Repair and Recovery in Long-Term Care: Restoring Trust in the Aftermath of COVID-19 (2020-2023)

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An update to Restoring Trust: COVID-19 and The Future of Long-Term Care (2020)

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Land Acknowledgement

The headquarters of the Royal Society of Canada is located in Ottawa, the traditional and unceded territory of the Algonquin Nation.

The opinions expressed in this report are those of the authors and do not necessarily represent those of the Royal Society of Canada.

Background on the Policy Briefing Report Process

Established by the President of the Royal Society of Canada in April 2020, the RSC Task Force on COVID-19 was mandated to provide evidence-informed perspectives on major societal challenges in response to and recovery from COVID-19.

The Task Force established a series of Working Groups to rapidly develop Policy Briefings, with the objective of supporting policy makers with evidence to inform their decisions.

This report is an update to *Restoring Trust: COVID-19 and The Future of Long-Term Care*, originally published in 2020.

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Executive Summary

Three and a half years after the World Health Organization first declared COVID-19 a global pandemic and the disease first appeared in a Canadian long-term care (LTC) home, older adults in LTC still die every week from COVID-19. The LTC workforce emergency continues and remaining staff work short-handed, some without benefits. Despite new cash injections, LTC homes remain deeply under-resourced.

During the pandemic, Canada and the provinces made mistakes. We were slow to establish proper infection control practices and to provide personal protective equipment, we were unable to staff adequately, and we applied severe and cruel isolation practices, keeping those practices in place too long in many homes. Older adults deteriorated and died as a result. Many died alone. LTC residents, families, and essential care partners suffered from the profound confinement and isolation of residents. Staff not only worked short-handed, they took on new and extra duties. They experienced stigma and protests as the pandemic wore on. They stayed at their posts, adapted, and pulled together under extraordinary and often incredibly difficult circumstances. Managers and staff worked under combat-like conditions. When the pandemic was declared over, they struggled to re-enter normal work life. They were heroes and then they were not. Many of the staff and managers who have left LTC and many of those who remain experience devastating mental health consequences.

There is no doubt that we were unprepared for a global pandemic, despite the SARS experience in 2003 and the review that followed. There is no doubt that we are struggling with pandemic recovery and repair. It is unlikely that LTC homes are ready for another major event.

Still, Canada has had successes. We did fix the gaps in infection control and personal protective equipment. We bought vaccines, a lot of them, and we got them rapidly to the residents of LTC on a first priority basis. We stopped the hemorrhage, but not the affliction. Many jurisdictions came up with highly creative ways to integrate acute care and LTC. Innovative programs appeared that supported staff needs for childcare and transportation. LTC workers' wages were lifted in most provinces and some workers got sick benefits.

The Canadian government supported 2 major and robust new LTC standards, developed and issued by the Standards Council of Canada, the Canadian Standards Association, and the Health Standards Organization – this alone is nothing short of incredible in the middle of a pandemic. These standards, if fully implemented, monitored, and ensured, will change everything. However, they are voluntary. In Budget 2021, $3B was allocated to assist with implementation of the Standards. That Budget also allocated over $40M plus ongoing funds to Statistics Canada to improve data infrastructure and collection broadly including supportive care. Canada lacks an infrastructure to support the accountability that must accompany federal cash transfers.

At the time of this report the federal government is in the process of public engagement preceding a new Safe Long-Term Care Act. This legislation, if it is more than aspirational, could close many of the gaps. Particularly with implementation of the LTC standards, it could even be a game changer – maybe. The months ahead are important. The need for **federal and provincial action and leadership** is urgent.

In this report we have updated where Canada's LTC reform stands now, using publicly available sources. We make 8 recommendations, some of them repetitions of the ones we made in our 2020 report for the Royal Society of Canada, *Restoring Trust: COVID-19 and the Future of Long-*

Term Care. We have deliberated and reviewed what has been written about Canada and other countries' performance during the pandemic. We scanned scientific papers and reputable reports from global agencies, such as the work from the Organization for Economic Co-operation and Development, the World Health Organization, the United Nations, and the Australian Royal Commission on Aged Care Quality and Safety. The United Nations Decade of Healthy Aging initiative (2021–2030) places a strong focus on the social and moral determinants of health – and a stronger focus on values and human rights. As with all major disasters, natural or communicable, the COVID-19 pandemic had a significantly disproportionate impact on older people, women, and other equity-deserving people. All people were not treated fairly.

Older people and their human rights

Even if we adequately meet problems specific to COVID-19 and pandemic preparedness, even if we begin to focus resources and efforts on equity-deserving people and on the basic social and equity needs required for health – we will not achieve transformative change in the care of older adults living in LTC. To achieve genuine transformation, we must meaningfully adopt **a human rights framework that applies to older people who live in LTC homes**, one in which **all** older people are viewed and treated as fully human under both the Canadian Charter of Rights and Freedoms and the Universal Declaration of Human Rights.

We recommend beginning immediate human rights reform in LTC in the areas of governance, education, and training/re-training. In our 2020 report for the Royal Society of Canada, we identified systemic age and gender discrimination as the root causes of COVID-19's impact on LTC homes. Without immediate human rights reform, we will be unable to end these injustices. We will be unable to ensure that all older people are able to live well and die well. Older adults will not be prioritized, recognized, or acknowledged. Resources will not be sufficiently allocated, care givers will not be prepared or available, profit may triumph over compassion, and our governments' commitments will flag. Canada's potential as a global leader in caring for older adults who need support as they age will not be realized. Older Canadians will continue to suffer, particularly those who grow infirm.

This will diminish all of us.

The time for more reports is long past. Reports will continue to be written of course, and some of them may be worthwhile. But surely now – after hundreds of reviews and reports about LTC, over 30 in the last 3 years – we can muster **the grit to act** and to strike at the heart of the challenges. And to do this with a clear human rights mirror.

Our recommendations

We propose 8 recommendations, including an emphasis on human rights, that all need **action**. We identify 3 areas of immediate **priority**.

1. **The LTC workforce** (recommendations 1 and 3).
2. **Federal transfer payments** (recommendation 2)
3. **An accountability structure** (recommendation 6)

The LTC workforce crisis remains the highest priority for action that will address immediate, medium, and longer-term solutions that will aid recovery from COVID-19 pandemic effects and

contribute to a resilient LTC system. The LTC workforce crisis is now a true emergency, not only in numbers but in deeply worrying outcomes for poor health and wellbeing of staff.

Recommendation 1:

1a. The federal government must, in collaboration with provinces and territories, move immediately to ensure sufficient funds are available to raise the *minimum level of direct care hours* to 4.5 hours per day for each LTC resident.

1b. The federal government must, in cooperation with provinces and territories, immediately commission and act on a comprehensive, pan-Canadian, data-based assessment of necessary *staffing and staffing mix* guidelines in LTC homes. These guidelines must account for both characteristics of LTC residents and characteristics of all levels of staff and of the work environment. They should be updated every 5 years.

1c. The federal government must, in collaboration with provinces and territories, move immediately to implement a plan for health human resources that ensures *adequate* ***recruitment and effective retention*** *policies and practices*, emphasizing the mental health and wellbeing of staff and the health of their work environments.

Recommendation 2: The federal government must, in cooperation with provinces and territories, implement transfer payments that are conditional on provinces and territories achieving *transparent outcomes*. The federal government must assist the provinces and territories in meeting national staffing guidelines and in implementing the new national LTC standards.

Recommendation 3: The provinces and territories must, with support from the federal government, implement *mental health and other workforce support strategies* to underpin recovery and ensure resilience in all levels of the LTC workforce going forward. They must also examine and address **structural** causes of mental health and well-being stressors, such as staffing levels, work conditions, rigid hierarchical work structures, workplace identity-based aggressions, imbalances of risk, and resident quality of life.

Recommendation 4: The provinces and territories must, with support from the federal government, implement *anti-oppression strategies* in LTC for leaders, managers, administrators, and owners to remove systemic discrimination experienced by staff, residents and their families, and essential care partners.

Recommendation 5: The federal government must move immediately to guarantee that Canada's *data systems* are both adequate and sufficiently integrated to meet requirements for transparent data reporting from all provinces and territories to the public, about all relevant aspects of LTC care, care giving, and work environment.

Recommendation 6: The federal government must require provincial and territorial accountability through strategies such as making federal transfer payments conditional on acceptable performance metrics from provinces and territories. The federal government must, in cooperation with the provinces and territories, establish appropriate arm's length structures to monitor data and reporting transparency and enforce an *accountability framework*.

Recommendation 7: Provinces and territories must, to receive transfer payments, be required to demonstrate meaningful consideration of the *social and moral determinants of health* for both

residents and staff in their planning for LTC needs. Resources and services for equity-deserving older adults who are under-served must be allocated proportionate to their needs.

Recommendation 8: The federal government must, in cooperation with provinces and territories, begin *human rights reform in LTC* – in 2 areas immediately – and do this in close cooperation with older adults, including those with dementia.

> **8a.** Reform LTC **governance, laws, and practices** in partnership with people living with dementia and their families and essential care partners, using a human rights lens.
>
> **8b.** Implement **education and training** on human rights of older adults and older adults with dementia for (i) all education institutions that prepare staff who work in LTC; (ii) all levels of LTC staff – unregulated and regulated care staff, ancillary staff, and medical staff; and (iii) LTC Board members and senior leadership teams. Implement **awareness programs** on the human rights for older adults in LTC, families, and essential care partners.

LTC homes as homes

LTC homes are part of the continuum of healthcare from community-based care (such as home care) and primary care through all levels of acute care. LTC homes are however distinct from all other places where older adults receive care and live. These congregate living homes offer both social and health care. They are primarily *homes* (not chronic care hospitals) and social care is often the majority of care. They are places where many older Canadians, often with dementia and frailty, live the end of their lives. These lives should be lived free from age and gender discrimination, as well as discrimination based on race, ethnicity, and disability. LTC homes and their governors must adopt a perspective that recognizes the multiple intersecting vulnerabilities of older adults. These older adults must receive their full rights and protections under the Canadian Charter of Rights and Freedoms.

Living well is what matters most. Living well is being free from pain, fear, and indignities, having the right and freedom to move and to feel sunshine on one's face. It is companionship, social connection, intergenerational activities, laughter and joy, good food, animals, flowers, music, and ice cream, meaning and purpose in existence. Not every day, all day – but the goal is to accumulate moments, lots and lots of good moments, enough moments to make up a good end of life.

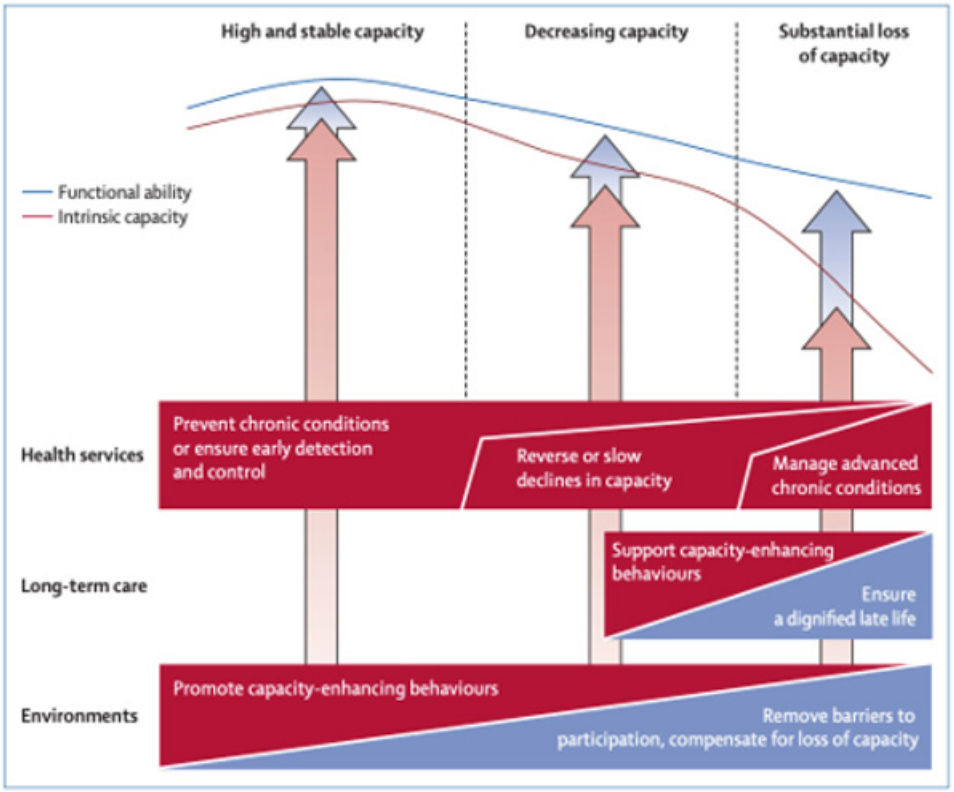
This is the big mission before us – it is as much a human rights mission as a mission of care.

