

Restoring Trust: COVID-19 and The Future of Long-Term Care

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A Policy Briefing by the Working Group on Long-Term Care

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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.

Policy Briefings have three sections:

- Context and policy status before COVID-19
- Vulnerabilities exposed as a result of COVID-19
- Principles for action and leading options.

Overview of Restoring Trust: COVID-19 and The Future of Long-Term Care

This Policy Briefing Report on Long-Term Care focuses on the workforce. The report begins by reviewing the research context and policy environment in Canada's long-term care sector before the arrival of COVID-19. It summarizes the existing knowledge base for far-sighted and integrated solutions to challenges in the long-term care sector. The report then outlines profound, long-standing deficiencies in the long-term care sector that contributed to the magnitude of the COVID-19 crisis. Equally important contributors to this crisis are the characteristics of the older adults living in nursing homes, their caregivers and the physical environment of nursing homes.

The long-standing deficiencies in Canada's long-term care sector and the characteristics of the key players had direct impact on the immediate causes of the COVID-19 crisis in our nursing homes. This report enumerates those immediate causes.

The report then articulates principles for action and recommendations for urgent action.

Note from the Working Group

Although the issues addressed in this study apply to all those who live in long-term care facilities, the LTC Working Group acknowledges that this document does not address all issues relevant to long-term care homes (nursing homes), nor was this the mandate of this group. We encourage others to address other aspects requiring attention. Of note, this study has not addressed Indigenous people in long-term care settings, other than emphasizing the need for intersectionality. Members of the Working Group believe the issues facing Indigenous people in the context of COVID-19 require a distinct path of study toward understanding the challenges faced by aging Indigenous people broadly both outside and within multiple institutional settings.

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Table of Contents

Executive Summary	5
How did LTC emerge and how it is governed in Canada?	9
Hope: Research offers promising practices in the LTC sector	10
The two current components of the COVID-19 crisis in LTC	11
Deep, long-standing causes of the COVID-19 crisis in the LTC sector	12
The challenges ahead in nursing homes	15
Pre-pandemic characteristics of older adults living in nursing homes.....	15
Pre-pandemic characteristics of care for older adults living in nursing homes	16
The special case of dementia.....	17
Pre-pandemic characteristics of the workforce in LTC.....	18
The unregulated paid workforce.....	18
The regulated paid workforce.....	19
Workforce staffing and staffing mix for quality of care and quality of life.....	20
Care by unpaid family and friends	21
Pre-pandemic characteristics of social, living and working spaces in nursing homes.....	22
Physical environment	22
Plans, protocols and resources for delivering care	22
The context that created the COVID-19 crisis in LTC	23
Principles to guide future action	25
Recommendations to manage COVID-19 in Canada’s LTC sector	26
Workforce recommendations to reform and redesign LTC in Canada	28
Canada’s choice	29
Attachment 1. Long-Term Care reports inquiries, commissions and related	40
Attachment 2. 10 years of media focused on LTC homes (nursing homes)	46
Table 1. Long-term Care Homes (nursing homes) by Province: Number of facilities, terminology, governing policy/legislation	53
Table 2. Unregulated workers providing direct care in LTC homes	57

Executive Summary

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

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

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

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

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

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

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

Canada's older adults are entering nursing homes later in life. As Canada ages and older adults live longer, we have worked toward more capacity for those people to age in community. At the same time, prevalence of chronic diseases—foremost dementia—and the social challenges of living into one's 80s, 90s and 100's have increased. The consequence is that residents enter

nursing homes—commonly their final home—with much more complex and higher social and medical needs. This has dramatically raised the complexity of care that nursing homes are faced with providing, even compared to the care required a decade ago.

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

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

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

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

A preferred future for the LTC sector in Canada

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

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

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

hospitals, reduce workforce injury claims, and interface more effectively with home and community care.

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

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

1. The federal government must immediately commission and act on a comprehensive, pan-Canadian, data-based assessment of national standards for necessary staffing and staffing mix in nursing homes. National standards must encompass the care team that is needed to deliver quality care and should be achieved by tying new federal dollars to those national standards.
2. The federal government must establish and implement national standards for nursing homes that ensure (a) training and resources for infectious disease control, including optimal use of personal protective equipment and (b) protocols for expanding staff and restricting visitors during outbreaks.
3. The provincial and territorial governments, with the support of new funding from the federal government, must immediately implement appropriate pay and benefits, including sick leave, for the large and critical unregulated workforce of direct care aides and personal support workers. Appropriate pay and benefits must be permanent and not limited to the timespan of COVID-19. Pay and benefits must be equitable across the country and equitable both across the LTC sector and between the LTC and acute care sectors for regulated and unregulated staff.
4. Provincial and territorial governments must make available full-time employment with benefits to all unregulated staff and regulated nursing staff. They should also evaluate the impact on nursing homes of “one workplace” policies now in effect in many nursing homes and the further impact on adequate care in other LTC setting such as retirement homes, hospitals and home care. Provincial and territorial governments must assess the mechanisms of infection spread from multi-site work practices and implement a robust tracking system.
5. Provincial and territorial governments must establish and implement (a) minimum education standards for the unregulated direct care workforce in nursing homes, (b) continuing education for both the unregulated and regulated direct care workforce in nursing homes and (c) proper training and orientation for anyone assigned to work at nursing homes through external, private staffing agencies.
6. To achieve these education and training objectives, provincial and territorial governments must support educational reforms for specializations in LTC for all providers of direct care in nursing homes, care aides, health and social care professionals, managers and directors of care.

7. Provincial and territorial governments, with the support of federal funds, must provide mental health supports for all nursing home staff. In addition to extraordinarily stressful pandemic working conditions, these staff are experiencing significant deaths among the older adults they have known for months and years, and among colleagues. They are grieving now, and this will continue.
8. Federal support of the LTC sector must be tied to requirements for data collection in all appropriate spheres that are needed to effectively manage and support nursing homes and their staff. Data collected must include resident quality of care, resident quality of life, resident and family experiences, and quality of work life for staff. Data must be collected using validated, appropriate tools, such as tools suitable for residents with moderate to severe dementia. Captured data must address disparities and compounding vulnerabilities among both residents and staff, such as race, ethnicity, language, gender identity, guardianship status, socioeconomic status, religion, physical or intellectual disability status, and trauma history screening.
9. Data collection must be transparent and at arm's length from the LTC sector and governments. Provincial and territorial governments must evaluate and use data to appropriately revisit regulation and accreditation in nursing homes. They must take an evidence-based and balanced approach to mandatory accreditation, as well as to regulation and inspection of nursing homes. They must engage the LTC sector in this process, particularly the people receiving care, their families, managers and care providers.

Canada's choice

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

This is our choice.

Restoring Trust: COVID-19 and The Future of Long-Term Care

*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.*²

The poor conditions of care in nursing homes have, with increasing frequency, been given prominence over the last 50 years in more than 100 published **reports** (Attachment 1). Those reports come from all high-income countries, but Canada has far more than its share. A quick search of the **media** for just the past 10 years yields over 150 reports in Canada alone (Attachment 2), describing unacceptable and sometimes scandalous conditions experienced by our older adults in nursing homes. They all report similar findings, they all reflect our underlying outrage, they all make recommendations, they are all read, one or two actions are taken and then they all sit on a shelf. Nothing changes. Not really, not *fundamentally*. Of course great strides have been taken since the mid 20th century—newer nursing homes are organized with opportunities to better support quality of care and quality of life, dementia care programs are more regularly embedded in nursing homes, and encouraging examples of promising practices exist.^{3,4} But still, concerns about quality of care and safety persist, tragic events continue, inequities deepen, root issues are not challenged, older adults suffer needlessly, and many Canadians are truly frightened at the prospect that they themselves may need to be admitted to a nursing home.⁵⁻¹²

Each report and each event that motivated it are treated as isolated and unique. They are not. The persistent string of events that motivate the various reports and media coverage have their root causes in a long-fractured sector. The causes are multiple and complex, but their core is systemic and deeply institutionalized implicit attitudes about age and gender—running deeply and barely hidden. The state of nursing homes *is* solvable, but the solutions require choices.

