4: Summary: Private long-term care inspection report analysis

Key messages

- The COVID-19 LTC Review Panel commissioned an analysis of private LTC quality and safety inspection reports to determine what, if any, differences were observed between the pre-pandemic period and during the pandemic.
- During 2021 to 2022, there was a decrease in the number of full licenses and an increase in the number of provisional licenses issued to private LTC homes.

Background and Methodology

Private LTC homes and community care facilities on PEI are licensed annually through a series of inspections that inform licensing decisions by the Community Care Facilities and Nursing Homes Board. The licensing decisions and inspection reports are publicly posted on the government website (<https://www.princeedwardisland.ca>). The inspection reports detail inspectors' assessments of each home's performance against a set of specific quality and safety standards as outlined in the Community Care Facilities and Nursing Homes Act and related regulations and operational standards. Based on available evidence, inspectors may assess a home as being compliant (all requirements for a standard are met), partially compliant (some standards for a standard are met) or non-compliant (insufficient evidence that standards are met). Inspections and licensing of private LTC homes continued throughout the pandemic.

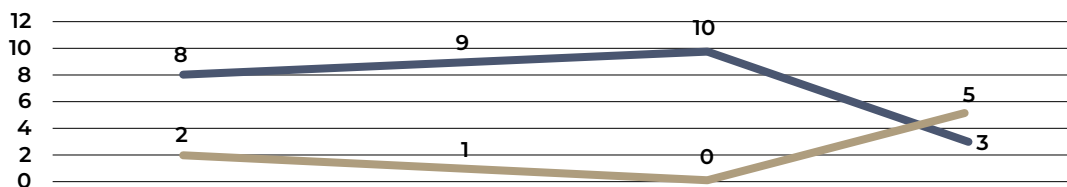
Note: The analysis was completed in October 2022, which represents a partial year of inspection reports.

Findings

The figure which follows illustrates an increase in the number of provisional licenses granted to LTC homes in 2022.

Figure 6

Licenses



| | 2019 | 2020 | 2021 | 2022 |
|---------------------|------|------|------|------|
| Full License | 8 | 9 | 10 | 3 |
| Provisional License | 2 | 1 | 0 | 5 |

Full License Provisional License

As depicted in table 1, a review of the inspection standards that were assessed as partially compliant or non-compliant in private LTC homes found that, between 2019 and 2022, there was an increase in the number of issues cited that were not fully compliant can be classified as follows:

Table 1 Standards: Partial or Non-Compliance

| Total | 2019 | 2020 | 2021 | 2022 |
|-------------------------------------------------|------|------|------|------|
| Standard 2.0: Management and Administration | 44 | 35 | 34 | 50 |
| Standard 4.0: Resident Care | 56 | 34 | 41 | 69 |
| Standard 5.0: Physical Environment and Security | 16 | 20 | 14 | 20 |
| Standard 6.0: Social Environment | 5 | 5 | 2 | 9 |
| Standard 7.0: Human Resources Management | 35 | 23 | 27 | 38 |

Excluding the partially compliant standards, specific non-compliant standards fell into the following three categories:

- management and administration
- physical environment and security
- human resources management.

It should be noted that exceptions may result from either actual non-compliance or because of lack of documentation to support compliance that, in fact, may have been satisfactory but not evident.

Specific non-compliant standards were:

Standard 2.0: Management and Administration

Standard 2.4: Nursing Service Administration

Reasons for non-compliance with this standard included:

- Director of Nursing's process for monitoring, managing and follow-up on incident reports requires improvements
- risk management practices and process and documentation of incidents require improvements
- notification of family and/or resident representative
- notification of immediate supervisor and management
- staff education and in-service training.

Other areas for improvement included:

- the role of the Director of Nursing specifically for tasks such as performance reviews
- evidence of in-service education and staff development in personnel records

- planning and organization of nursing and personal care service delivery
- evaluation of nursing and personal care services provided to residents
- consistently staffing with persons who have demonstrated competencies
- ensuring facility is staffed with adequate professionally designated and unregulated staff appropriate to meet residents' needs
- conducting regular audits to include staffing reviews and assessment of performance
- development and education needs
- management process for review of incident reports and risk management practices,
- implementing and monitoring quality improvements
- coordination and/or facilitation of staff education and in-services
- management of complaints and concerns
- implementation of Long-Term Care Clinical Standards and evidence-based practice (e.g. Braden skin assessments, falls risk, least restraints, end of life, dementia care, pain and comfort, responsive behaviors, TLR).

Standard 5.0: Physical Environment and Security

Standard 5.3: Safety & Security

Reasons for non-compliance with this standard included:

- requirements for CPR certifications to be updated annually
- staff education and training.