Repair and Recovery in Long-Term Care: Restoring Trust in the Aftermath of COVID-19 (2020-2023)

In May of 2023, *The Lancet* announced a commission on person-centred long-term care (LTC*) for older persons.[1] This marked another step toward recognizing that older people matter and that things as they are – are not "OK." *The Lancet* Commission argued that discrimination based on age, mental health, and physical ability contributes to enduring misconceptions that older adults receive disproportionate benefits at the expense of younger generations. The Commission also argued that such discrimination contributed to the catastrophic and disproportionate impact of COVID-19 on older adults. *The Lancet* Commission offered a public health framework for healthy aging (Figure 1). The substance of our report lies in the *third column of this framework*. *The Lancet* Commission is another action, and an important one, in a series of actions emerging internationally and in Canada. Whether all of these actions will coalesce into a societal movement and structural **action** resulting in change is an unanswered question. It is also a question in part of whether we believe old and very old adults are fully human, with the full human rights that this belief ought to bring in Canada.

The disproportionate impact of COVID-19 in Canada's LTC homes took shape even as the pandemic began unfolding. On March 11, 2020, the World Health Organization (WHO) declared COVID-19 a pandemic, 3 days after the first Canadian death in LTC (Appendix 1). In June 2020, the Royal Society of Canada published *Restoring Trust: COVID-19 and the Future of Long-Term Care*.[2] We were at that time 4 months into the pandemic and living with high degrees of uncertainty (Appendix 1). Canada was struggling with shortages of personal protective equipment (PPE) and ventilators, and with high levels of fear. We had no clear picture of how COVID-19 was spread, no clear guidance on masks, and no effective treatment. A vaccine seemed months or years away. Most Canadians undoubtedly believed that soon this would be over, and things would return to normal. While we did not foresee the next 3 years, we knew even at that

Figure 1. *A public health framework for healthy ageing*



Reproduced from Beard and colleagues' Health Policy paper, The World report on ageing and health: a policy framework for healthy ageing, published in The Lancet. Reproduced with permission from The Lancet, May 2023

* LTC in this report refers to 24-hour care in a residential centre that includes health services, personal services, and other services such as housekeeping, laundry, and meals.[2]

early stage that older adults living in LTC were at extremely high risk and that LTC homes were not prepared for that risk. We feared that the impact would be severe and enduring – it was.

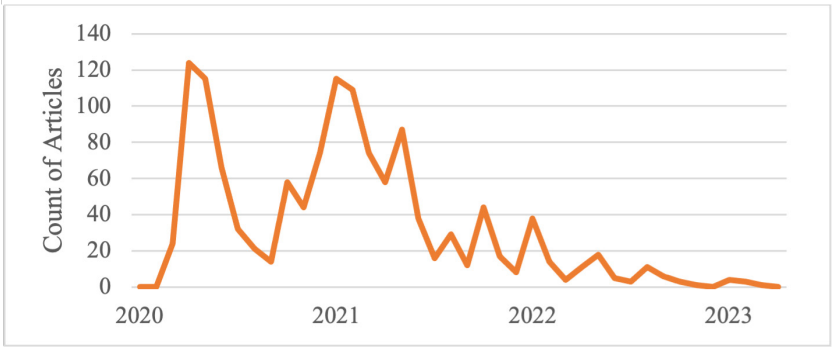
Three years later, normal seems a distant recollection. We now face significant medium- to longer-term impact and aftermath of COVID-19. Our decades-long inattention to a brewing workforce crisis in healthcare and LTC is a major barrier to recovery, threatening our ability to run our health and LTC systems. The recent *Organization for Economic Cooperation and Development* (OECD) report, on readiness and health system resilience[3] demonstrates how deeply connected a resilient health system and a resilient LTC system are to meeting other global phenomena, such as climate degradation, species extinction, global conflict, and intolerable health and social inequities and resulting disparities. Our ongoing decisions to ignore these *wicked problems*[4] of our time and to avoid seeing their interconnectedness will make it increasingly difficult to solve them. These problems, characterized by high social complexity and high interdependencies, with no easy solutions, require a great many people and governments to collaborate and change their world view and their behaviours.

In this report, we

- summarize the impact of COVID-19 on LTC residents, families, and workforce
- review actions that have been taken toward the recommendations in our 2020 report
- outline new or renewed recommendations in key areas
- discuss the need for a human rights perspective for the future of older Canadians needing LTC in Canada.

We are concerned that both new and old pressing issues (climate change, inflation, housing, global conflicts) have begun to eclipse interest in and attention focused on the impact of COVID-19 on LTC homes. For example, national media were active in keeping the crisis in LTC at the forefront of public attention during the pandemic, but attention to this issue has clearly waned since mid-2022 (Figure 2).

Figure 2. *Canadian national media articles on COVID-19 and LTC month, Jan 2020 – Aug 2023*



Two injustices

In our 2020 *Restoring Trust* report[2] we discussed the extreme and long-standing neglect of LTC homes and their occupants. This neglect is possible because of 2 fundamental discriminations: **age discrimination** and **gender discrimination**. If one looks, the literature is rife with material – theoretical, empirical, and popular – about these 2 long-standing discriminations. For example, the WHO, the OECD, and the United Nations have all produced substantive reports on aging and gender.[5-9] These reports describe the economic, social, and individual costs of such discrimination in the context of a rapidly aging global population. Some specifically include LTC in their coverage.[9] These examples of reports and the scientific literature make it clear that when we discuss the impact of age and gender discrimination broadly and in LTC specifically[10], we must

include older adults, care workers, and ancillary workers.[11,12] We often see stated or we hear that women's work is undervalued and that the work in LTC is women's work – the work of caring. The work of the largely female and ethnically diverse care workers in LTC homes has been historically undervalued.[13] This is compounded by the fact that the people in their care are old (often very old) residents, and the majority of them are also women. However, "caring can be understood only as women's work within *unequal relationships, structures and processes* [emphasis added] that help create women as carers and undervalue this caring work."[14] The structural causes of inequity are important, not just for age and gender discrimination, but also to understand both the complex interplay of multiple sources of discrimination (e.g., race, ethnicity, disability, gender identity) and their solutions[15-17] **and** to understand the critical mental health challenges that we discuss in this report and that face the care provider workforce in LTC homes. To do otherwise is to stoke a tendency to place culpability on individual workers – a stance from which we cannot properly support, recruit, or retain this workforce.[11,12,18]

Limitations of this report

We do not cover the entire landscape of review and diagnoses of Canada's performance in the LTC home sector or all the remedial actions that are possible and that will be needed to recover and be prepared for future crises. Appendix 2 is a brief overview of how we searched for relevant information. Several important reports have covered many of the problems both broadly and specifically. Among the most relevant:

- The *Canadian Academy of Health Sciences'* recent report on health human resources assesses the critical problems of Canada's health workforce emergency. While it does not specifically assess LTC, it offers an in-depth diagnostic look and makes core recommendations that affect all healthcare workers.[19]
- The recent *British Medical Journal* series, titled *The world expected more of Canada*, examines Canada's performance during COVID-19. This series offers broad-ranging assessment of how Canada's health systems performed during COVID-19. It covers problems such as vaccine hoarding, inadequate and non-integrated data systems, equity-deserving people, and LTC, and argues that Canada needs a formal National Inquiry.[20]
- The recent 2023 OECD report on preparation and resilience in health systems, including LTC, lays out requirements for better preparation and performance as future global crises emerge.[3]

Section 1 – Background

Global context

As of July 5, 2023, a total of 767,726,861 infections and 6,948,764 deaths from COVID-19 had been reported globally.[21] In Canada, 52,860 deaths have been reported and we have had 4,688,830 confirmed infections.[21] The Pfizer-BioNTech vaccine was first approved for use in the United Kingdom on December 2, 2020[22], and approved by Health Canada on December 9, 2020.[23] It was first administered in Canada on December 14, 2020.[24] Vaccines were quickly rolled out on a priority basis, beginning with residents and staff of seniors' congregate living settings, adults over 80 years of age, healthcare workers, and adults in Indigenous communites.[25] As of April 23, 2023, the cumulative percentage of Canadians who had completed a primary series (2 doses)

of a COVID-19 vaccine was 80.5%.[26] Since December 14, 2020, in total 98,118,881 doses of COVID-19 vaccines have been administered in Canada.[24]

In May 2020, Canada's percentage of COVID-19-related deaths in LTC homes was reported to be 81% of the total deaths in the general population (Canadian Institute for Health Information), significantly higher than the OECD average of 38%.[27] The mortality rate in LTC in Canada eventually settled at about 43% (almost 23,000 LTC residents as of July 5, 2023)[28], closer to the later OECD average of 40%.[29] Evidence suggests that lockdowns in LTC homes (e.g., complete or severe visitor restrictions and confining residents to their rooms exclusively for long periods) may have occurred too late[30-32] – once community spread of COVID-19 had begun, it was inevitable that it would get into LTC homes.

Between June 2021 and January 2022, at least 46 healthcare workers in Canada died due to COVID-19.[33] Estimates from the WHO suggest that between 80,000 and 180,000 health and care workers globally died between January 2020 and May 2021.[34]

Compared with other healthcare workers, staff in LTC who contracted COVID-19 were more likely to live in lower income neighborhoods, in higher density settings, and with another essential service worker. With each wave of the pandemic, low-waged essential service workers were at highest risk of COVID-19 morbidity and mortality.[35]

Not all countries experienced similar impact and suffering from the COVID-19 pandemic. New Zealand and Australia saw relatively low case counts and deaths, due in part to strict implementation of and adherence to public health measures.[30,31,36] However, the COVID-19 pandemic had significant effects globally on child and youth education and on equity-deserving people, due to factors such as ethnicity, age, and the economy.[32,37-39]

The WHO downgraded the COVID-19 pandemic from a global health emergency on May 5, 2023[28], and most COVID-19 restrictions have been lifted globally. Much of the reporting of cases and deaths wound down between mid-2022 and early 2023.[40-44] However, COVID-19 has not gone away – several thousand cases, and around 70 deaths, are still reported each week in Canada.[21] The lasting effects of the pandemic will persist for some time, including post-COVID syndrome (long COVID), mental health effects such as depression and post-traumatic stress disorder, and strains on health and social care systems.[45] We have also seen reduced life expectancy due to COVID-19 in 75% of OECD countries.[3]

The population context of residential LTC in Canada

As projections have indicated for many years, the proportion of Canada's population over the age of 65 is rapidly increasing. Some estimates suggest that it will reach 25% by 2051.[46] The number of Canadians aged 65 and older increased by 18.3% between 2016 and 2021.[47] As life expectancy increases and medical care advances, more people will live longer *in* – not just *to* – older age.[47] Not unexpectedly, the most rapidly growing segment of the older population is people over 85 years of age.[48-50] The number of Canadians aged 85 and over increased 12% between 2016 and 2021, more than double the 5.2% growth of the overall population in Canada.[51] Projections are that the population of Canadians aged 85 and over could reach 2.7 million by 2050.[49]