COVID-19 did not, as we are hearing repeatedly, break this sector. *It is simply another event.* This time an event with high rates of fatalities in nursing homes globally. Nowhere are those *excess death rates in nursing homes* higher than in Canada.¹³ COVID-19 has precipitated, in the worst circumstances, high levels of physical, mental and emotional suffering for our older adults. Those unnecessarily lost lives had value. Those older adults deserved a good closing phase of their lives and a good death. We failed them. We broke the covenant. We have a duty, a responsibility *and the ability to fix this*—not just to fix the current communicable disease crisis, but to fix the sector that helped that crisis wreak such avoidable and tragic havoc. We can restore trust.

How did LTC emerge and how it is governed in Canada?

Canada uses two encompassing terms for the full continuum of care outside acute care (hospitals)—long-term care (LTC) and continuing care. **We focus here on 24-hour residential LTC** (often called nursing homes in Canada) as **defined by Health Canada:**¹⁴

In general, long-term care facilities provide living accommodation for people who require on-site delivery of 24 hour, 7 days a week supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping.

Most residential LTC for older adults in Canada has its roots in the Elizabethan Poor Law of 1601. In Quebec its roots are primarily in Christian religious orders. Canada's LTC sector first unfolded as poorhouses, county homes, parishes, poor farms and almshouses. These facilities housed people

who were unable to care for themselves, including older adults, people with mental illnesses and people living in poverty. Depending on jurisdiction, some facilities were associated with charities and religious orders. Over time, people in different groups were separated into different facilities. Facilities housing only older adults were introduced gradually during the early part of the 20th century. Some of those early facilities were in use well into the 1950s in parts of Canada.

Provincial and territorial jurisdiction over LTC stems from interpretation of the Constitution Act of 1867. From 1977 to 1996 the federal government provided cost-shared funding for beds for the elderly and on a per capita basis for LTC, through its Canada Assistance Plan and Extended Health Care Services program. However, **LTC remains outside universally insured health services** protected by the Canada Health Act.¹⁵ Health Canada notes that:¹⁴

Long-term facilities-based care is not publicly insured under the Canada Health Act. It is governed by provincial and territorial legislation. Across the country, jurisdictions offer a different range of services and cost coverage. Consequently, there is little consistency across Canada in: what facilities are called (e.g. nursing home, personal care facility, residential continuing care facility, etc.), the level or type of care offered, how it is measured, how facilities are governed, or who owns them.

We summarize differences in LTC across provinces in Table 1.

Hope: Research offers promising practices in the LTC sector

Much of what follows in this report is sobering, but we must face the reality of what we have let happen in the care of our most vulnerable older adults. We must also learn from it, so that we do not continue to reach short-sighted and siloed solutions that just patch over the issues. Here we outline some of the promising practices in the LTC sector that exist internationally and across Canada.

A body of research (conducted by Working Group members and others) tackles multiple challenges and solutions in improving nursing homes:

- *Re-imagining Long Term Residential Care*—A research program led out of York University¹⁶ (Toronto) examines and evaluates approaches to care, work organization, accountability, and financing and ownership.¹⁷ They also address unpaid work, invisible women and healthy aging in nursing homes.
- *Family/friend caregivers of older people needing assistance and formal caregivers and human resource issues in LTC and home care*.¹⁸ This research group out of Mount Saint Vincent University also studies *end-of-life care*¹⁹ in nursing homes, dementia care, rural aging and the physical nursing home environment.
- *Translating Research in Elder Care*,²⁰ a longitudinal program of applied research in residential LTC at the University of Alberta. This team studies quality of care, quality of life and quality of work life in nursing homes. They develop and evaluate strategies and interventions to improve quality in all these domains.

A number of the Working Group members have chaired panels investigating various aspects of quality in nursing homes²¹⁻²⁵ or the roles of families,^{26,27} or have been active members of teams generating reports and recommendations.²⁸⁻³⁰ Their policy, data and legal expertise also informs this document. Other Working Group members have conducted research on family caregivers

of persons with dementia,^{26,31} civil liberties, future financing of LTC,³⁰ evidence-based care of older adults, personal support worker education, care worker communication,³² the relationship between staffing and care quality,³³ care models for residential care settings,^{34,35} and impacts on the vulnerable during COVID-19.^{36,37}

Together, and in addition to an enormous international body of research on nursing homes, we have an abundance of promising solutions. *There is no one solution.* We can look for guidance to models used by other countries in Scandinavia and Europe, such as Dementia Villages and Green Farms. In our own country, excellent nursing homes have been studied and will continue to need to be studied. Some nursing homes in Canada³⁸ in some locations prepared for and avoided COVID-19 infections and deaths of residents to date, or have managed outbreaks well. For example, in Kingston, Ontario, long-term care homes have seen few COVID-19 cases. In Edmonton, Alberta, one family-run nursing home remains COVID-19 free. We need to understand how they were able to achieve this and why others did not. For example, what was the role of regulation and inspection in better or worse outcomes?

The **first** challenge is not that we lack evidence. We have a great deal of evidence that would contribute to major improvements, but this evidence has not been acted on.

Second, researchers alone cannot transform the LTC sector—our role is to bring high-quality evidence. Evidence, even when transformed into useable formats, still requires assessing and balancing benefit with issues of context, scale and cost. We have decades of evidence that languishes on shelves for many reasons, but at root the problem is a lack of political will to hear hard messages. One prime example is evidence on the right amount and type of staffing. This is, without any doubt whatsoever, one of the most critical components of quality in nursing homes.

Third, we must rigorously and comparatively evaluate reforms as they occur across Canada to improve LTC. This requires good data, something we are embarrassingly short of in the LTC sector.

Fourth, change in the LTC sector requires strong decisive leadership that is willing to move past incrementalism and tinkering at the margins to true transformative change. Leadership must also be willing to devote the resources needed to achieve this. We will need the ability and courage to not only implement promising practices, but also to cease practices that are not useful or effective.

Finally, and perhaps most importantly—if we are going to fix the LTC sector—Canadians and our governments will have to decide if it matters enough to us to do the hard work. This is a choice. We have a tremendous basis for hope that we can make this sector better for vulnerable older adults in nursing homes, but **we will have to consciously and deliberately decide as a country to act on that hope.**

The two current components of the COVID-19 crisis in LTC

The current pandemic challenge in the LTC sector has two major components. **First**, this is a crisis of excess levels of mortality in nursing homes. These far exceed the mortality rates of seasonal influenza in nursing homes (0.1% vs. 3%-4%).^{39,40} Numbers are changing rapidly, but to date Canada has the highest reported proportion of COVID-19 deaths nationally for nursing home residents. Canada reports that 81% of total COVID-19 deaths are of nursing home residents.¹ Other comparable countries report 27% (England and Wales),⁴¹ 28% (Australia),¹ 31% (US),¹ 34% (Denmark),⁴² 34% (Germany),¹ 47% (Scotland),⁴³ 49% (Sweden),⁴² and 66% (Spain).¹ Globally the

fatality rate for people who have COVID-19 is estimated at 3.4%,⁴⁰ but that rate varies strikingly from country to country—from as low as 0.1% (Qatar) to as high as 26.3% (Yemen)⁴⁴. In Canada the fatality rate is estimated at 8.2%,⁴⁴ but the Canadian fatality rate of nursing home residents is estimated at 25% (range 11%-35%).⁴⁵ The global fatality rate for all persons over age 85, regardless of location, is 10%-27%.⁴⁶

Second, and at least as disturbing, COVID-19 in nursing homes is a *humane crisis*. It is a crisis of how these older adults died and how they are still dying. In the most extreme cases seen in Europe, the US and Canada, harsh media images remain with us—older adults abandoned, left alone to die in their own excrement, without food or water, utterly alone.^{5-9,11,12,47-52} These images galvanized the world. Emergency measures have been instituted and the worst of this devastating crisis in a limited number of nursing homes has lessened, but older adults in nursing homes remain at extremely high risk—they are still dying and dying alone at high rates. Exacerbating the humane crisis is that 87% of nursing home residents have cognitive impairment,²⁹ 25% have a severe cognitive impairment⁵³ and two thirds have a stated diagnosis of dementia.^{54,55} They are anxious and afraid, unable to make sense of the people around them dressed in protective equipment, faces covered and voices muffled. These residents do best when things are familiar, but these are unfamiliar times in which to live and to die.