Standard 7.0: Human Resources Management

Standard 7.1: Orientation

Reasons for non-compliance with this standard included:

- requirements for a written staff orientation checklist for RNs and LPNs and an RCW Skills and Competencies Checklist

Standard 7.2: Staffing

Reasons for non-compliance with this standard included:

- requirements for sufficient number of staff scheduled at all times to provide for an evacuation or assistance in an emergency
- evidence of current/annual licenses to practice (RN, LPN) in personnel files
- evidence of completion of an RCW Skills and Competencies checklist in personnel files
- evidence of employee immunization records review
- orientation checklist to be contained in personnel records for all employees
- evidence of employee background checks with at least two most recent employers to be documented in personnel files
- nursing, dietary and personal care staff to have annual certification of CPR including anti-choking

- employee-signed confidentiality agreement on employee record prior to first shift.
- insufficient amount of staff positions filled to meet the total operational demand of the facility: 24/7 staffing patterns did not meet minimum requirements for direct-care hours and/or SAST resident monitoring. 24/7 scheduling requires Director of Nursing's review, updates and consistency in staffing assignments..

Standard 7.3: Staff Development and Training

Reasons for non-compliance with this standard included:

- evidence of opportunities for staff to attend education both inside and outside facility
- all staff to have person-centred care training annually
- annual education for all staff on caring for the cognitively impaired
- education for all staff on least restraint policy in initial orientation with refresher training at least annually
- staff education on protection of vulnerable adults including reporting requirements for suspicion of abuse or neglect
- staff training on incident reporting
- education on end of life and palliative care for nursing and personal care staff
- nursing, dietary and personal care staff to have annual certification of CPR including anti-choking.



Appendix 5: Health PEI Accreditation Report Executive Summary and Accreditation Decision (2022)

Qmentum Program

Executive Summary

Health PEI (referred to in this report as "the organization") is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

As part of the Qmentum accreditation program, the organization has undergone a rigorous evaluation process. Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed this organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

This report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

The organization is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

Accreditation Decision

Health PEI's accreditation decision is:

Accredited (Report)

The organization has succeeded in meeting the fundamental requirements of the accreditation program.

Accreditation Report

1

Executive Summary

Standards Set: Long-Term Care Services - Direct Service Provision

| Unmet Criteria | High Priority Criteria |
|----------------|------------------------|
|----------------|------------------------|

Priority Process: Clinical Leadership

The organization has met all criteria for this priority process.

Priority Process: Competency

The organization has met all criteria for this priority process.

Priority Process: Episode of Care

The organization has met all criteria for this priority process.

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The physical space in long term care is designed with the resident at the center. There is clear input from client and families and evidence of inclusiveness with cultural diversity. The environment is free from clutter and the atmosphere is home like. One of the challenges that exists is the charting within the program. There is a hybrid paper and electronic charting that is a concern for staff.

LTC is using paper-based charting and has a read only access of the larger CIS system. Communication could be improved with one system that was integrated.

Priority Process: Competency

The long-term care team provides training to its staff to ensure a standardized approach to care. Gentle Persuasive Technique is provided to all staff. There is evidence of concern for spiritual and cultural beliefs and residents are encouraged to embrace their heritage. The program follows a Least Restraint policy. There is strong collaboration in all departments at the sites. There is a feeling of pride and ownership of the building, and everyone is wanting the best experience for their residents.

There are no infusions pumps present in LTC currently.

The team speaks of having performance conversations and feel that feedback is ongoing with their leadership. Formal performance evaluations were in place but has been some time since the last ones.

Priority Process: Episode of Care

Long Term care is a champion of in person / family centered care. They have threaded the principles throughout all staff. This is evident in food choices, the physical spaces, and the design. Residents and family pick a winner for staff who show leadership in this initiative. There is evidence of cultural diversity. Bilingual services are available in some neighborhoods in LTC. Staff demonstrate a commitment to quality care and are interested in improving safety and quality of experience for their residents and families. Medication carts have just been introduced in some of the homes. There is opportunity to help the staff create a low distractible space to assist in safer delivery of medications with the new carts. The program has recently changed their policy on suicide assessment and are in the process of formalizing a new tool. This new tool will help increase the standardization of this ROP. Education is under way but not fully implemented. There has been much attention to detail by staff around mealtimes and insuring meal choices are offered. One site has added a service worker to mealtimes as a result of data around falls. This service worker assists with morning meals and allows nursing staff to attend to residents who want to have a delayed start to the day. It has helped lower falls. This service worker is also tracking all intake on a new form which, in turn, assists the clinical team in assessing nutritional status, impacting skin integrity. LTC in PEI does not have infusion pumps at their sites.