While the prevalence of dementia appears to be stabilizing, age is the primary risk factor for developing dementia. Thus, dementia will become increasingly common as large numbers of baby boomers (born from 1946 to 1965) reach older ages.[50] The Alzheimer Society of Canada

predicts that 13.2% of Canadians aged 65 and over will be living with dementia by 2050.[50] Frailty is also on the rise, with over 2 million Canadians predicted to be living with frailty by 2025.[51,52] Both dementia and frailty, but especially dementia, are major drivers of admissions to LTC homes.[3,53-55]

Other demographic and population trends will also influence the future of LTC in Canada. Families are changing in structure, with the nuclear family of the last 70 years no longer as prevalent.[56] Canadian families are becoming smaller, dropping from an average census family size of 4.2 persons in 1931 to 2.9 persons in 2021.[57] This is in part a result of declining fertility rates, with global fertility rates projected to fall from 2.3 births per woman in 2021 to 2.1 in 2051.[58] Projections suggest that, combined with other socioeconomic changes, this decline in fertility will result in a 30% reduction in the availability of unpaid caregivers such as family members by 2050 in Canada.[46,59] The composition of families is also changing as a result of increased rates of divorce, with increasing numbers of one- and two-person households and lone parent families.[60] Increased geographic distance and increased costs of living also affect the ability of family members to act as informal caregivers to older adults. This has become increasingly common as adult children move further away because of trends in globalization, urbanization, and greater workforce mobility, among other factors.[3,61,62] Together, these trends mean that the typical older adult will not have the same social support system of geographically proximate kin caregivers that they may have had in the past. And as complexity of their health situations increases, such as with advancing dementia, the care required by some older adults also becomes highly complex and increasingly difficult to provide or to access at home.

The recent trends toward *aging at home (aging in place)* are attractive to most older Canadians, particularly in light of the shocking events and conditions revealed in LTC over the course of the COVID-19 pandemic.[63] As more LTC services are available in the home or community and more older adults choose to age at home for as long as possible, people will increasingly enter LTC homes later and later in their aging trajectories with higher and more complex social and medical needs.[64] We already see significant trends to shorter lengths of stay in LTC homes before end of life.[64] We are experiencing a compression of acuity, dependency, and complexity at end of life in LTC homes. These are accompanied by severe misalignments between care needs and the numbers, mix, and preparation of LTC workers such as their education and skills.[60]

These demographic trends will also be reflected in significant increases in Canada's LTC costs. LTC in Canada has been dangerously underfunded for decades and requires significant, critical catch-up. Estimates suggest that informal caregivers provide $24 billion to $31 billion worth of care each year.[65] Absorbing these unpaid service costs into the public sector would increase the annual cost of LTC from $22 billion in 2019 to $98 billion in 2050.[46,66] Without appropriate funding action, further out-of-pocket expenses will be passed on to Canadians, seriously disadvantaging many older people who live on limited, fixed incomes and do not have sufficient savings to absorb the high costs of private services.[46] Without appropriate funding action, proper implementation of Canada's new LTC standards[67,68], detailed in Section 3 of this report, will remain only an aspiration and out of reach for most LTC homes. The $3B allocated in Budget 2021 for their implementation, while important is far from sufficient. Further, the mechanism for ensuring that the funds are used for implementation of the Standards is not clear.

These trends underscore the ongoing need for LTC services in the late stages of life for many and the pressures that are changing the characteristics of LTC residents. More, not fewer, resources are needed for those who require this level of care.

Section 2 – Impact of COVID-19 on an Already Highly Strained LTC System

Residents in decline

Beyond the direct consequences of the SARS-COV-2 virus, the public health measures severely restricting visitors had significant impact on LTC residents. Restrictions on visits varied across provinces and territories and evolved quickly over the course of the pandemic. Primary differences in policies restricting visits were in the number of visitors allowed, frequency of visits allowed, required vaccination status of visitors, and masking requirements.[69] It is now clear that the isolation imposed by these severe restrictions had catastrophic impact on residents, families, and staff. During the first wave of the pandemic, 11% of LTC residents in Canada had no contact with friends or family, almost triple the number (4%) in 2019.[70] Reports have emerged of increased rates of loneliness, depression, agitation, and restlessness, as well as residents feeling "imprisoned" or "trapped."[70-75] Other effects on residents include reduced cognitive function, refusal to eat, loss of muscle mass, decreased activities of daily living, and excess mortality.[76,77] Residents with dementia and other cognitive impairments experienced the added burden of not understanding *why* restrictions were imposed or *why* family and friends could not visit.[77]

LTC residents experienced disruptions to non-urgent care, including physiotherapy, physical activity programs, and in-person visits with general practitioners.[3,70] They also lost access to social activities and shared mealtimes. Vaccines diminished these disruptions, but the consequences of these restrictions may have already become irreversible: functional and cognitive declines, declines in mental and physical health, increased severity of loneliness and social isolation, worsened responsive behaviours, and increased use of medication such as antipsychotics and of restraints.[78,79]

One strategy used in attempting to mitigate the effects of restricted visits was technology such as video calls. Reviews on the use of video calls in LTC homes suggest that they can help promote social connection and wellbeing and prevent social isolation and loneliness.[80,81] However, problems of access, digital literacy, staffing to support video calls, and infrastructure constraints limited the ability of some LTC homes to use such technology.[80,82] Research on digital interventions such as video calls is limited, so the extent to which technology can supplement in-person interactions is still unclear.[83]

Older adults without homes

At least 235,000 Canadians experience lack of access to housing in a year, and 25% of them are adults over 50.[84] A 2021 report for Toronto identified that 37% of people without housing were over 50 years old. National data show that adults over 50 years old[85] are the only demographic age group for whom use of public shelters has increased, even adjusted for the proportion of older adults in Canada.[84] From 2009 to 2022, numbers of older adults experiencing lack of housing doubled in Toronto.[86] In Toronto alone, in 2023 there are over 35,000 active applications by older adults for social housing.[87] Reasons for lack of housing among older adults are multiple. They include unaffordable housing, unavailability of affordable housing, worsening physical and mental health, substance addiction, loss of a partner, violence and abuse, social isolation, and inability or lack of awareness of how to access benefits.[86]

Geriatric conditions (impaired function, falls, urinary incontinence) are more common among older adults who lack housing than those who are housed adequately. The prevalence of these

conditions has been reported as *higher than the prevalence in housed adults who are **20 years older***.[88] A 2023 report found that a third of the people seen in geriatric outreach in Toronto met criteria for LTC, but only 5% of those referred were accepted.[89] In coming years, growing numbers of older adults will require more affordable housing, more appropriate geriatric and social services, and greater LTC capacity. Combined with the disproportionate impact of COVID-19 and most disasters on equity-deserving people such as older adults, improving social and moral determinants of health (Box 1) is urgent as a condition for preparedness.

Families and essential care partners unable to be present

Families and essential care partners of people living in LTC were negatively affected by the pandemic. Both family members and essential care partners provide companionship to residents and have significant roles in providing care.[90] Across OECD countries, 13% of people aged 50 and over provide *unpaid* care daily or weekly.[91] Early in the pandemic, Canada's national media reported the struggles families faced in deciding whether to keep their loved ones in LTC, where they were at high risk of contracting COVID-19, or moving them into family homes, where they might not have access to all the necessary care.[92-95] As the pandemic wore on, media reports documented heartbreak, joy, anger, and confusion experienced by families as rules around visits changed and evolved.[96-99] When LTC homes started to reopen, some family members were overjoyed to see and speak to their loved ones without a window between them. Some were angry or disappointed that only people who met certain criteria were allowed to visit and that distancing rules remained in place. Others were distressed by the physical and mental declines they saw in their loved ones since the start of the pandemic.[95,99-103] Although systematic reviews on the impact of restrictions on visits are limited, existing reviews describe the negative effects of restrictions on family members and essential care partners, including increased levels of worry, anxiety, and distress and decreased psychosocial wellbeing.[74,75,77] They experienced concern about their loved

Box 1. Social and moral determinants of health

Social determinants of health

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality

From: WHO. *Social determinants of health*. 2023. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Moral determinants of health

- Social solidarity, which means individuals in a community or country can rely on one another to secure the basics of healthy lives underpinned by a government that defends and prioritizes improved health
- Ratification of basic human rights treaties from the international community at a national level
- Health care as a basic human right
- Acknowledgment and action on climate change
- Reform of the criminal justice system
- Compassionate immigration reform
- End hunger and homelessness
- Ensure order, dignity, and equity in democratic institutions

From: Berwick D. The Moral Determinants of Health. *Journal of the American Medical Association* 2020;324(3):225–226. doi:10.1001/jama.2020.11129

ones' psychological wellbeing, the care they were receiving, and their daily activities.[77] End-of-life care also had to be modified, with families and essential care partners unable to be physically present and grieving processes altered for family and staff.[104,77]

A workforce under severe strain

COVID-19 also exerted disproportionate effects on the LTC workforce, with its high proportions of point of care workers from equity-deserving groups.[3,105, 106] These workers faced significant changes in day-to-day function while experiencing considerable mental health strain. We knew that working conditions and mental health and wellbeing among LTC staff and managers were poor before the pandemic, and these worsened with the emergence of COVID-19.[107-110]

Among the general healthcare workforce, prevalence of depression, anxiety, burnout, insomnia, and post-traumatic stress disorder increased from pre pandemic levels and increased as the pandemic progressed.[107-109] However, LTC workers across OECD countries reported experiencing stress, anxiety, and depression at a rate that was a full percentage point higher than that of all employees.[105,106,108,110] LTC staff across the world reported intensified emotional, mental, and physical exhaustion, with some describing feeling like "zombies" or like they "could not take any more."[108] LTC home managers also had statistically significant decreases in their mental health and job satisfaction.[107]

LTC workers report significantly higher exposure to mental health risks (~66%) than average employees (43%) due to the nature of the work: high caseloads, greater work intensity, threats of violence, and exposure to verbal abuse, humiliation, bullying, and harassment.[105] Beyond these risks, particularly during early pandemic months, LTC staff worried about the presence or threat of COVID-19, access to and use of PPE, increased workload due to staff shortages, and decreased work hours due to 'one workplace' policies.[96-113] They also experienced fear of infecting their loved ones while caring for residents with COVID-19, having to cope with loss and death of residents, worsened working conditions due to COVID-19 restrictions, and jeopardized job security.[109,111-113] Worryingly, some Canadian jurisdictions have ended important benefits that were brought in during COVID-19, such as paid sick leave for LTC workers.[114] Restrictions on family visits also had negative effects on LTC home staff: increased emotional distress, moral injury, and burnout due to increased workload, grief, and fear of infection.[74,106,115]

Globally, estimates of staff turnover during the pandemic are mixed, with some countries indicating perceived increases in turnover and others seeing decreases in total turnover.[105] LTC workers across OECD countries have a higher frequency of short tenure of work (<12 months) than other employees.[105] Approximately half of LTC workers have tenure greater than 60 months, compared to over 60% of nurses and personal care workers in other healthcare sectors.[105] LTC staff and managers also reported high rates of intention to leave their jobs.[3,107] In the 2019–2020 period, 4% reported actively searching for another job – a rate that was a full percentage point higher than that of nurses and personal care workers in other areas of healthcare.[105,107] In Canada, data from the Canadian Institute for Health Information suggests a 2.2% decrease in the number of registered nurses employed in direct care in LTC between 2020 and 2021.[116]

Section 3 – Progress on recommendations from the 2020 Restoring Trust report

We made 9 recommendations in 2020. Of these, one has been implemented (✓ **green**), 4 are partially implemented at some level (♦ **yellow**), and 4 have no implementation of our recommendation of which we are aware (● **red**).