Deep, long-standing causes of the COVID-19 crisis in the LTC sector

Canada's response to COVID-19 has exposed long-standing, wide-spread and pervasive deficiencies in the LTC sector. Deep operational cracks compromise a pandemic response. They also sabotage ongoing quality of care, quality of life and a good death, quality of work life for staff, and health and safety of residents, caregivers, family and staff. Deficiencies are underpinned by implicit negative attitudes on the value and need for expertise in LTC. While the following problems occur to potentially differing degrees in all jurisdictions, they are recognized as common across jurisdictions.

1. Canada has failed to confront present and future **financing of LTC**. This requires first identifying a national perspective on what older Canadians who need to live in a nursing home *should be able to expect*. Financing a sturdy LTC sector also connects intimately with all other components of continuing care, including community programming, home care, assisted living and retirement homes. When those interlocking components are stronger, needs for nursing homes will be lower. *However, the need for nursing homes will not and should not go away*. The key for older Canadians is the right care, in the right place, at the right time.
2. Canada has failed to optimize **integration across community, continuing care and acute care sectors**. These settings largely function independently and ignore the important and frequent transitions that happen across settings. Further, what happens in one of these settings, such as an outbreak of communicable disease, can and does affect all other sectors. Integration will require, among other things, robust linked data and a whole-system governance approach. If a whole-system approach had been in place, then hospitals would not have discharged people who tested positive for COVID-19 back to nursing homes without proper infection control.
3. Canada lacks **data for managing the LTC sector**. This lack is pervasive and deep. If Canada cannot measure the vital aspects of this sector, we cannot effectively manage it. Managing

a complex sector such as LTC embedded in the larger continuing care sector—without data—is like managing with a Ouija board. However, standardized (or any) data collection, analysis and use remain minimal across Canada.

We have no shortage of data sources to cite. But this does not mean that Canada has sufficient data to manage a complex LTC sector. Many sources cited here are from other countries. Many studies cited are cross-sectional and cannot be used to determine causes. Studies are incredibly inconsistent in methods used and in the settings and individuals included. Few studies are longitudinal, and many are small “one-off” studies that we cannot confidently extrapolate to Canada’s large, complex and heterogenous LTC sector. It has been 25 years since the only available good quality, substantive multi-country comparison was carried out that included Canada.⁵⁶ It focused on basic descriptions of services, residents, funding, regulations and staffing, and was somewhat biased to one province.

Canada requires data on its own nursing homes, on the residents, on the staff working in them and on the LTC sector broadly:

- Robust administrative data on aspects such as finances, payroll (staffing levels, actual hours worked by category of worker, staff mixes and costs), staff events (absences for illness or other reasons, turnover, retention, injury rates and costs) and resident dispositions (transfers to and from acute care, deaths in home vs in acute care, etc.). For COVID-19, such data must include availability of personal protective equipment (PPE), diagnostic supplies and testing, and medication stocks matched to master lists of residents where this is relevant.
 - Routinely collected and comparable data on *care quality* and outcomes of care. Currently not all provinces use the international standard of the interRAI suite of measurement tools for nursing homes.⁵⁷
 - Routinely collected data on *quality of work life* for all levels of the nursing home *workforce* using validated measurements. Examples of key data are job satisfaction, intention to leave, health status, burnout, work engagement, empowerment, and measures of work processes (e.g., missed care, rushed care, working short-staffed).
 - Routinely collected data on *resident quality of life* using measurement tools *validated with people who have moderate to severe levels of dementia*.
 - Routinely collected data on experiences of unpaid caregivers: family and friends of nursing home residents.
 - Routinely collected data on volunteers and paid companions.
 - Publicly available, comprehensive, and relevant data for each nursing home.
4. Canada is not **using data to act**. Having good quality, comprehensive and verified data is only half the battle. To be of value, data must be fed back to provincial and territorial governments, the federal government, the managers of health regions, nursing home organizations (e.g., owners and managers of chains of nursing homes), and importantly, managers of individual nursing homes. It must be acted on and the results evaluated. This is a continuous cycle required for any **learning health system** seeking to improve. The data must be in useable forms, with expectations and accountabilities for sound management. Just feeding back large quantities of data to managers in the LTC sector is completely inadequate. The data must be accessible and understandable, we must implement supports

to help managers act on data and evaluate the impact of those actions, and accountabilities must be clear and transparent.

5. Canada has failed to look at **LTC accreditation and regulation** in a *whole systems* way, with best practices underpinning regulation. We have also failed to systematically and regularly revisit regulation, monitoring and enforcement as a *whole systems process*. Nursing home care is both heavily regulated and highly risk-averse. Conversely, it is still missing critical pieces of regulation such as workforce standards and quality of work conditions. These broad regulation factors (or lack thereof) negatively affect quality of life and end of life, and quality of care. When we as individuals see a primary healthcare provider or go to a hospital, we have standards of expectation for staff preparation and experience. We do not expect to avoid all risk through severe restrictions in our own lives or in our healthcare.
6. Levels of **regulated staff in nursing homes have been systematically reduced**, including staff providing medical coverage, regulated nursing staff⁵⁸ and all other regulated health professionals such as physical and recreational therapists. Work by therapists, for example, links directly with both quality of care and quality of life. Social and spiritual care are too often nearly non-existent. Most members of these professional groups are women.
7. The **unregulated workforce that provides upwards of 90% of direct resident care in nursing homes has no voice**.⁵⁹ We do not count these care aides and personal support workers accurately in Canada, we do not regulate them, and we do not have consistent educational standards or ongoing continuing education standards for them across Canada. Despite their daily contact with residents, they are rarely engaged in decision-making about resident care and rarely included in family conferences. More than 90% are women, up to 70% are over 40, about 60% speak English as a second language,^{60,61} and about half in urban centres are immigrants.^{60,61}
8. We have failed to support **resilience of a paid nursing home workforce that is more than 90% women**. More women than men undertake significant caregiving responsibilities outside of work for children and for aging parents. Lack of affordable and accessible childcare or respite care sharply reduce the capacity of these workers to respond to crisis situations in their LTC work. Under pandemic conditions, and in preparation for a possible second wave of COVID-19, this must be changed immediately for the paid LTC workforce.
9. We have not developed or adequately supported **managers and leaders** in the LTC sector, either with adequate, ongoing leadership and management training or with sufficient resources to manage their nursing homes effectively and optimally.
10. We have not maintained adequate levels of properly oriented **dietary, laundry and housekeeping staff**, and have not recognized their role in creating a quality nursing home environment.
11. Canada has generally failed to acknowledge the **profound inequities and inequalities** faced by many older Canadians, which are exacerbated in nursing homes. *High among them is poverty*, a particular problem when fees are attached to many services and products and treatments. Poverty is an independent risk factor for lower health-related quality of life.⁶²⁻⁶⁵ We also see inequity and inequality based on mental illness, substance abuse and

addiction, homelessness, absence of family or friends, intellectual and physical disability, visible minority status, Indigenous status and LGBTQ2S+* identity.