Overall, LTC has shown evidence in meeting the Required Organizational Practices (ROP). They are an eager committed team who are, clearly, interested in resident safety and love what they do.

Priority Process: Decision Support

There is a provincial ethics framework and the team that can be accessed as needed to support decisions. The health records are paper paper-based and kept in the units in cupboards.

There is evidence of audits and feedback on the health record.

Priority Process: Impact on Outcomes

There is a strong safety culture in long term care. The Quality and Risk manager is connected with the program and there is ongoing dialogue on incidents and how to prevent occurrences. Staff spoke of disclosure at the time of occurrence (E.g. a fall or medication error) and transparency with residents and families. There is a quality board at the sites.

Wedgewood Manor long-term care facility is an older facility with a very committed staff and very appreciative residents. Residents in this home tend to have very complex nursing needs.

The leadership, for this home, also supports two other homes and they are to be commended for their efforts in having staff work across all three homes to support the staffing needs. To assist with workload, the support staff have been training to take on additional roles. This includes making beds, which then

frees up the time for nursing staff.

Residents spoken to feel very comfortable in the facility and indicated they it feels like a "family".

Interactions seen with residents were very respectful and individualized.

Residents have had the opportunity to be engaged in groups planning the gardens as well as indoor space and feel it very much represents their home.

There is a good awareness of the ethics program and the supports that are available to the team.

Recognizing the importance of nutrition to the health and safety of the resident, the home created a nutrition intake sheet to monitor the amount of food and drink the resident was consuming.

Several indicators are being monitored at the Wedgewood Manor including pressure ulcers, hand hygiene, polypharmacy situation, and incidents for responsive behaviors. Results of audits are found on the quality boards within the resident care areas.

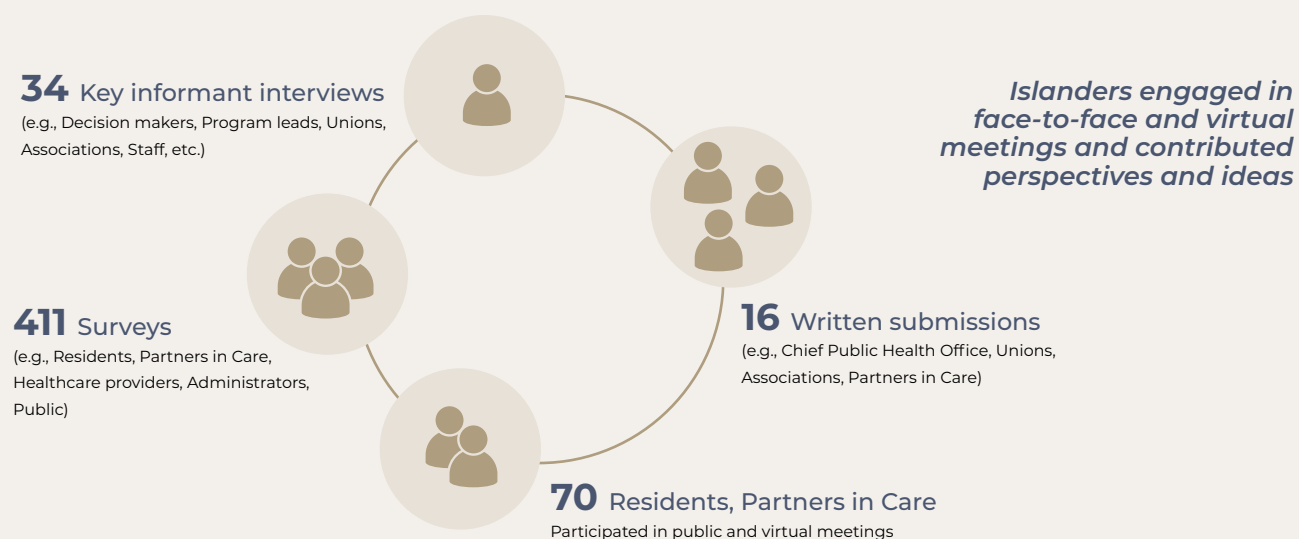
Appendix 6: Consultation Summary

In preparation for this review we collected information and invited submissions from several sources:

June-September 2022

- Reviewed past documents assessing PEI's LTC sector (see Bibliography)
- Commissioned a review of LTC reports from other jurisdictions
- Assessed LTC inspection reports pre- and during the pandemic (2019 to October 2022)

Stakeholder Engagement



Surveys

We developed surveys to gather the perspectives of residents, partners in care, the general public, health care providers, and administrators. The surveys were available online and in hard copy format, in English and French, from September to December 9th, 2022.