● **Recommendation 1**: The federal government must immediately commission and act on a comprehensive, pan-Canadian, data-based assessment of national standards for necessary *staffing and staffing mix* in LTC homes.

✓ **Recommendation 2**: The federal government must establish and implement national standards for LTC homes that ensure *(a)* training and resources for infectious disease control, including optimal use of personal protective equipment, and *(b)* protocols for expanding staff and restricting visitors during outbreaks.

♦ **Recommendation 3**: Provincial and territorial governments, with the support of new funding from the federal government, must immediately implement appropriate pay and benefits, including sick leave, for the large and critical unregulated workforce of direct care aides and personal support workers.

♦ **Recommendation 4**: Provincial and territorial governments must make available full-time employment with benefits to all unregulated staff and regulated nursing staff. They should also evaluate the impact on LTC homes of 'one workplace' policies now in effect in many LTC homes and the further impact on adequate care in other LTC settings such as retirement homes, hospitals, and home care.

● **Recommendation 5**: Provincial and territorial governments must establish and implement *(a)* minimum education standards for the unregulated direct care workforce in LTC homes, *(b)* continuing education for both the unregulated and regulated direct care workforce in LTC homes, and *(c)* proper training and orientation for anyone assigned to work at LTC homes through external, private staffing agencies.

● **Recommendation 6**: To achieve these education and training objectives, provincial and territorial governments must support education reforms for specializations in LTC for all providers of direct care in LTC homes – care aides, health and social care professionals, managers, and executive.

♦ **Recommendation 7**: Provincial and territorial governments, with the support of federal funds, must provide mental health supports for all LTC home staff.

♦ **Recommendation 8**: Federal support of the LTC sector must be tied to requirements for data collection in all appropriate spheres that are needed to effectively manage and support LTC homes and their staff.

● **Recommendation 9**: Data collection must be transparent and at arm's length from the LTC *sector and governments.*

In Table 1 of Appendix 3, we give an overview of recent provincial and territorial reports on their LTC standards and impacts of COVID-19. In Table 2 of Appendix 3, we summarize federal, provincial, and territorial actions that we have identified as aligning with one or more of the 9 recommendations in our 2020 *Restoring Trust* report. These actions in Table 2 were sourced from publicly available provincial and territorial reviews of LTC and from federal budgets. Where we found no actions related to a particular recommendation in the publicly available reports, this

is identified in Table 2. While Appendix 3 does not capture every report and action undertaken provincially, territorially, or federally, it offers a cross-country overview.

In 2020, in the *Restoring Trust* report, we called for a moratorium on further reports and reviews of LTC homes – there had been over 100 in the last 50 years. They all said essentially the same things. One or 2 recommendations from each might have been implemented and then each report was shelved to gather dust. We argued in 2020 that **we already knew enough to have acted** and to have made the significant changes and improvements in Canada's LTC homes that would have buffered this sector against some of the worst COVID-19 effects. We failed to do so. Since the beginning of the pandemic, 31 more reports (Table 1) have been published in Canada alone that relate specifically to COVID-19 in LTC homes[117-144] or to critical associated challenges, including the workforce crisis[19,145] and data collection.[146] As of August 2023, the provinces of Newfoundland, New Brunswick, and Saskatchewan also have reviews underway.[147-149]

We have now accumulated more evidence, and undoubtedly more is coming. In specific areas a report or study will be useful, but **actions are needed rather than more reports.**

The most significant progress in Canada at the federal level in the last 3 years is the remarkably rapid development of 2 robust **National Long-Term Care Standards** and the initial allocation of $3 billion in Budget 2021 to support the provinces and territories in implementing the standards.[150] The 2 standards are: *(1)* the Canadian Standards Association Group standard focusing on infection prevention and control, building design, and operations[67] and *(2)* the Health Standards Organization standard focusing on safe, reliable, high-quality care.[68] The Canadian Standards Association standard is new, while the Health Standards Organization standard is a revision of the existing but limited Long-Term Care Services standard.[67,68] Both were shaped by extensive engagement with interested groups, including LTC residents, families and essential care partners, and the LTC workforce.[67,68] Together, the standards' technical committees sought and received input from over 18,800 Canadians through surveys, workbooks, town halls, virtual visits with LTC residents, public information sessions, and consultations with point of care workers.[67,68]

Federal government actions on Restoring Trust recommendations (Appendix 3, Table 2)

The federal government has taken some steps toward several of the recommendations in *Restoring Trust.*

Pay and benefits (recommendation 3). The federal government has allocated $50 million over 5 years to develop and test ways to strengthen retirement savings for care aides and personal support workers, $1.7 billion over 5 years to support hourly wage increases for care aides and personal support workers and related professions, and $115 million over 5 years to expand the Foreign Credential Recognition Program to reduce immigration barriers for internationally trained healthcare professionals.[151,152]

Mental health supports (recommendation 7). The federal government pledged $100 million over 3 years, beginning in 2021–2022, to support mental health initiatives for LTC staff disproportionately affected by COVID-19, as well as funding for a number of mental health and wellness and suicide prevention services.[151]

Requirements for data (recommendation 8). Limited action toward this recommendation includes providing $505 million to federal data partners for developing data indicators, improving

data tools, and supporting efforts to use data for improving healthcare safety and quality. Over 6 years, Statistics Canada will receive $41.3 million to improve data infrastructure and collection.[151]

Provincial and territorial government actions on Restoring Trust recommendations (Appendix 3, Table 2)

Actions have included funding for full-time positions in LTC (***recommendation 4***), and funding for access to wellness support programs (***recommendation 7***).[117,128] However, there is great variability across provinces and not all provinces have made explicit the kinds and amounts of funding. We found no actions in the publicly available reports on development and funding for continuing education and training programs (***recommendation 5***), or on education reforms for specializations in LTC for all providers of direct care (***recommendation 6***), or on transparent and arm's length data collection (***recommendation 9***).

Additional federal, provincial, and territorial responses to COVID-19 with impact on LTC

The federal government response has included rapidly securing ample **COVID-19 vaccines** for Canada on a priority basis and a strong national distribution strategy.[153] Provinces similarly organized massive vaccine administration programs first for high priority populations and then for the entire population. The federal government provided $50 million to the Public Health Agency of Canada to support operations of the National Emergency Strategic Stockpile, containing **supplies** that can be requested by provinces and territories for major public health events such as natural disasters or infectious disease outbreaks.[152]

In fall of 2020, the federal government announced $1 billion for creation of a **Safe Long-Term Care Fund**, designed to help provinces and territories protect people living and working in LTC and to improve infection prevention and control measures in LTC settings.[154,155] Provinces and territories received funding under the conditions of providing a detailed spending plan and demonstrating investments based on these spending plans.[155] All 13 provinces and territories signed agreements with the federal government in late 2021 to early 2022 to receive support through this Fund.[154,156]

In July 2023, the federal government-initiated stakeholder and public engagement processes to develop a **Safe Long-Term Care Act**.[157] Federal legislation of this sort – if funding and accountabilities are put in place – could go a long way toward major positive changes. To date, the federal government has said it will not mandate the new National LTC Standards[158], nor has it made transfer commitments sufficient for widespread implementation of the new standards. It has committed dollars to workforce stability, including through wage top-ups and improvements to workplace conditions such as staff-to-resident ratios and hours of work. It has also committed dollars to strengthen enforcement of regulations including through accreditation and regular inspections.

Overall, we view the state of actions specific to transformative change in LTC with (considerably) cautious optimism. Progress has been made since the pandemic began, but is insufficient. This is in part because LTC homes went into the pandemic with severe deficiencies. It is too early to give the federal government or the provinces a passing grade, and it is quite likely that some provinces will be able to accelerate their plans while others will take much longer. If the federal government responds fully, then it will both lift older adults in LTC and prevent disproportionate lag in struggling provinces or territories.

Section 4 – Going Forward

Resilience and preparedness

Here we identify critical areas for urgent actions needed to *(1)* create resilience in the LTC sector and *(2)* ensure preparedness for future emergencies. Such future emergencies may include communicable disease, climate change impact such as fire and flood, bioterrorism, war, and as yet unknown events. Preparedness is an urgent priority regardless of event scope. Events with impact on the LTC sector can be global, like COVID-19, major climate events, and major climate diaspora. They can be regional, like many smaller climate events and disasters. They can be more localized, such as the L'Isle-Verte LTC home fire. Resilience is a core component of preparedness. The 2023 OECD report titled *Ready for the Next Crisis? Investing in Health System Resilience* evaluates countries' responses to COVID-19 across all health sectors using the *disruption cycle* (Figure 3, Box 2).[3] The report points out which stages of the cycle were most dysfunctional and when.[3] LTC homes and the LTC sector were clearly **unprepared**, with almost no capacity to absorb the shock of COVID-19 because of pre-existing deficiencies and decades of neglect.

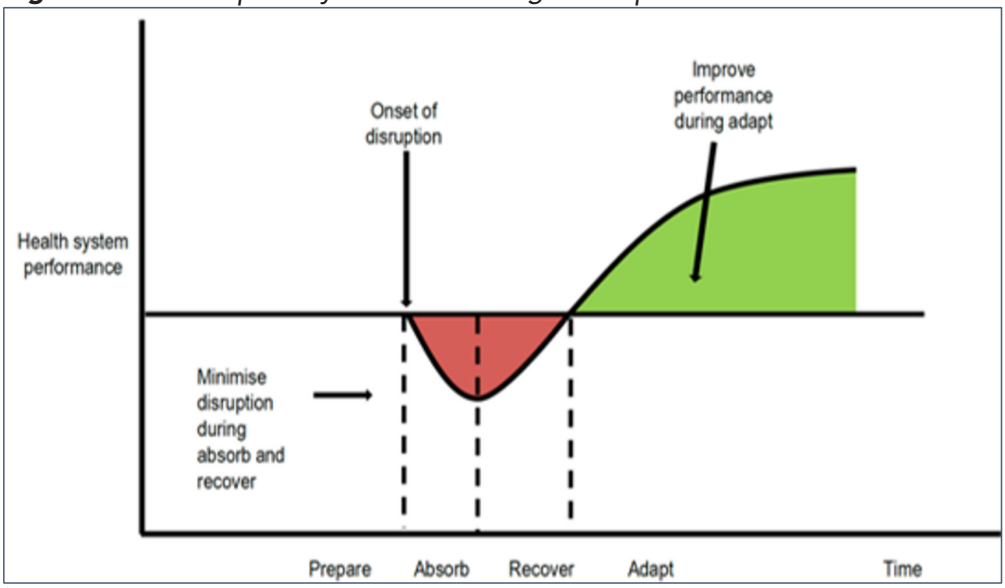
LTC homes **continue to struggle to recover** in no small part due to extreme workforce shortages and deficiencies. Whether they will adapt is unclear. It is clear that **to adapt and be prepared** for another major event, the LTC sector in Canada must: *(1)* tackle pre-existing deficiencies, *(2)* build its capacity to respond to major events (resilience), and *(3)* importantly, recover. Recovery *must not* take decades. It will take time, significant investments, a long view strategy, and the iron will to implement that strategy. It will be possible with federal, provincial, and territorial cooperation, new funding, and an unwavering focus on the common goal. Success will benefit all jurisdictions and strengthen performance at all levels.

The cost of ***not*** acting will be steep.

Disruption Cycle Stage 1: Prepare – Tackle pre-existing deficiencies

Multiple deficiencies in LTC before COVID-19 included *(1)* staffing, *(2)* data (and action on data and accountabilities related to performance based on data), *(3)* integration and cooperation among parts of the health system, *(4)* an almost total absence of primary prevention and health promotion to keep older adults at home and in their communities as long as possible, and *(5)* any

Figure 3. *The disruption cycle: The four stages of representation over time.*



Adapted from OECD (2019), "Resilience-based Strategies and Policies to Address Systemic Risks", https://www.oecd.org/naec/averting-systemic-collapse/SG-NAEC(2019)5_Resilience_strategies.pdf, and National Research Council (2012), Disaster resilience: A national imperative, https://doi.org/10.17226/13457.

meaningful consideration of the social (poverty, shelter, education, climate stability, etc.) and moral (equity, inclusivity) determinants of health.