12. Older Canadians with dementia who are frail and vulnerable **do not have a voice**. They are no longer part of Canada's economic engine. They no longer vote. They are rendered voiceless by advanced age, debilitating diseases and our inadequate care and attention. *Two thirds of them are women, and two thirds of them are persons with dementia. **Their voice must be restored.***
13. Canada has systematically failed to deal with the **consequences of population trends** in aging, dementia prevalence and fewer family caregivers for older adults. We have relied increasingly on family to provide unpaid care without appropriately supporting them. We do not acknowledge the economic value of that care, or the high physical and mental health consequences of that work, or the loss of family caregivers from Canada's broader workforce.^{66,67} Two thirds to three quarters of unpaid caregivers are women.⁶⁶⁻⁷⁰ Under pandemic conditions, they may be caring for older family members and simultaneously home schooling children, bearing the brunt of the burden caused by the pandemic. Some families can afford to employ private paid companions for older adults with dementia in nursing homes during normal times, but those employees may or may not be formally trained to fill gaps in care and companionship. This also requires that families enter into employer relationships that they may be ill equipped to manage.

The challenges ahead in nursing homes

Pre-pandemic characteristics of older adults living in nursing homes

We cannot build a better sector if we do not understand the people it is intended to serve. By 2036, up to 25% of Canadians will be 65 or older,⁷¹ with the most rapid growth in people 85+.⁷² Our changing population structure will sharply increase the number of Canadians living with Alzheimer's disease and other age-related dementias. Today, 1 in 40 Canadians aged 65-74 and 1 in 3 over 85 have an age-related dementia.⁷³⁻⁷⁵ Without dramatic preventive, curative or treatment breakthroughs, more and more of these people will rely heavily on supportive care services such as nursing homes, especially in advanced stages of dementia.

At any given time about 1.2% of older Canadians live in nursing homes or residences for older adults.⁷⁶ About 225,000 older adults live in nursing homes⁷⁷ and another 168,000 in other types of residences for older adults.⁷⁷ However, turnover in nursing homes is rapid. About 80% of residents either die in the nursing home or are discharged or transferred to hospital immediately before death.^{78,79} Thus, over the span of each year, many more than 225,000 older Canadians live in nursing homes. While waiting times for older adults to enter nursing homes are beyond the scope of this report, we know that they are unacceptably long: 150 days from community and 100 days from acute care in Ontario, for example.^{80,81}

The characteristics of older adults in nursing homes have changed dramatically over the last two decades. From 2011/2012 to 2018/2019, the proportion of residents living with moderate to severe cognitive impairment passed 60% in most provinces and reached 68% in Ontario. During

* LGBTQ2S+: Lesbian, gay, bisexual, transgender, questioning, two spirit. + refers to other sexual identities including pansexual, asexual and omniseual.

the same period, the proportion of residents aged 85+ (the oldest old) increased from 49% to 54%.^{55,82} Canadians are now entering nursing homes when they are older, more dependent and have more complex medical and social needs.^{53-55,83-90} Between **65% and 70% of nursing home residents are women.**^{54,55,87,91,92} They have multiple co-existing health conditions, such as dementia and chronic heart, lung, kidney and metabolic diseases including diabetes.

Residents in nursing homes also more and more reflect the tremendous heterogeneity of Canadian society, for example:

- **LGBTQ2S+ identity:** Increasing numbers of LGBTQ2S+ older adults require nursing home care. Roughly 3%⁹³ of Canadians identify as LGBTQ2S+, but actual numbers are underreported and likely much higher. Members of the LGBTQ2S+ community are largely invisible within LTC sector services, and reporting on that community is often inaccurate and unreliable.⁹⁴ LGBTQ2S+ older adults express numerous fears about going to a nursing home⁹⁵
- **Require a public guardian:** Older adults with reduced decision-making capacity and no family or friends may require a public guardian.⁹⁶ Prevalence of this group in nursing homes is around 4% in Alberta and can be extrapolated to roughly 9000 people nationally.⁹⁷ They often have unmet personal and care needs and experience poor quality of life.⁹⁸ Many have experienced homelessness or lived with mental health issues and alcohol or substance use.⁹⁸
- **Mental illness:** Many more older adults in nursing homes have a serious mental illness than older adults in the community. Reportedly 40% of older adults living in nursing homes in Ontario need psychiatric services,⁹⁹ but less than 5% receive that care. Depression, dementia and anxiety are the most common mental health problems in nursing homes.¹⁰⁰ Bipolar depression, major depressive disorder and schizophrenia also occur independent of dementia.¹⁰¹ A recent review reports that nearly 25% of nursing home residents in North America without dementia experience major depressive disorders.¹⁰¹ In Canada, 27% have depression and approximately 23% have depression and dementia.^{100,102}
- **Race:** Canada is multi-racial and that is reflected in our nursing homes, but data on race, language spoken and ethnic group are *not routinely collected*.¹⁰³ This is particularly problematic because COVID-19 has differentially affected racialized populations.

Pre-pandemic characteristics of care for older adults living in nursing homes

The goals of care in nursing homes differ radically from goals in the acute care (hospital) sector. For nursing home residents, their goals of care centre on quality of life, quality of life as the end of life nears, and a good death. A good death is an eventual, anticipated and appropriate outcome. In the US in 2009, 1 in 4 deaths were of people who died in a nursing home.¹⁰⁴ Despite this and although palliative care in nursing homes is rapidly evolving,¹⁰⁵ palliative services are often unavailable.¹⁰⁶ We do know that older adults in Canada face significant gaps in accessing palliative services,¹⁰⁷ but we do not have evidence on the quality of palliative care in nursing homes across Canada or to what extent “palliative approaches”¹⁰⁸ are implemented. We do know that structural inequity has a profound impact on access to palliative care generally.¹⁰⁹

Residents of nursing homes experience unacceptable rates of highly burdensome symptoms and high rates of potentially inappropriate care at the end of life in Canada^{110,111} and internationally.¹¹²⁻¹¹⁴

Burdensome symptoms are highly distressing, largely preventable or treatable, and cause unnecessary suffering. Common burdensome symptoms for nursing home residents are pain (26%-86%),¹¹⁵⁻¹²² eating problems (47%-70%),^{115,116,123,124} shortness of breath (10%-75%)^{112,115,116,118,125,126} and delirium (29%-46%).^{118,125,127}

On average, nursing home residents experience more than one transfer to hospital in their last days of life.¹²⁸⁻¹³¹ Of those transfers, 75% could have been avoided because appropriate treatment was unavailable in the nursing home or because transfer to hospital was inconsistent with resident and family preferences.^{130,132} Common (but usually inappropriate) care at end of life in nursing homes includes administering antipsychotic medication without a diagnosis of psychosis,¹³³⁻¹³⁷ inappropriate medication management for depression,^{138,139} use of physical restraints,¹⁴⁰⁻¹⁴⁴ multiple simultaneous medications prescribed,¹⁴⁵⁻¹⁴⁸ indwelling urinary catheters¹⁴⁹⁻¹⁵¹ and aggressive treatments such as renal dialysis^{152,153} or non-pain-related intravenous therapy such as antibiotics.¹⁵⁴⁻¹⁵⁶

Nursing home care in Canada is not structured or staffed to maintain or improve the functional abilities of residents. For example, residents often lose functional mobility rapidly.¹⁵⁷ Up to 70% of nursing home residents use wheelchairs,^{87,158-160} putting them at high risk for injury from falls, incontinence, pressure injuries and pneumonia.¹⁶¹

The special case of dementia

Life expectancy continues to rise in Canada, along with chronic diseases. On average, Canadian women can expect to live 84 years and men 79.9 years.¹⁶² Critically for the LTC sector, dementia has increased dramatically. Globally, 75 million people will have a dementia by 2030 and 131.5 million by 2050.¹⁶³ Today, 1 in 40 Canadians aged 65 to 74 years old and 1 in 3 over 85 years old have an age-related dementia.⁷³⁻⁷⁵ By 2038 1.125 million Canadians, or almost 3% of the entire population, are projected to have an age-related dementia.⁷⁴ Rates of dementia will continue to climb because age is the major risk factor.