An invitation to participate in the survey was shared with the following groups:

- Francophone associations
- PEI Senior Citizens Federation
- PEI Seniors College

- East Prince Seniors Initiative (Facebook page)
- Age-Friendly PEI (Facebook page and committee)
- Seniors Secretariat members
- Senior Navigator (Dept of Social Development and Housing)
- Seniors Policy Advisor (Dept of Social Development and Housing)
- National Association of Federal Retirees
- Association des francophones de l'âge d'or de l'ÎPE
- Le Comite Bel Age
- PEI Women's Institute
- Mi'kmaq Confederacy of PEI
- Aboriginal Women's Association of PEI
- PEI Citizen Advocacy
- PEI Council of People with Disabilities
- PEI People First
- AccessAbility Advisory Council
- Youth Advisory Council
- Spinal Cord Injury PEI
- PEI Association for Community Living
- United Way
- PEI Literacy Alliance
- Community Foundation of PEI
- Immigrant & Refugee Services Association of Prince Edward Island
- Women's Network PEI
- Cooper Institute
- Home and School Federation
- PEI Teachers' Federation
- PEI Federation of Municipalities
- Seniors Committee – City of Charlottetown
- CHANCES Family Resource Centre
- Mi'kmaq Family Resource Centre
- Community Legal Information
- 211 PEI
- PEERS Alliance

Consultations

We faced several challenges in planning public consultations. Although originally scheduled in O'Leary, Summerside, Charlottetown, and Georgetown during October, media and online promotion of these events resulted in limited advance registration. Furthermore, challenges created by post-tropical storm Fiona destruction, ongoing COVID outbreaks, and limited advance notice due to scheduling timelines were also contributing factors.

In-person public consultations were held on October 31 in Charlottetown (translation services available) and interested participants in other locations were contacted to ensure that they had an opportunity to participate. We extended offers to LTC homes for onsite consultations, and an in-person consultation was held with residents and partners in care at The Mount Continuing Care Community on November 16. A public virtual consultation was held on November 16.

Written submissions

Individuals and organizations were invited to make written submissions to us beginning in August until December 9th, 2022. Email correspondence and written submissions were received from fourteen individuals and groups including several partners in care of current and former residents of LTC homes.

Key informant interviews

We invited 60 individuals and organizations to make submissions through an in-person or virtual interview or by written submission in September. Invited groups included each private LTC home owner/operator, public LTC home administrators, Health PEI leaders and administrators, unions, health care

provider colleges and associations, educational institutions (Holland College, UPEI, Marguerite Connolly Training and Consulting), non-government organizations (including Alzheimer Society, Hospice PEI, and the Immigrant and Refugee Services Association). Like the consultation process, the unforeseen demands of the Fiona recovery and COVID outbreak response necessitated delaying stakeholder interviews until November 2022 to January 2023.

We would like to thank the individuals and representatives of organizations for sharing their expertise and insights and apologize to any that may have inadvertently been omitted.

| Stakeholders | |
|----------------------------|------------------------------------------------|
| Katie Adams | Health PEI |
| Kari Barnes | Health PEI |
| Juliana Barry | Department of Health and Wellness |
| Barbara Brookins | PEI Nurses' Union |
| Dr. Martha Carmichael | Health PEI |
| Chief Public Health Office | |
| Lindsay Dickieson | The Mount |
| Marion Dowling | Health PEI |
| Ramsay Duff | Private LTC Association |
| Lori Ellis | Department of Health and Wellness |
| Tara Ferguson | Health PEI |
| Leonard Gallant | CUPE PEI |
| Dr. Michael Gardam | Health PEI |
| Donna Gormley | CUPE PEI |
| Louise Hall | Save Our Seniors Canada Inc |
| Angie Heinz | Health PEI |
| Karen Jackson | UPSE |
| Paul Jenkins | The Mount |
| Calvin Joudrie | Health PEI |
| Gale Lamont | Health PEI |
| Jennifer LeBlanc | CUPE PEI |
| Shelley MacCallum | Department of Health and Wellness |
| Anne MacEachern | Department of Health and Wellness |
| Mary Anne McMahan | Community Care Facility and Nursing Home Board |
| Wayne McMillan | Private LTC Association |
| Charlotte Murray | Public Service Commission |
| Tracy Perrin | Perrins Villa |
| Jennifer Petrie | Health PEI |
| Crystal Praught | Health PEI |
| Jason Rendell | UPSE |
| Sheila Rix | Health PEI |
| Marlene Robichaud | Department of Health and Wellness |
| Dr. Jan Rogerson | Health PEI |
| Claudette Theriault | Chez Nous |
| Cecil Villard | PEI Association for Community Long Term Care |
| Rochelle Visser | The Mount |
| Tracy Wolbaum | Health PEI |
| Allison Wyatt | Health PEI |

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