Multiple critical reports and papers have been and will be published about these deficiencies.[3] If most pre-existing deficiencies are tackled successfully, then better absorption of shocks (whatever they may be) will be possible next time. As well, recovery will be possible and more efficient next time.

Box 2. The disruption cycle

The disruption cycle comprises 4 stages (Figure 3):

- **Prepare** includes the steps taken by the health system and related institutions to plan and prepare critical functions and features to avoid and mitigate a universe of potential shocks. It occurs prior to the disruption.
- **Absorb** comprises the capability of the health system to maintain core functions and absorb the consequences of an acute shock or extended stress without collapse. It involves limiting the extent of the disruption and minimizing the morbidity and mortality impact.
- **Recover** involves the health system attempting to regain lost functions as quickly and efficiently as possible. It also refers to the time and resources needed for the system to recover its functionality after the shock.
- **Adapt** relates to the capacity of the health system to "learn" and improve its capacity to absorb and recover from shocks based on past experience, reducing the impact of similar threats in the future. It informs planning and preparation for the next cycle.

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The most urgent recommendation that we made in 2020 was to **strengthen the LTC workforce**. **It remains the core urgent deficiency** that, if not met, will make the other deficiencies moot and make safe LTC homes impossible.

The problem is **not** only insufficient numbers of staff. It is far deeper, broader, and more multidimensional. Briefly, 4 areas of urgent need for action remain.

1. **The workforce broadly**
   - Supply, recruitment, training, and education
   - Workforce retention
   - Remuneration, including benefits such as basic annual sick leave, equitable remuneration practices, and access to full-time work
2. **Staffing allocations**
   - Skill mix and ratios of professional nursing to care aides, types of and proportions of allied professionals (such as physical, occupational, speech, and recreational therapists; social workers, pastoral care), and appropriate numbers and ratios of ancillary staff
   - Hours of care, one of the few areas that warrants a commissioned, arm's length study to ***assess minimum standards for hours of care and staff ratios required to meet stated goals of care***
3. **Attention to the work environment, because conditions of work are conditions of care**
   - Safe, supportive workplaces where highly functional teams flourish
   - Reduction or absence of discrimination such as identity-related aggressions, moral injury, gender and ethnic and racial aggressions, and other damaging attitudes and practices

- Capable and supportive leadership (by registered nurses and managers)
- A safe and trauma-informed approach to both resident care and staff functioning

4. **Data, action, and accountability**
   - Availability of high-quality data – collected with appropriate protective measures and some regularity – on resident quality of life and staff quality of work life, such as mental health and wellbeing, burnout, and resilience. Data on resident quality of care and status are routinely collected in most but not all Canadian jurisdictions.
   - Remedial and improvement action driven by the data. Acting on data is almost always the segment of learning health systems that fails. LTC homes and managers, and the public, need substantial and appropriate support to act on data and need to receive the data in a timely, accessible, and meaningful way.
   - Federal transfers for LTC resources and funding allocations based on meeting acceptable performance metrics and improvement plans

Recent progress on tackling pre-existing deficiencies

A few Canadian provinces have made some progress. For example, Alberta has passed new and broadly sweeping Continuing Care legislation that brings all parts of LTC under one act. It is currently writing regulations and updating standards. It is regulating the largely unregulated care aide workforce, has abolished 4-bed LTC rooms, and is implementing a strategy with some resources to improve workforce mental health and reduce burnout. It has not reached its direct hours of care goals. It struggles, as do all jurisdictions, with severe workforce shortages, an under-trained direct care workforce, and high care manager stress and turnover.

Nova Scotia is developing toolkits and bedside programs to ensure staff have practical training necessary to meet residents' needs. It is updating regulations and allocating funding to increase the roles of licensed practical nurses and nurse practitioners in LTC. It is implementing strategies to improve recruitment and retention, including funding for full-time positions and tuition reimbursements.[117] Longer term actions under development include reviewing and modernizing legislation.[117]

In Ontario, arbitrators recently ruled that Bill 124 (which capped wage increases for nurses and other public sector workers at 1% per year for 3 years) was unconstitutional and awarded wage increases, although at the time of this writing this is still under appeal.[159] The Ontario government also announced a $16.5 million investment into the *Learn & Earn Accelerated Program for Personal Support Workers in Long-Term Care*. This program will train existing LTC staff to grow their skills for becoming personal support workers while reducing geographic and financial barriers to career growth.[160]

While these movements forward (and others) are encouraging, they are woefully inadequate to tackle pre-existing deficiencies – because those deficiencies are so deep. Sweeping reform must happen across all provinces and territories and in all jurisdictions.

Staffing

Current recommendations usually cite 4.1 total hours of direct care per day for each LTC resident, but this standard is based on US reports more than 20 years old, when the LTC resident population was significantly different. A recent US report[161] recommended **4.1 to 7.68 hours of direct care** based on resident needs data, with 5+ hours cited for most levels of care. That paper also proposed

appropriate **ratios** of staff based on these hours. Recent work out of Europe and Australia argues that determining adequate care hours should integrate both resident characteristics and thorough understanding of workforce and work environment characteristics for safe and quality care.[162] All provinces aspire to reach 4.1 hours of direct care per resident in each 24-hour period, and some have plans and resources to do so. **A more realistic assessment of needed hours of care for today's LTC residents is an average of 4.5 hours, with a range of 4.1 hours to 7.7 hours**.[161] No *one-size-fits-all* number is of course entirely satisfactory. In the absence of data and algorithms to integrate resident characteristics with a thorough understanding of both workforce and work environment characteristics, minimum hours and an appropriate range may be the best we can do at present.

Further, hours of care alone are necessary but insufficient. Equally important are the ratios for the kinds and levels of staff. For example, if care aides or personal support workers are to function well, they must be embedded with appropriate numbers and types of regulated nursing and allied care providers. As LTC homes continue to struggle with resource constraints, they have coped in part by reducing staffing in some professions. Physiotherapists, recreation therapists, and therapist aides are often cited as in critically low supply. Some jurisdictions have substituted licensed practical nurses for registered nurses. Some LTC homes have reduced registered nurse coverage to one per building per shift or one on call per shift. Some jurisdictions have added a level of assistant, with virtually no training, below the care aide/personal support worker. All these changes, and multiple others, without adequate evaluation and in a hodgepodge of regional, provincial, and local actions, have created an uneven system with little guidance. In the worst circumstances, it has created staffing levels far below anything safe.

Amid such chaos and disagreements over jurisdiction, it can be easy to lose sight of the need to develop **national evidence-informed guidance**. In 2020 we strongly recommended a commissioned study on hours of care and staff ratios as an urgent and early step that the federal government could take – *this has not occurred*. Provinces, regions, and LTC organizations and homes need robust evidence-informed guidance around this core resource of staffing. Such guidance also needs periodic updating to match changing characteristics of the LTC resident population, surely more frequently than every 25 years. Not undertaking this work because, for example, we would never be able to afford its findings is not a solution. We need to understand the **multiple dimensions of our staff resource deficit**: how staffing resources are employed and could be employed, how staffing models could be changed and evaluated in innovative ways, how mobile teams might be integrated permanently, how reserve capacity could be developed, and what the costs will be.

Again, existing staffing problems and deficiencies are not just about insufficient numbers of staff, and are far deeper, broader, and more multidimensional than hours of care.

2023 Recommendation 1:

1a. The federal government must, in collaboration with provinces and territories, move immediately to ensure sufficient funds are available to raise the *minimum level of direct care hours* to 4.5 hours per day for each LTC resident.

1b. The federal government must, in cooperation with provinces and territories, immediately commission and act on a comprehensive, pan-Canadian, data-based assessment of necessary *staffing and staffing mix* guidelines in LTC homes. These guidelines must account for both characteristics of LTC residents and characteristics of all levels of staff and of the work environment. They should be updated every 5 years.

1c. The federal government must, in collaboration with provinces and territories, move immediately to implement a plan for health human resources that ensures *adequate recruitment and effective retention policies and practices*, emphasizing the mental health and wellbeing of staff and the health of their work environments.

2023 Recommendation 2: The federal government must, in cooperation with provinces and territories, implement transfer payments that are conditional on provinces and territories achieving *transparent outcomes*. The federal government must assist the provinces and territories in meeting national staffing guidelines and in implementing the new national LTC standards.

Disruption Cycle Stages 2 & 3: Absorb and recover

Absorption *occurs after the shock begins, comprising the capacity of the health system to maintain core functions and cushion the consequences without collapse. Absorption limits the extent of the disruption and minimizes the morbidity and mortality impact.*[3]

It is clear now that LTC in Canada and globally was ill prepared for the COVID-19 pandemic, had significant pre-existing deficiencies, and thus had significant difficulty absorbing the impact of the pandemic. This was seen most dramatically in pre-vaccine 2020.[3] Three areas of deficiency stand out:

1. poor infection control preparedness
2. an insufficiently resilient workforce
3. poor integration of LTC homes with other parts of the healthcare system.

The new National LTC Standard from the Canadian Standards Association lays out detailed guidance for infection control, infection prevention, and building rehabilitation and construction. It sets guidelines on multiple operational components of LTC, from hand hygiene to design of washrooms, ventilation, lighting, and outdoor spaces. Most jurisdictions have changed infection control practices, PPE supplies are stockpiled, and (we hope) we have learned that we cannot privilege acute care over LTC in distributing PPE.[106,163,164]

We articulated some of the key workforce challenges in the Disruption Cycle 1 section of this report. The *Canadian Academy of Health Sciences* recently completed a broad assessment of the health system workforce[19], with recommendations focused on recruitment and retention across the system.

LTC has an added set of disadvantages on the workforce supply side.

- LTC is not seen as a desirable place to work, a view deeply rooted in age discrimination within societal, health, and education institutions.[165-167]
- LTC is a gendered environment among residents, paid staff, and essential care partners such as family members. Care of older adults is not seen to warrant highly skilled labour or even a workforce that is regulated. Both age discrimination and gender discrimination contribute to this. For example, essential and complex care that includes significant support of activities of daily living (bathing, assistance with eating, walking, social interaction, etc.) is viewed as 'women's work,' which is highly undervalued in our society.
- LTC homes rely heavily on immigration for their workforce, particularly for care aides and personal support workers. These immigrants, almost entirely women[168,169], are surely not valued for the complex work they do and experience gender, ethnic, and racial discrimination. Further, the implications for necessary solutions with such a multifaceted workforce – from perspectives of culture, ethnicity, race, and language – has had little systematic (if any) consideration.
- Education systems in Canada, most notably nursing and medicine, have not placed a major and positive emphasis on aging, gerontology, or geriatrics. Curricula are sparse in these areas, positive role models are scarce, and research in woefully insufficient. The vast majority of care in today's LTC home is nursing care by a care aide or personal support worker, a registered nurse, a licensed practical nurse, and in some instances, a nurse practitioner. Better communication among the schools that prepare all these workers would benefit LTC through a better-informed professional nursing workforce.

We need concentrated effort by education systems – nursing, medical, allied health – to better prepare health professionals and **elevate desirability of a career in aging**. We also need joint effort by the LTC sector and federal, provincial, and territorial governments to implement a workforce strategy that moves beyond rhetoric to actions and evaluation of those actions. These are essentials to create capacity for absorbing future shocks.