Dementia is itself life-limiting. Dementia is an umbrella term for a set of degenerative brain disorders. It results in decreasing cognitive and functional abilities, starting with higher brain functions for planning, focus and memory. Eventually even low brain activities such as bladder and bowel control, recognition, moving and swallowing do not function. Dementia is ultimately fatal if something else does not cause death first, such as pneumonia.^{164,165} People with dementia experience progressive decline. Even assuming optimization of all community care, home care and alternative supported living, eventually the care demands of dementia normally exceed the coping capacity of family and community. Unsurprisingly then, dementia is the *major driver of admission to nursing homes*. More than two thirds of older adults with dementia will require nursing home care.^{166,167} Dementia can be an untenable challenge during crises such as COVID-19—and some countries have discussed rationing of resources for people with dementia, raising complex questions of discrimination and vulnerability.¹⁶⁸ We are also learning that older adults with dementia have a different disease course and symptoms for COVID-19 and have higher mortality rates than those without dementia.¹⁶⁹

Dementia defines the complex health and social care that is required in nursing homes. Dementia care is demanding and specialized.¹⁷⁰⁻¹⁷³ It requires knowledgeable and skilled staff. *It is patently false that anyone can provide health and social care for people with dementia.*

Pre-pandemic characteristics of the workforce in LTC

We cannot build a better LTC sector if we do not understand, value, train and appropriately compensate the people who deliver the essential services needed by the older adults living in nursing homes. In the past, many older adults lived in an “old age home.” People who required a higher level of medical care lived in facilities staffed by regulated nurses (registered nurses and licensed practical nurses), with some complementary care by nursing assistants or orderlies. As costs increased, staff configurations changed.

Today we see a decline in all regulated caregivers in most jurisdictions^{174,175}—even as the medical and social needs of older adults in nursing homes have risen sharply. The dominant staffing model in nursing homes now is a few registered nurses and some licensed practical nurses. Most direct care of residents is carried out by unregulated staff variously called care aides, personal support workers, orderlies or nurse assistants. Small numbers of other regulated care providers are included in the mix: physiotherapists and physio aides, recreation therapists and aides, social workers, occupational therapists, and others. Evidence exists, and continues to grow, that staffing levels and staffing mix are linked to quality of care¹⁷⁶⁻¹⁸⁰ and quality of work life.¹⁸¹

The unregulated paid workforce

Personal support workers, care aides, orderlies, nurse assistants

Workers in nursing homes care for frail, vulnerable older adults with increasingly complex medical and social needs. Those needs of residents have a significant impact on **unregulated care aides**, the predominant staff in nursing homes who provide upwards of 90% of direct care.¹⁸²⁻¹⁸⁶ Care aides have limited formal training and manage high workloads with frequent interruptions.¹⁸⁷ They frequently experience responsive behaviours of dementia from residents, such as being yelled at and hit.^{59-61,188} They are at high risk for job dissatisfaction,¹⁸⁹ burnout¹⁹⁰ and poor mental and physical health.¹⁹¹ In addition, care aides are themselves a vulnerable group, mostly older women from ethnic minorities.⁶⁰

Canada cannot currently plan for a workforce with sufficient numbers of well-trained staff to secure quality care in nursing homes. We do not even accurately count the numbers of unregulated workers providing care in Canadian nursing homes or in other LTC settings, such as retirement homes or private homes. It is impossible using data national data sources to tease out where the unregulated workers are actually working and in what numbers. *No data are routinely collected nationally or provincially* on the characteristics of the care aide workforce or on the quality of their work life or on standards in each province for their training.

By searching websites and tapping our professional networks in the LTC sector, we collected limited information on care aides nationally (Table 2). From published research, media reports and informal channels, we also know that, **pre-pandemic**:

- Care aides receive the lowest wages in the healthcare sector (\$12-\$24 per hour).¹⁹²⁻¹⁹⁴
- Care aides receive variable and minimal formal education.
- Many care aides cannot get full-time or regular part-time work with benefits, because some employers rely on casual staff.^{195,196}
- In some provinces, such as Ontario, many care aides are hired out on demand to nursing homes through agencies. Care aides with these agencies are not well paid, although

nursing homes pay a premium for them. Agency staff may not be well oriented to LTC, making team work more difficult and increasing the work of already stretched staff.

- No groups of care aides are regulated or licensed in Canada. Few are registered.^{60,61,197}
- All care aides work at the bottom of a rigid hierarchy. They are rarely engaged in decision-making about care for residents and rarely included in family conferences or in decisions about how a nursing home is organized or governed.¹⁹⁸
- Pre-pandemic, a nursing home resident received only 2.2 to 2.3 hours of direct (worked) care from care aides in each 24-hour period.^{61,181}

Largely from an ongoing longitudinal study in western Canada we know that, **pre-pandemic**, frontline care aides:

- are mainly middle-aged or older women (66%-71%)⁶¹
- are often newcomers or immigrants (60% of care aides working in urban areas), with English as their second language⁶⁰
- are often not required to complete any continuing education and are often not offered it⁶¹
- often work in more than one job (25%–30%) and in healthcare settings other than nursing homes (e.g., hospitals; 15%)^{59-61,196,199,200}
- often work short-staffed¹⁹⁸
- have insufficient time to complete necessary care tasks and must rush essential care (up to 65% of care aides per shift)²⁰¹
- are at worryingly high risk for burnout and physical injury^{59-61,190}
- report feeling that their work is important and has meaning, despite high levels of work-related stress^{60,61,198}

The impact of COVID-19 on psychological health and safety of direct care workers in nursing homes is being added to already worrisome pre-existing trends.²⁰² Studies from the 2003 SARS epidemic²⁰³ and recent studies documenting effects of the COVID-19 pandemic on point-of-care workers in China²⁰⁴ point to severe long-term traumatic impacts on mental health of point-of-care staff. Care aides are already under severe psychological stress and are predicted to develop symptoms of acute stress disorder, depression, alcohol abuse, anxiety, insomnia and posttraumatic stress disorder (PTSD) even years after the COVID-19 pandemic.²⁰⁵

Unregulated indirect care workers

Additional large groups of unregulated workers in nursing homes are housekeeping, laundry and food services staff. They contribute importantly to infection control, to the sense of each nursing home as *home* for residents, and to quality of life.²⁰⁶ However, many such services are contracted out and those staff are less integrated into nursing homes. Despite their essential work, we have little data on them and few studies include them. A notable exception is work out of York University.^{16,36} Although these workers are rarely considered when nursing home reform and redesign are discussed, they are key to a high-quality and safe nursing home.

The regulated paid workforce

Medical coverage in nursing homes varies significantly across provinces, from a designated roster of family physicians who care for residents at one or more nursing homes to an individual

resident's family physician.²⁰⁷ Some regions use combinations of these or offer almost no care on site ("medical care by fax"). A few provinces and regions offer medical coverage by nurse practitioners, either primarily or in collaboration with general and specialist medical services. Access to mental health services varies widely and is usually by consultation only when it is available.²⁰⁸ Mental health and palliative services are generally insufficient to meet demand.²⁰⁹ We still know little about availability of palliative services for residents who died in nursing homes under COVID-19 conditions.

Nursing homes also require a diverse cadre of **regulated nursing and other health professionals**. Most numerous are nurses—registered nurses, licensed practical nurses and registered psychiatric nurses (and in some nursing homes in some provinces, nurse practitioners). Over the past two decades, ratios of regulated nurses to care aides have steadily declined.^{174,210} At the same time, regulated nursing staff must give more time to required documentation ("paperwork")—time that is taken from direct care and supervision. Numbers of registered nurses have also decreased in favour of licensed practical nurses as a cost saving measure.¹⁷⁴ These changes reflect widening inability or reluctance to meet the increasingly complex needs of nursing home residents by matching those needs to appropriate nursing skills.¹⁹⁵

Nursing homes often lack access to an array of specialized services accessible to all residents. Residents often need support from **physical, occupational, speech and recreational therapists and technicians**. Skills of those workers affect both care quality and quality of life by prolonging mobility, optimizing assistive devices, assisting with swallowing difficulties (often encountered by people with later-stage dementia), and programming meaningful recreational and social options. **Social workers and pastoral care** are important in assisting both residents and families. However, as cost containment becomes more pressing, all regulated services have dwindled despite a resident population with higher needs than ever before.^{174,211}

Many nursing home residents need access to **uninsured services** such as vision care, dental care, hearing care, podiatry, assessment for hip protectors, and special mobility devices or wheelchairs. Few mobile services come to nursing homes, so residents and caregivers (paid or unpaid) must travel to the service. Not all service providers even can or will offer services to nursing home residents with impaired mobility or dementia.

Sensory loss is a major impairment in dementia, making lack of vision and hearing services a serious concern. Lack of dental care is a major problem for health, quality of care and quality of life.^{212,213} Dental needs are increasing dramatically as Canadians age with their own teeth and with complex dental work (bridges, crowns, implants) that require specialized care—care that is not available in nursing homes.

Workforce staffing and staffing mix for quality of care and quality of life

Most studies on appropriate staffing mix in acute care and nursing homes have been in the US, with some in Europe and almost none in Canada. Most studies in acute care are highly focused on effects of daily hours²¹⁴ of nursing care on one outcome, such as mortality.^{215,216} Recent papers point out wide differences in regulated staffing hours.²¹⁷ Reviews of staffing studies, most in the US,^{178,180,218-220} all identify major issues with how studies were conducted and lack of comparability across studies. However, a body of evidence has emerged despite the inherent challenges of cross-sectional studies and other methodological challenges. In 2001, the Centres for Medicare & Medicaid Services in the US issued a major report to Congress on nursing home staffing.²²¹ Since

then multiple reports have increased pressure and guidance, despite the challenges, to bring standards to bear on US nursing homes. US health care is organized differently and data and findings are not directly translatable to Canada, but they illustrate trends that likely are significantly similar between the two countries. If staffing is inadequate, quality plummets.

A useful process proposed to establish adequate and appropriate staffing by all groups of nursing personnel²²² is to: a) determine the collective resident care needs, b) determine the actual nurse staffing levels, c) identify appropriate nurse staffing levels to meet resident's care needs, d) examine evidence on the adequacy of staffing and e) identify gaps between the actual and appropriate staffing levels. Harrington, a recognized US leader and expert in nursing home staffing, also advises that the minimum total nursing hours to ensure care quality is about 4.1 hours per resident per 24 hours.²²³ This does not include physician care or the allied services required for good care quality (medical, physical, occupational, recreational, speech and language therapy, social work, pastoral care, support from laundry, housekeeping and dietary). This estimated requirement of 4.1 hours of nursing care in 24 hours is significantly higher than nursing hours in Canada—BC has the highest *recommended* funded hours per resident day at 3.36 hours, higher than the Canadian average of 3.30.^{224,225}

Importantly, adequate staffing is a necessary but insufficient condition for quality.²²⁶ A nursing home is a *complex adaptive system*^{227,228} with many moving parts and multiple elements that contribute to quality of care and quality of life for residents. We must not focus attention exclusively on staffing and think this will solve the challenge of quality. Other essential dimensions of quality are person-centered and relational care, strong leadership and management, working conditions and the care unit environment, the built environment, and resident and family/friend experiences. And these are just some of the essential elements required for quality. To improve quality of care, we need data that are routinely collected in multiple areas, in multiple forms—and we must put in place mechanisms and supports for these data to be acted upon and those actions evaluated. *Quality data and action cycles are hallmarks of a learning health system.*²²⁹

Canada lacks a comprehensive, data-based assessment of necessary staffing in nursing homes—minimum hours of care needed to give an acceptable level for quality of care and quality of life. Minimum hours of care must be based on each resident's needs, on how complex their social and medical needs are and on acute needs. Assessing necessary staffing in nursing homes must also thoughtfully consider the **care team** required to deliver quality care. This must include staffing and skill mixes and the widest possible definition of a care team. A staffing assessment for nursing homes must also consider the needs (and solutions for those needs) of a *predominately female workforce*, such as childcare and care for aging parents. Finally, it must consider cost, benefit and sustained implementation.

No comprehensive empirical work has ever been done in Canada to determine *minimal, adequate, appropriate, or optimal staffing* needed to ensure good quality social care (quality of life) and health care (quality of care) for residents. *It is long overdue.*

Care by unpaid family and friends

The LTC sector and nursing homes rely increasingly on unpaid care by family members and friends of residents. These are disproportionately women, especially for daily care. They provide many different care activities. However, our society gives little attention to respite for these caregivers or to the negative effects of their caregiving burdens.

Compounding this problem, by 2050 approximately 30% fewer close family members—spouses and adult children—will be available to give this unpaid care.²³⁰ Family configurations are changing with declining fertility rates, smaller families and families dispersed across the country and internationally. More people will have no available family or friends. Relying on unpaid care by family and friends leaves the LTC sector especially vulnerable in crises such as COVID-19, when those unpaid caregivers suddenly become unavailable—or as in the first wave of COVID-19, are not permitted into the nursing home. As with aging of our population and rising levels of dementia, the dwindling numbers of unpaid family caregivers can be predicted with some certainty—when it occurs it will not be a surprise. Whether we will be ready is uncertain.

Volunteers are often proposed to meet gaps in care and social activities for nursing home residents. However this is not a straight-forward solution. Are there enough trained volunteers regularly available? Do volunteers receive planning, orientation and support for equitable, safe and consistent care? Are we using volunteers as a substitute for experienced and knowledgeable workers and is that appropriate? Care for residents in nursing homes is not care that just anybody can do. For example, having volunteers help residents with eating requires special training on problems with swallowing and risk of choking. Even in social activities, volunteers must be keenly aware of challenges in communicating with people living with dementia and associated disruptive behaviors.

Pre-pandemic characteristics of social, living and working spaces in nursing homes

Physical environment

The physical layout of nursing homes (~1800 in Canada) does not help to contain viruses or control infection, even in newer homes. Many nursing homes in Canada are old and were built between 1950 and 1990. Older buildings tend to be larger, with 200–400 residents. They resemble hospitals, with communal bathrooms, rooms for 2 to 4 residents, narrower hallways, large communal dining areas, small crowded nursing stations and medication areas, and limited areas for staff and families away from resident rooms. They may lack outdoor areas or adequate natural light and certainly lack modern technologies that improve care, such as appropriate flooring.²³¹ Physical distancing is nearly impossible without reducing the number of residents. Isolation or segregation of residents infected with COVID-19 is difficult within the design of these older buildings. Worryingly, we are seeing early reports of associations between facility size and age and COVID-19 status.^{30,232,233}

Nursing homes built in the last 20 years often accommodate only 80 to 120 residents. They are designed specifically to support the social needs of residents living with dementia, with smaller ‘neighborhoods’ of residents, physical characteristics that make living less stressful and more enjoyable for people with dementia, wide hallways and doorways, individual large bathrooms, and smaller local communal dining areas. They often have spacious and safe outdoor spaces where people living with dementia can enjoy the outdoors without danger of wandering. At least three provinces have building standards for nursing home construction that include these features (NS, AB, ON). These standards can also make physical distancing and infection control less challenging.

Plans, protocols and resources for delivering care

When the COVID-19 outbreak occurred, nursing homes lacked capacity to handle the surge. They faced a major challenge in rethinking what care to deliver and how to deliver it. Quality of life and

quality of care for residents became secondary in many instances. To have been fully prepared, nursing homes would have needed multiple plans and resources:

- infection prevention and control through PPE sourcing and training in its use and conservation
- strategies for clustering and isolating ill residents and those who tested positive
- infection surveillance strategies for staff
- appropriate policies on visitors, recognizing the risk of infection, but also recognizing how essential friends and family are to both residents' quality of life and in providing care in understaffed facilities
- capacity to test and carry out contact tracing
- sufficient staff with relevant training to fill staff vacancies from illness and self-isolation, as well as volunteer vacancies
- effective *on-site* leadership and management
- ongoing, productive links to acute care hospitals
- training in end-of-life care and access to relevant medications and staff to administer them
- resources for end-of-life decisions
- wellness resources for staff
- adequate IT capacity and internet access to enable video communication with families and others

An additional complexity is that nursing homes are a social environment. Much work has been done to invite the community—families, volunteers, children, pets—into nursing homes. Many policies normally welcome this influx, rather than managing it—no set visiting hours, open door policies, free inflow of food and pets, and residents free to leave and return. Under COVID-19, nursing homes as a public social place clashed sharply with nursing homes as a safe space for residents to live and staff to work. Staff were charged with keeping the space safe. Clearly, having so many homes become hotspots for COVID-19 put an enormous strain on the willingness of residents, family and staff to comply with changes in policies in favour of safety. Communication has been a problem in many, although not all, nursing homes.