Recovery means *regaining disrupted functions as quickly and efficiently as possible, including mustering the time and resources needed for the system to recover its functionality*.[3]

The progress of recovery depends on the magnitude and type of deficiencies present before COVID-19, and on the LTC system's ability to absorb the COVID-19 shock. Recovery in some areas has been immediate, largely due to robust understanding of how the SARS-COV-2 virus and its variants behave, vaccine availability and administration, improved supply chains, and stockpiles of essential equipment. Recovery overall, however, will be slow. The current LTC workforce, including care managers, are dealing with the impact of COVID-19 after working through the severe conditions of the last 3 years,[105,107,108,113,170] be those mental, physical, emotional, or spiritual impacts. We have little idea yet of the extent of, for example, moral injury on various workforce groups and people. Recovery will also be slowed by LTC homes that need to continue to deal with ongoing COVID outbreaks and profound workforce challenges. To accomplish recovery, coordinated and strong leadership at multiple levels will be required –leadership at federal, provincial, owner and operator levels, supported by strong science and strong implementation leadership.

2023 Recommendation 3: The provinces and territories must, with support from the federal government, implement *mental health and other workforce support strategies* to underpin recovery and ensure resilience in all levels of the LTC workforce going forward. They must also examine and address **structural causes** of mental health and well-being stressors, such as staffing levels, work conditions, rigid hierarchical work structures, workplace identity-based aggressions, imbalances of risk, and resident quality of life.

2023 Recommendation 4: The provinces and territories must, with support from the federal government, implement *anti-oppression strategies* in LTC for leaders, managers, administrators, and owners to remove systemic discrimination experienced by staff, residents and their families, and essential care partners.

Disruption Cycle Stage 4: Adapt

Adaptability is the *system-level capacity to learn from previous experiences and make improvement to absorb and recover from shocks in order to reduce future impacts.*[3]

2023 Recommendation 5: The federal government must move immediately to guarantee that Canada's *data systems* are both adequate and sufficiently integrated to meet requirements for transparent data reporting from all provinces and territories to the public, about all relevant aspects of LTC care, care giving, and work environment.

2023 Recommendation 6: The federal government must require provincial and territorial accountability through strategies such as making federal transfer payments conditional on acceptable performance metrics from provinces and territories. The federal government must, in cooperation with the provinces and territories, establish appropriate arm's length structures to monitor data and reporting transparency and enforce an *accountability framework*.

2023 Recommendation 7: Provinces and territories must, to receive transfer payments, be required to demonstrate meaningful consideration of the *social and moral determinants of health* for both residents and staff in their planning for LTC needs. Resources and services for equity-deserving older adults who are under-served must be allocated proportionate to their needs.

Canada's LTC home system is clearly not learning, despite over 100 reports written in the last 50 years and *over 30 in the last 3 years*. Reports, commissions, and now standards have been developed.[1,3,68,105] Without action, though – including resources and accountability structures – there can be no adaptation. There can be no learning or any growth of resilience. Learning and building resilience will require strong policies and policy at federal, provincial, and territorial levels. Examples of **critical policy areas** include promoting[3]: population health, especially of equity-deserving people, workforce health, stability, and resilience; data collection and use, cross-jurisdiction collaboration and collaboration internationally, and supply chain resilience.

Section 5 – A Bolder Vision

True transformative change – at the root and branches of the LTC system, affecting residents, families, essential care partners, and care staff – is an often-stated aspiration in Canada. Many good people and good governments work toward this goal.[171] Despite this we remain at the margins of transformative change. Old people are not considered fully worthy of society's resources. They often experience severe discrimination based on age, gender, and disability. They not uncommonly experience therapeutic nihilism (skepticism that therapies are worth using with them) and resulting under-treatment. If they are old people with dementia or other cognitive disorders, or old and poor, or old and unhoused, or old and poorly educated – it is worse, often far worse. How older Canadians live and thrive, or not, in our country is a matter of the core values we hold as Canadians and the core values to which we hold our governments accountable.

For Canadian society and its governments to fully engage in genuine LTC transformation, older people and older people with dementia (who are the majority of people in LTC) must be seen as fully human. This begins with ensuring that the experiences of older adults in LTC translate into their full sets of rights under the *Universal Declaration of Human Rights* and other international human rights instruments[172,173], the *United Nations' Principles for Older Adults*[174], the *Canadian Charter of Rights and Freedoms*[175], the *Canadian Rights of People with Disabilities*[176], and the *Canadian Charter of Rights for Persons with Dementia.*[177] Usually in our society, people seek assistance and action on Charter violations as individuals with agency. However, this is all too commonly **not** the case for older adults in LTC. Either they, speaking broadly, have a serious cognitive disability such as dementia or they simply are not considered to warrant the same treatment as a person with agency.

Human rights-based reform

Many of the reports and scientific papers about reform in LTC internationally, produced since the beginning of the COVID-19 pandemic, speak to a human rights approach. The new *Lancet* Commission on person-centred LTC for older persons argues that overcoming "... *societal and political challenges requires the lens of human rights and a rethinking of the provision of LTC so that it respects the rights of older people and addresses their diverse needs and preferences in fragile LTC systems.*"[1]

In 2023, on the heels of the Australian Royal Commission on Aged Care Quality and Safety, Steel and Swaffer produced a report titled *Reparations for Harm to People Living with Dementia in Residential Aged Care*. They argue that harm has been done and reparations are due. Steel and Swaffer engaged people living with dementia, family members, care partners, and lawyers, among others, in a multi-stage process that developed 25 principles for Australia. Three of those principles set out some of the actions needed for human rights-based reform (Box 3). Long before a system considers pursuing reparations, though, the basic requirement is to make sure that LTC homes and the LTC system do not exclude residents from the rights and freedoms of international and national human rights charters.

The selected guiding principles excerpted from the Steel and Swaffer report (Box 3) cover multiple actions. Many education institutions, governing bodies, and LTC home administrators will argue that these are well in place. They may be in some LTC homes. However, if these principles and actions were well in place in LTC, we would not see ongoing persistent problems – some of which are well known, some revealed during COVID, and some buried more deeply. Nor would LTC

homes continue to be run as if older adults – especially those with dementia – have no rights as human beings when it comes to restraint, movement, and choice. Some organizations and governments will argue that we cannot have human rights for all people in LTC homes, especially those with dementia, because we cannot afford it. Or it is not realistic. Or it is not 'safe.' These are not adequate responses. Governments, health regions and zones, and LTC operators must all work with LTC homes to achieve this fundamental state. It will seem very hard, maybe impossible, but that is no reason to not begin the work.

Old people are, simply put, *fully* human. Not half or a quarter or three quarters. Fully.

Box 3. Actions needed for human rights-based reform

Principle 13: Human rights-based reform

- Systems and policies at all levels need to be transformed.
- All reforms need to be human rights-based, so they do not result in more human rights violations.
- De-institutionalisation and de-segregation are needed in line with international human rights norms.
- De-institutionalisation and de-segregation are happening in the broader disability sector.
- Reforms need to prevent chemical, physical and other methods of restraint.
- Change in the future must be based on what is learned from the past, otherwise the past is repeated in reforms.

Principle 14: Staff and board training

- The lack of training on dementia, and on dementia as a disability creates harm in itself.
- Education only about dementia is insufficient and inadequate, and also needs to be framed
- in human rights.
- Respect, dignity, and personhood are critical to provide the kind of change needed, and for a more humane person-centred care within Australian residential aged care facilities.
- Education must be co-designed with people living with dementia.
- All residential aged care staff must receive training, including hospitality and cleaning staff
- and training must be frequent, ongoing and updated.
- University and TAFE students also need training – ideas are formed before people start
- working in residential aged care.

Principle 15: Empowerment and advocacy

- Reparations must include measures to empower people living with dementia to realise their human rights and provide resources to advocate.
- Too few people living with dementia are able or willing to speak up for their own rights.
- Families and care partners are often unwilling to make complaints or take legal action, for fear of retaliation and additional harm to the person living with dementia in care.
- The voices of people with the lived experience of dementia must be better represented, including from more diverse groups.

From: Linda Steele and Kate Swaffer, *Reparations for Harm to People Living with Dementia in Residential Aged Care* – Executive Summary. (University of Technology Sydney, 2023), p 21.

Therefore, our final recommendation is to begin implementing principles and practices to recognize and achieve full human rights for older adults in LTC.

2023 Recommendation 8: The federal government must, in cooperation with provinces and territories, begin *human rights reform in LTC* – in 2 areas immediately – and do this in close cooperation with older adults, including those with dementia.

8a. Reform LTC **governance, laws, and practices** in partnership with people living with dementia and their families and essential care partners, using a human rights lens.

8b. Implement **education and training** on human rights of older adults and older adults with dementia for *(i)* all education institutions that prepare staff who work in LTC; *(ii)* all levels of LTC staff – unregulated and regulated care staff, ancillary staff, and medical staff; and *(iii)* LTC Board members and senior leadership teams. Implement **awareness programs** on their human rights for older adults in LTC, families, and essential care partners.

Still Our Choice

In 2020 we ended our report by talking about the **choice** in front of Canada with respect to its LTC homes and the older Canadians living within them. We talked about lofty principles like our **duty to care**. Three and a half years have passed – and many, many reports, scientific papers, media stories, and personal anecdotes later – we conclude that yes, we have made some progress. Canada's performance during the COVID-19 pandemic was "middle of the G20 pack" level – not the best, not the worst. We did some things right – we vaccinated aggressively and that made a significant difference for older adults in LTC, we fixed PPE shortages, we somewhat remarkably developed 2 new sets of LTC standards in the middle of the pandemic, money was spent and continues to be spent. We did some things wrong in LTC – severe isolation practices, a dangerous lack of preparedness, decades of staggering under-resourcing and neglect, and a failure to properly recruit, prepare, compensate, support, and retain a skilled LTC workforce.

Our **LTC workforce crisis** is now a true emergency, not only in numbers but in deeply worrying outcomes for poor health and wellbeing. **It remains the highest, most urgent priority for immediate action**. Without good care and good care providers, older adults in LTC homes cannot have quality of life or quality of care. No last days of peace and dignity. No life with joy and meaning. If we do not strengthen the LTC workforce – all of the workforce – any progress will fade quickly. We must supply the resources needed to repair the LTC system and help it flourish. We have a promise, but no understanding yet, of whether Canada's new **Safe Long-Term Care Act** will be an instrument of change or simply another aspirational piece of legislation.

The world is changing – climate events, loss of critical natural geography, loss of species, economic disparity, inflation, global conflict, populism, and the rise of hate threaten to push COVID aside. Governments will change and change their priorities.

These things can and will all happen. These things will each also affect older people disproportionately. Change and changing priorities should not trample older adults. Rather if we lift our older adults on our shoulders, with full human rights, we will be well judged by future Canadians – and older Canadians will not be afraid to go to a long-term care home.

As we began in 2020, we end in 2023.....