The context that created the COVID-19 crisis in LTC

Several factors operated to create the high degree of vulnerability experienced by older adults in nursing homes:

1. **Pandemic preparedness favoured acute care** (hospital) settings. Nearly all effort was diverted to create *surge capacity* in hospitals and ICUs, leaving most nursing homes unprepared and (worse) in some jurisdictions admitting older adults from acute care.
2. Residents in nursing homes have **reduced immune system capacity** as a result of aging. This markedly reduces their ability to fight any infection.
3. **COVID-19 is novel**. Neither nursing home residents nor staff are vaccinated against it, unlike annual influenzas for which most residents and staff are vaccinated. Such vaccination offers herd immunity.
4. **COVID-19 is highly contagious** and has a **long incubation period when infected people have no symptoms**. Spread can be invisible. In the early weeks of the pandemic, before

this was widely known, invisible asymptomatic spread was deadly. The virus spread into and back out of nursing homes as family, visitors and staff came and went unknowingly. Basic infection control practices and PPE that should have been in place were too often missing. A proportion of nursing home staff were working in more than one nursing home and other healthcare facilities, silently bringing the virus in and out of nursing homes in the early weeks.

5. Many nursing homes in Canada are **physically not designed for infection control practices** that are needed to avoid COVID-19 or to contain its spread. Nursing homes have many communal settings, including bathrooms, dining areas and rooms with multiple beds. Separation of COVID-19 positive residents was not recognized as critical in the early days, and many nursing homes are not physically designed to make this achievable. This is particularly challenging in care for people living with dementia who are also at risk of wandering and cannot remember to physically distance.
6. Staff **did not know or misunderstood how to prevent and control the spread of COVID-19** in the early days of the pandemic. *Infection control knowledge was inadequate* among care staff. The ways that nursing homes were managed to control spread varied significantly between and within provinces.
7. Nursing homes experienced **shortages of PPE**, problems and lack of support in teaching how to use PPE properly, and lack of understanding that PPE was essential for nursing homes. At times, PPE was pulled from nursing homes for the acute care sector.^{234,235} Nursing home staff must be routinely in close contact with residents and must have PPE to care for residents adequately under COVID-19. Often PPE and education in its use did not include critical staff for infection control, such as housekeeping.
8. Some hospitals discharged patients who tested positive for COVID-19 to nursing homes. Some hospitals would not accept infected patients from LTC settings.
9. Up to 30% of **care aides and other staff worked at more than one job**. Because care aides are not in registries, these numbers were not known or considered. In the early stages of the pandemic this increased spread of COVID-19 infection.
10. Many nursing homes lacked **screening resources for symptoms, travel history and contacts** of both residents and staff. Many also lacked testing, contact tracing and plans to respond effectively.
11. **Staff were not able to work**, for many reasons. Some were symptomatic and had to isolate at home. Some were sick or had a sick family member. Some had to care for children at home when schools closed. Some were afraid to work or in some instances left their posts. Fear and misinformation led to pressure on staff from families, landlords and unions to stay away from nursing homes with COVID-19 cases. The LTC sector works with a complex combination of *barely enough* full-time staff and mostly part-time staff. It fills the gaps with casual and agency staff, with few reserves to replace absent workers. Families, who often provide significant care, were not permitted to visit. The LTC sector could not meet unexpected pandemic pressures from reduced staffing and volunteers and the 24/7 needs of residents. Those pressures quickly became catastrophic.
12. Troubling reports from Europe²³⁶ and now Canada^{11,12} indicate that many preventable deaths occurred in nursing homes under COVID-19. *Some deaths were from lack of timely care, water, food or basic hygiene, not from COVID-19 infection*. This underscores the frail

and highly vulnerable condition of older adults in nursing homes. It epitomizes our failure. Many are not mobile or cannot vocalize their needs. **This was more than a communicable disease crisis.**

Principles to guide future action

While there is more to be learned about controlling COVID-19, the following principles should guide efforts to improve safety and quality of life for residents and staff of Canadian nursing homes. We must create a better future for older Canadians who need nursing home care and ensure their voices and wishes are honoured. *At their heart these principles are about our shared values as Canadians.*

1. Funding must be adequate and sustained, with the federal government supporting provincial and territorial governments to achieve high standards across Canada in LTC.
2. Quality of care in nursing homes is fundamental and intimately linked to quality of life.
3. Quality of life for the frail elderly is a *non-negotiable* objective.
4. Quality of end of life and a good death are similarly non-negotiable objectives.
5. Standards of care are essential and must be clearly articulated along with accountability.
6. Responsibility for policy, standards and regulation must be clear. Desired outcomes must be articulated and evaluated, and accountability for those outcomes ensured.
7. Routine evaluation of performance must occur, including performance measures that are important to residents and families.
8. High-quality and comprehensive data (quantitative and qualitative) are required to manage the LTC sector and must be routinely collected, verified, analyzed and reported for effective regulation, evaluation and monitoring.
9. Mechanisms for *acting on data* must be in place and be supported from point-of-care to policy levels.
10. Funding for nursing homes must be tied to ongoing evaluating and monitoring of indicators of quality of care, resident quality of life and quality of end of life, staff quality of worklife, and resident and family experiences. All information must be publicly accessible.
11. The federal government must take a major role and develop a mechanism for supporting provincial and territorial governments to achieve high standards in LTC across the Canada. This could be achieved through a similar framework to the Canada Health Act, where core standards are articulated. Provincial and territorial governments who meet those standards receive additional federal transfers.
12. Working relationships must be collaborative among stakeholders—government, health authorities, nursing home owners and nursing homes themselves, with the vital input of the people who live, work in and visit nursing homes.
13. All citizens in all regions must have *universal, affordable and equitable access* to 24/7 nursing home care, if they need it, without long wait lists.
14. There must be better integration across community, continuing care and acute care sectors. Transitions between LTC settings must be better managed, with a whole-systems approach to governance, regulation and incentive design.

15. Nursing home staffing must be consistent and adequate, with qualified staff in the right mix of skill and knowledge.
16. Nursing home physical environments and plans, protocols and resources for delivering care must meet complex medical, social and home-like needs of residents. They must also meet complex needs for space, safety and infection control and prevention. They must not sacrifice the ability of close family members (of origin or choice) to assist with care and be with dying residents.

Recommendations to manage COVID-19 in Canada's LTC sector

Reform and redesign will take time. Multiple organizations globally have begun to outline the many specific and immediately practical things that need to be done to manage COVID-19 in LTC in the shorter term.^{13,237-239} In May, 2020 Comas-Herrera et al.²⁴⁰ outlined policy recommendations. Subsequently, members of this working group laid out their prescription for preparing for the second wave of COVID-19 in nursing homes, reproduced here.²⁴¹

First, all (not just some) nursing homes, retirement homes and other assisted living places must each have an approved plan for responding to infectious outbreaks, including COVID-19. The plan must specify who is responsible for preventing and managing an outbreak and that person must be on site, with clear and measurable performance metrics. Residents and their families must be consulted in the development of the plan and there must be transparent reporting to the public.

Second, in-person inspection of all homes must occur regularly by the relevant public health unit (and not by an accreditation body) to ensure that plans are being operationalized and that residents and workers are safe. It should go without saying that such inspections cannot be by telephone and that LTC facilities should not be warned ahead of the inspection, which is the practice in some provinces. Results of inspections must be made public and there must be consequences for non-compliance.