> *The moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those in the shadows of life, the sick, the needy and the handicapped.*[178]

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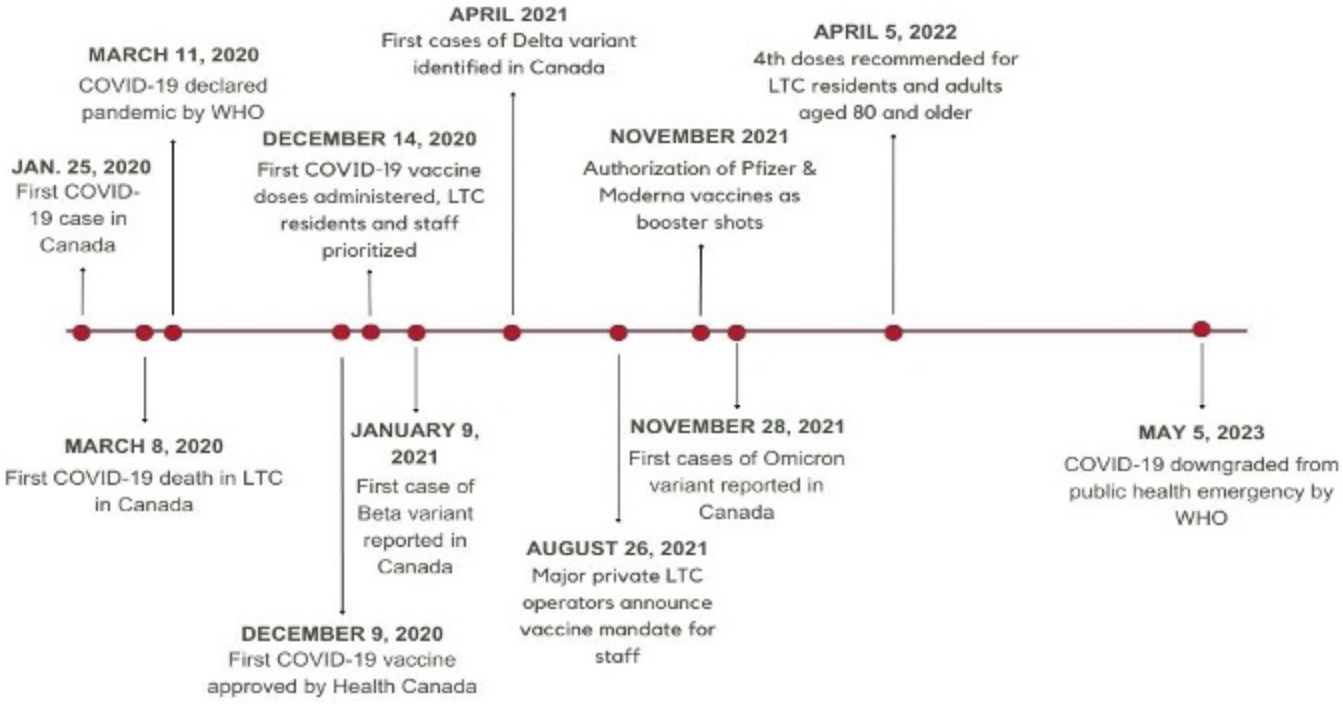
Appendix 1 - Timeline of COVID-19 in Canada



Sources: [23,24,38,179-183]

Appendix 2 - How we scanned the literature and the media

Scientific literature

Our search strategy was designed and executed by a University of Alberta librarian in consultation with members of the research team. Searches were conducted in June 2023, covering the period January 2020 to June 2023. Search terms for LTC workers included 'health care aide,' 'personal support worker,' 'LTC personnel,' 'nursing assistants,' and 'long term care worker,' among others. For the COVID-19 pandemic, search terms included 'Coronavirus Infections,' 'SARS-CoV-2,' 'covid*,' and 'pandemic,' among others. Terms related to long-term care homes included 'nursing home,' 'long term care home*,' 'continuing care,' 'residential care*,' and 'long term care facilit*.' These terms were combined using Boolean operators OR and AND. Databases searched included OVID Medline, PubMed, Scopus, CINAHL, and PsycInfo. Searches were limited to systematic reviews or meta-analyses. Search results were independently analyzed by 2 research assistants for relevance, and results were compared to assess interrater reliability. No formal appraisal of quality was conducted on the reviews.

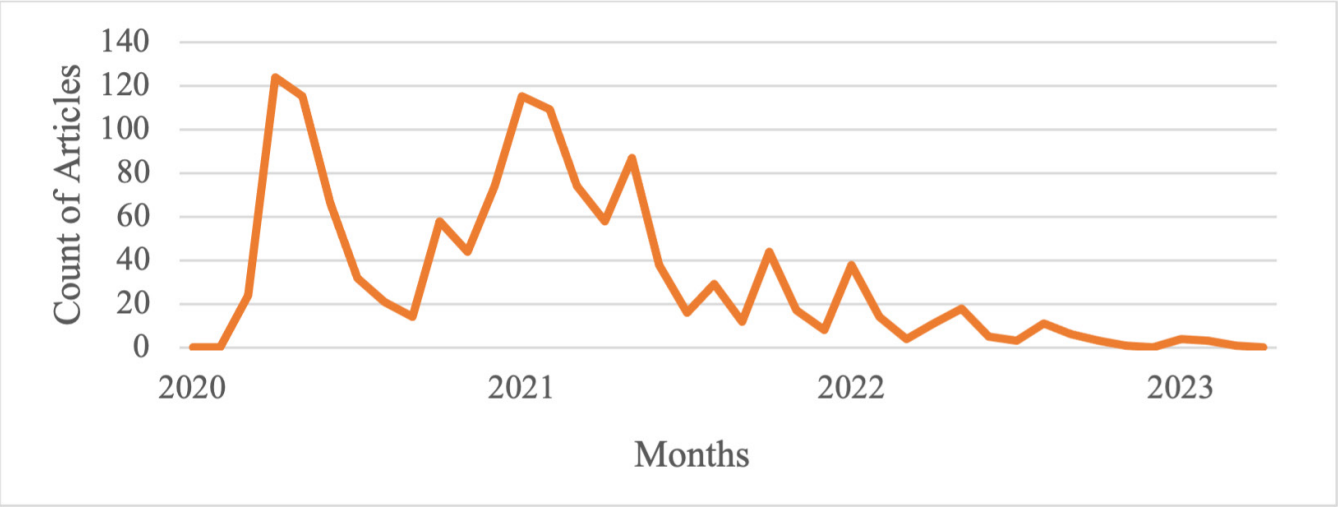
Provincial and territorial reports

Grey literature searches were conducted to identify publicly available reports and reviews from each of the Canadian provinces and territories. Provincial and territorial government websites were searched, as well as the websites of provincial/territorial auditors general, seniors' advocates, and ministries of health and long-term care. Search terms included "long-term care" or "LTC" and "report" or "review." Reviews and reports published between January 2020 and May 2023 were selected for inclusion. Press releases and announcements of currently ongoing reports and reviews were also included. These documents were compiled (Appendix 3, Table 1) and their contents were analyzed by a research assistant to determine their contents and alignment with the recommendations in the original 2020 *Restoring Trust* report. Relevant actions and recommendations were identified and used as sources for Table 2 of Appendix 3. As noted in Section 2 of this report, to the best of our ability, we scanned what was publicly available. This may not reflect the entirety of the work being done by the provinces and territories regarding long-term care.

National media

We conducted a brief scan through the Canadian News streams of the media from national outlets, including the Toronto Star, Globe & Mail, National Post, CTV National, and CBC National, for news articles containing the terms "COVID" and "long term care" published between January 2020 and March 2023. The titles and keywords of all articles were scanned to determine the subject themes of the articles. Where subject themes could not be determined from titles and keywords, the full text of the articles was analyzed. Broad subject themes across the articles published included virus reporting, infection prevention and control measures, LTC ownership, human rights, the broader LTC crisis, politics, the workforce, and recommendations. Figure 4 shows the count of articles published in the national media each month from January 01, 2020 to August 31, 2023. The national media were active keeping the crisis in long-term care during the pandemic at the forefront of public attention. However, it is clear from the data points in this graph that attention on this issue has waned since mid-2022.

Figure 4. *Canadian national media articles on COVID-19 & LTC by month, Jan 2020 – Aug 2023*



Appendix 3 - Summaries of provincial and territorial reports and alignment with recommendations from the 2020 *Restoring Trust* report

Table 1. Overview of provincial and territorial reports on LTC

Title	Purpose and Contents	Status
Newfoundland		
Review of Long-Term Care and Personal Care Home Programs	Response to Health Accord NL recommendations regarding improving the quality and availability of LTC and the development of legislation for home care, personal care homes and LTC homes.	Ongoing – announced 9 Feb. 2023
Status Report on Recommendations 2022–2023	Provides a progress report on the implementation of recommendations presented in a 2019 report from the Office of the Seniors' Advocate. Is the first of what will be an annual report until all of the recommendations are implemented.	Completed – Nov. 2022
Government of Newfoundland and Labrador: Department of Health and Community Services Long-Term Care and Community Support Services Funding Models – Final Report	Provides a review of funding arrangements for third-party providers of LTC and continuing care services, including an inventory of current services provided by third-party providers; a literature review and jurisdictional scan of reimbursement methodologies in Canada and internationally; an overview of key factors for funding model development; and an implementation plan for the proposed funding models.	Completed – Feb. 2020
Prince Edward Island		
COVID-19: Long-Term Care External Review	Provides a background on COVID-19 in PEI, analyzes performance across 4 key areas, and outlines recommendations with links to the National Long-Term Care Standards.	Completed – Aug. 2023
Department of Health: Internal Long-Term Care Review	Describes the current context of LTC in PEI, including characteristics of LTC homes in the province, comparisons between publicly and privately owned LTC homes, resident characteristics, experiences with LTC, rates of adverse events and injuries, characteristics of LTC staff, and brief overviews of funding, legislation, and regulations for LTC homes.	Completed – Jun. 2022
Nova Scotia		
COVID-19 First Wave Review: March to September 2020	Reviews infection prevention and control (IPAC) in Nova Scotia LTC through survey responses from LTC management, conversations with LTC home staff, virtual LTC home tours, and a literature review of IPAC best practices in LTC. Presents immediate and future solutions focused on access to IPAC expertise; access to IPAC education and tools; challenges related to on-site systems, standards, and processes; equipment and material resources; monitoring and reporting mechanisms; and infrastructure and space design.	Completed – Sep. 2020

Northwood Review	Identifies key factors related to the COVID-19 outbreak at Northwood, and provides 17 recommendations for Northwood, the Department of Health and Wellness, and the government, focused on IPAC, communication, and quality of care.	Completed – Sep. 2020
Expert Advisory Panel on Long-Term Care Outcome Report Update – March 2022	Provides an update on progress made toward 22 recommendations from 2019 on improving the quality of care in LTC homes in Nova Scotia. Recommendations focus on staffing, education, and infrastructure, among other things.	Completed – Mar. 2022
New Brunswick		
Long-Term Care Review	Examining the needs of the LTC sector in relation to governance, portability, human resources, quality and security, and quality of life. Making recommendations for improvement.	Ongoing – announced 13 Feb. 2023
Québec		
Réorganiser les soins de longue durée à la lumière de la pandémie	Identifies 3 causes that help to explain the COVID-19 crisis in residential and long-term care centres (CHSLDs) in Québec: epidemiological causes, crisis management, and prior enduring causes that made LTC particularly vulnerable. Outlines 3 areas of priority for projects to be launched.	Completed – Dec. 2021
The Quebec Ombudsman's Final Report: COVID-19 in CHSLDs during the first wave of the pandemic	Provides an overview of the COVID-19 crisis in CHSLDs, including a timeline of events in Québec and a review of causes that contributed to the crisis. Includes 27 recommendations that address 11 larger areas of priority.	Completed – Nov. 2021
COVID-19 in CHSLDs during the first wave of the pandemic: Learning from the Crisis and Moving to Uphold the Rights and Dignity of CHSLD Residents	Provides an overview of shortcomings in CHSLDs and how they were amplified by the COVID-19 crisis. Includes comments from an orderly, a nursing assistant, a nurse, integrated health and social services (CISSS) managers, and an informal caregiver about their experience during the pandemic. Notes 5 lessons learned that coincide with priorities for action.	Completed – Dec. 2020
COVID-19: An Action Plan for the Second Wave: Summary Document	Provides a brief summary of lessons from the first wave of COVID-19, outlines measures taken to slow the spread of COVID-19 and problems encountered throughout the first wave, and describes 9 intervention focus points for the action plan to handle the second wave.	Completed – Aug. 2020
Rapport d'enquête sur la qualité des services médicaux et des soins infirmiers au CHSLD Herron et à l'Institut universitaire de gériatrie de Montréal durant la première vague de la pandémie de COVID-19	Provides an overview of quality of medical services and nursing care at CHSLD Herron and at the University Institute of Geriatrics of Montreal during the first wave of the COVID-19 pandemic.	Completed – Feb. 2021

Commissaire à la santé et au bien-être. Le devoir de faire autrement. Partie 2 : Réorienter la gouvernance vers des résultats qui comptent pour les gens	Examines the performance of the health and social services system in the context of management of the first wave of the pandemic. Focuses on reorienting governance toward results important to people.	Completed – Jan. 2022
COVID-19 et main-d'oeuvre en santé: Déminer le terrain et lever les verrous institutionnels	Critically examines Québec's response to the COVID-19 crisis in terms of the health workforce and explores policies to strengthen capacities in this area.	Completed – Jul. 2020
Ontario		
Review of pricing practices of nursing agencies involved in long-term care homes	Responds to queries about price gouging by nursing agencies.	Ongoing – announced 1 Mar. 2023
The COVID-19 Pandemic's Impact on Long-Term Care Homes: Five Lessons Learned	Consolidates findings and recommendations from 5 reports on COVID-19 and LTC into 5 priority areas: enhancing staffing, reducing crowding, incorporating palliative care, communicating and connecting with families and essential care partners, and optimizing IPAC.	Completed – Apr. 2022
Ontario's Long-Term Care COVID-19 Commission: Final Report	Provides an overview of LTC and pandemic preparedness before COVID-19, the response to COVID-19, and best practices and promising ideas. Provides 85 recommendations grouped broadly into 11 categories.	Completed – Apr. 2021
COVID-19 Preparedness and Management Special Report on Pandemic Readiness and Response in Long-Term Care	Provides an overview of LTC, detailed observations grouped into 5 categories, recommendations, and responses from the Ministry of Long-Term Care, Ministry of Health, Auditor General, Secretary of Health, etc., outlining what has or will be done to address these recommendations.	Completed – Apr. 2021
Ministry of Long-Term Care COVID-19: Long-term care preparedness	Provides a very brief overview of steps taken by the government as part of the COVID-19 fall preparedness plan, broadly grouped into the categories of supporting LTC homes and strengthening the workforce.	Completed – Sep. 2020
Manitoba		
Stevenson Review	Examines the COVID-19 outbreak at the Maples Personal Care Home, including a review of the home before the outbreak, a timeline of the outbreak, an overview of staffing, care documentation, and communication during the outbreak. Reviews interviews and consultations with people involved in the situation. Includes 17 recommendations, divided into LTC home level, regional level, and provincial level.	Completed – review published Jan. 2021, implementation plan published Mar. 2021
Final Report of The Provincial Implementation Plan for the Stevenson Review	Reports on the work done to address the 17 recommendations in the initial Stevenson Review.	Completed – Feb. 2022
Revitalizing the Conditions of Care in Manitoba	Reports on the experiences of continuing care staff working in home care and LTC during the COVID-19 pandemic in Manitoba. Provides policy recommendations to improve standards of care.	Completed – Aug. 2023

Saskatchewan		
Review Of Long-Term Care Pharmacy Procurement Process	Responds to concerns from SK residents following changes in policy for the pharmacy procurement process in LTC homes operated by the Saskatchewan Health Authority.	Ongoing – announced 30 Jun. 2021
Caring in Crisis: An investigation into the response to the COVID-19 outbreak at Extendicare Parkside	Examines the outbreak at Extendicare Parkside. Outlines recommendations for Extendicare and at the Saskatchewan Health Authority level.	Completed – Aug. 2021
Alberta		
Improving Quality of Life for Residents in Facility-Based Continuing Care	Outlines findings across 11 areas related to facility-based continuing care, providing a brief description of the current context, what the reviewers heard from stakeholder engagement, and leading practices or findings from other jurisdictions. Provides recommendations for each area, 42 in total grouped into 11 broader policy directions.	Completed – May 2021
Auditor General Report: Seniors Care in Long-term Care: Assessment of Implementation Report	Reviews actions taken on recommendations provided in 2014 and reports on whether they have been implemented (and if so, how).	Completed – Feb. 2023
British Columbia		
Review of COVID-19 Outbreaks in Care Homes in British Columbia	Provides an overview of the make-up of and the impact of the pandemic on LTC and assisted living homes in BC. Provides data on site-level characteristics, including staffing mix and sick leave data, and data from a survey of staff on their experiences. Provides 7 recommendations for IPAC.	Completed – Oct. 2021
BC Ministry of Health Long-term care COVID-19 response review	Provides a timeline of COVID-19 policy measures and observations from BC's approach to the COVID-19 pandemic, organized into 4 areas: governance, policy, operations, and workforce. Includes short-term recommendations for these areas and 5 long-term recommendations.	Completed – Oct. 2020
A Billion Reasons To Care: A Funding Review of Contracted Long-Term Care in B.C	Includes recommendations on funding for LTC in BC.	Completed – Feb. 2020
Nunavut, Northwest Territories, Yukon		
Nil		

Table 2. Federal, provincial, and territorial responses to recommendations in the 2020 *Restoring Trust* report

2020 Recommendations	What has been done federally?	What has been done provincially and territorially?
Recommendation 1: The federal government must immediately commission and act on a comprehensive, pan-Canadian, data-based assessment of national standards for necessary staffing and staffing mix in LTC homes.	The Canadian government commissioned the Health Standards Organization (HSO) and the Canadian Standards Association (CSA) to develop LTC standards. The HSO and CSA standards are more comprehensive than what was proposed in this recommendation, but they do not address staffing mix and levels.	To the best of our knowledge, the provinces and territories have not taken action on this recommendation. One report from Ontario called for development of a provincial staffing strategy to address staffing levels and mix, to which the Ministry of Long-Term Care responded that they will follow the direction of the December 2020 Long-Term Care Staffing Plan.[184]
Recommendation 2: The federal government must establish and implement national standards for LTC homes that ensure (a) training and resources for infectious disease control, including optimal use of personal protective equipment and (b) protocols for expanding staff and restricting visitors during outbreaks.	Development of HSO and CSA standards. The CSA standards address infection prevention and control, as well as building design and operation,[67] while the HSO standards address practices for high-quality care.[68] Beginning in 2022–2023, the Government of Canada plans to provide $3 billion over 5 years to Health Canada to support the application of LTC standards in the provinces and territories; with the federal government working collaboratively with provinces and territories while respecting their jurisdiction.[150]	Some provincial governments have indicated that they are reviewing the standards.[185,186] To the best of our knowledge, no provinces or territories have formally adopted them as of the writing of this report.

Recommendation 3: The provincial and territorial governments, with the support of new funding from the federal government, must immediately implement appropriate pay and benefits, including sick leave, for the large and critical unregulated workforce of direct care aides and personal support workers (PSWs).	Beginning in 2023–2024, the provision of $50 million over 5 years to Employment and Social Development Canada for developing and testing ways to strengthen the retirement savings of PSWs who do not have retirement security coverage through their workplace.[151] $1.7 billion over 5 years to support hourly wage increases for PSWs and related professions.[151] $115 million over 5 years, with $30 million ongoing, to expand the Foreign Credential Recognition Program. This program will assist up to 11,000 internationally trained health care professionals per year in getting their credentials recognized and finding work, and will support programs to reduce barriers related to foreign credential recognition.[151]	The Yukon government recently announced a government-funded program that provides 40 hours of paid sick leave for workers who makes less than or equal to $33.94 per hour and do not have paid sick leave through their employer.[187] While some provinces implemented measures such as wage increases and paid sick leave during the pandemic, not all of these measures have been permanent. Ontario ended the paid sick leave program in March 2023.[188] In Ontario, Bill 124, which capped wage increases for nurses and other public sector workers at 1% a year for 3 years, was recently ruled unconstitutional. Arbitrators awarded the nurses an additional 0.75% wage increase for the year starting April 1, 2020, an additional 1% for the following year and an additional 2% for the final year.[160]
Recommendation 4: Provincial and territorial governments must make available full-time employment with benefits to all unregulated staff and regulated nursing staff. They should also evaluate the impact on LTC homes of 'one workplace' policies now in effect in many LTC homes and the further impact on adequate care in other LTC settings such as retirement homes, hospitals and home care.	To the best of our knowledge, the federal government has not taken actions toward this recommendation.	Reviews from Nova Scotia, Quebec, Ontario, Manitoba, Alberta, and British Columbia include recommendations related to this recommendation, but the only reported actions were: o The Government of Nova Scotia announced $8 million for LTC to offer full-time positions to casual and part-time employees to provide direct care.[117] o $18 million investment from the Ontario government into the Nursing Graduate Guarantee, which provides full-time salaries and benefits to 600+ nurses, with a focus on recruiting in areas of need, including LTC.[128]

Recommendation 5: Provincial and territorial governments must establish and implement (a) minimum education standards for the unregulated direct care workforce in LTC homes, (b) continuing education for both the unregulated and regulated direct care workforce in LTC homes and (c) proper training and orientation for anyone assigned to work at LTC homes through external, private staffing agencies.	To the best of our knowledge, the federal government has not taken actions towards this recommendation.	o Health Association Nova Scotia received funding to launch a train-the-trainer wound management education program.[117] o The Government of Nova Scotia announced the implementation of a Work and Learn education program for continuing care assistants (CCAs).[117] o Other education-related actions in Nova Scotia include: reintroduction of a CCA bursary program and funding to reimburse tuition and related program costs for existing CCA students and funding to cover tuition costs for 2000+ CCA students over 2 years; funding for development of modules for flexible part-time CCA pilot programs; and provision of $1.28 million to Health Association Nova Scotia to increase professional development opportunities for staff.[117]
Recommendation 6: To achieve these education and training objectives, provincial and territorial governments must support educational reforms for specializations in LTC for all providers of direct care in LTC homes, care aides, health and social care professionals, managers and directors of care.	To the best of our knowledge, provincial and territorial governments have not taken actions towards this recommendation.	

Recommendation 7: Provincial and territorial governments, with the support of federal funds, must provide mental health supports for all LTC home staff.	A pledge of $100 million over 3 years, beginning in 2021–2022, toward supporting mental health initiatives aimed at those disproportionately impacted by COVID-19, including point of care workers.[151] Other mental-health related actions outlined in Budget 2023 include $5 billion over 10 years (beginning in 2017–2018) to provinces and territories to improve and increase the availability of mental health and addiction services; funding for the Wellness Together Canada portal; funding for a pan-Canadian 24/7 bilingual suicide prevention service; funding for trauma-informed, culturally appropriate, Indigenous-led service to improve mental wellness; and development and implementation of a 988 Suicide Prevention Line and funding for the Public Health Agency of Canada to support its implementation and operation.[151]	Reports from Nova Scotia, Quebec, Ontario, Alberta, and British Columbia include recommendations related to mental health supports, but the only reported action was the announcement by the Government of Nova Scotia of $466,000 to give employees in the LTC sector access to the wellness support program.[117]
Recommendation 8: Federal support of the LTC sector must be tied to requirements for data collection in all appropriate spheres that are needed to effectively manage and support LTC homes and their staff.	Provision of $505 million to the Canadian Institute for Health Information, Canada Health Infoway, and other federal data partners to aid provinces and territories in developing new health data indicators; to create a Centre of Excellence on health worker data; to advance digital health tools and an interoperability roadmap; and to support efforts to use data to improve the safety and quality of health care.[151] Provision of $41.3 million over 6 years, and $7.7 million ongoing, beginning in 2021–2022, for Statistics Canada to improve data infrastructure and data collection on supportive care, primary care, and pharmaceuticals.[150]	Reports from Nova Scotia, Quebec, Ontario, Alberta, and British Columbia included recommendations related to data collection but, to the best of our knowledge, the only action reported was the anticipated 2022 launch in Nova Scotia of the interRAI Long-Term Care Facilities Assessment System, a comprehensive, standardized system for evaluating the needs, strengths, and preferences of residents in chronic care and LTC homes.[117]
Recommendation 9: Data collection must be transparent and at arm's length from the LTC *sector and governments.*	To the best of our knowledge, no actions have been taken towards this recommendation.	

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