Third, provincial governments must manage procurement so that LTC settings are equipped for infection control. All workers or others who come into close contact with residents in LTC settings must be equipped with adequate personal protective equipment (PPE). These same people must have proper education in infection prevention and regular ongoing support and re-education in infection control and proper PPE use and conservation. Also, all nursing homes must adopt and have resources for a "test and trace" strategy for all residents and all workers.

Fourth, LTC workers must have full time work with equitable pay and benefits, including mental health supports for the PTSD many are experiencing due to COVID-19. Many personal support workers work for minimum wage, which is unacceptable normally, given the importance of this work and the expertise required. It is ridiculous in the face of COVID-19, given the personal risks for workers and their families. Similarly, workers providing essential food, cleaning and laundry services must receive equitable pay. When the military was deployed into LTC homes, in Quebec and Ontario they were paid "danger" pay on top of their relatively robust salaries.

Fifth, jurisdictions must continue the “one site work policy” both for the duration of the pandemic and going forward. Working in two or more settings contributed to COVID-19 spread both in and out of facilities and contributes to the spread of influenza at other times.

Sixth, all LTC homes must either have the capability of properly isolating an individual with COVID-19 or clustering positive residents in one area of the LTC home. If this is not feasible, the patient must be transferred to a hospital or other appropriate setting where isolation of positive cases is possible. No hospital should discharge any suspected or confirmed case of COVID-19 back to a nursing home until the person’s infection has resolved as evidenced by a negative test. Plans for managing COVID-19 must also include access to palliative care if needed, including appropriate medications and pain control.

Seventh, response plans for LTC homes must include measures so that technology and other means are fully employed to connect residents with family and friends and that at least one or two family members can safely visit (with PPE and proper infection control practices and training). Residents are closer to the end of their lives; many have dementia. Familiar voices, support and comfort are essential, and sometimes only a family member or friend can provide that. We cannot permit people to die without care at their end of their lives, whether from COVID-19 or otherwise. Family and friends have in the past helped ensure accountability particularly when a resident is too frail to vocalize concerns or make herself heard and with the significant stresses upon workers and management through COVID-19, this line of accountability is critical.”²⁴¹

Clearly, primary responsibility for LTC services rests with provincial and territorial governments, but we see across the globe serious efforts to create national coordination for a successful response to COVID-19 in the LTC sector. Canada’s reality is that, without federal financial support, provincial and territorial governments are unlikely to have resources for the high standards that our frail elderly deserve in nursing homes and LTC more broadly. We can look for inspiration to New Zealand, which was able to declare COVID-19 free status on June 8²⁴² (although it continues to see isolated new cases).²⁴³ Australia and South Korea have comparatively favourable results with strong national strategies. The Australian government prioritized the aged care sector for COVID-19—“On the 11th of March, \$440 million was committed to aged care including addressing staff retention and surge staffing, improving infection control. Aged care providers have priority access to the national stockpile of PPE, and healthcare rapid response teams and staffing support when an outbreak occur in a facility or in home care.”²⁴⁴ At the time of this Australian report, nursing homes had <1% of all COVID-19 cases and 17% of all deaths. This compares to Canada’s 81% of all its COVID-19 deaths in nursing homes.¹ South Korea’s aggressive national response to COVID-19 included nationwide monitoring and inspections, cohort quarantines of selected facilities, temporary reimbursement packages, low-cost masks for care workers, and provision of guidelines. At the time of South Korea’s report, only 8.1% of COVID-19 deaths were people in nursing homes, and another 25.9% in LTC hospitals.²⁴⁵

This Working Group, however, takes the position that **reform and redesign must tackle not just the pandemic crisis, but also long-standing systemic failures**—root causes—of the pandemic crisis in nursing homes in Canada. To fail in doing this leaves us with our currently woefully

inadequate LTC system and the certainty that the next crisis will create similar or more catastrophic outcomes. Reform and redesign

- must begin immediately
- are best done within a national framework with provinces/territories and the federal government working together
- must report progress transparently to the public in a timely manner
- must include immediate, mid and long-term targets and ongoing evaluation, in perpetuity, on both quality and safety.

Workforce recommendations to reform and redesign LTC in Canada

We recommend that *if we do nothing else, that immediately and with urgency Canada directs sustained focus, effort and resources to redress the workforce crisis in the LTC sector.* Meeting this major challenge will go a long way toward ongoing redesign and reform. It will have an immediate impact on the quality of care and quality of life for vulnerable older adults in nursing homes, on their families, and on the workforce responsible for their care. A high-quality, resilient and supported workforce is, without doubt, the major component of quality.

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

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

mechanisms of infection spread from multi-site work practices and implement a robust tracking system.

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

We do not need another whole-system commission, another inquiry, another report or to have the armed forces be the best or only alternative to stem a preventable crisis in nursing homes. What we do need is a transparent **national action plan** with strong and coordinated national and provincial/territorial leadership, broad stakeholder input, responsibilities, accountabilities and the ability to bring resources to bear as needed. Such an action plan must of course link with other relevant national strategies, such as the Public Health Agency of Canada's dementia strategy.

Canada's choice

Any recommendations and all reform and redesign of the residential LTC sector must recognize and place at the core of all thinking and action that these settings are **home** for their residents. In most cases, their last home. Quality of life and death must not be sacrificed with neglect, when

regulation is reasonable and warranted. They must also not be sacrificed with rigid over-regulation when risk tolerance is warranted. Good social and health care means that older adults in nursing homes experience a good quality of life and a good death. These are indispensable ingredients of our **duty to care** in nursing homes and must be primary.

We have failed our older adults by not keeping pace with care demands, by assuming that care of the frail older adults in nursing homes is “just basic care” and anyone can do it with little or almost no training and education, by ignoring the highly gendered nature of nursing home care, by “holding the line” on resources. We have failed by believing that the solution lies in a less than coherent approach to regulation—high regulation in some areas that may for example, infringe on individual rights and freedoms, and no regulation in others such as consistent education standards for direct care staff. Most shamefully, we have failed by not hearing the voices of older Canadians in their last phase of life. Canadian nursing homes had generally been able to “just manage”, something far from adequate *before* the pandemic.

Then came COVID-19, a shock wave that cracked wide all the pre-existing fractures in our nursing homes. It precipitated, in the worst circumstances, loss of life, along with high levels of physical, mental and emotional suffering for our older adults. **Those unnecessarily lost lives had value.** Those older adults deserved the last years of their lives and they deserved a good death. We failed them. We have a duty and a responsibility to fix this—not just to prepare for the second wave of COVID-19 and other future infectious diseases but a root-and-branch overhaul of the LTC sector that helped that crisis wreak such avoidable and tragic havoc. We can take steps to immediately begin restoring the trust we have broken. *It’s a matter of choice.*

Both the immediate and the long-term challenges in nursing homes and their solutions are complex. Comprehensive, integrated and evidence-informed change will take time. Many real and urgent priorities will appear and compete as action progresses. As a country we will be required to ask: “What choices are we willing to make so that none of us needs to fear the quality of life and care that may await us in a nursing home?” Breaking out of long-established patterns is hard and the easiest choice for many will be to not disrupt the status quo. To succeed to radically transform nursing homes we must lead with courage and resolve, making the necessary choices wisely.

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Attachment 2. 10 years of media focused on LTC homes (nursing homes)

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12. 08 Jun 2020: For-profit nursing homes have 17% fewer workers, data shows: Lower staffing levels raise concerns about quality of resident care. Toronto Star. For-profit nursing homes have 17% fewer workers, data shows: Lower staffing levels raise concerns about quality of resident care
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14. 08 Jun 2020: Lack of oversight led whistle-blower to sound alarm on seniors home. The Globe and Mail. Lack of oversight led whistle-blower to sound alarm on seniors home
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16. 08 Jun 2020: Policies led to 'horrendous deaths'; Advocates ask why only 13 per cent of LTC COVID-19 patients got hospital care. The Ottawa Citizen. Policies led to 'horrendous deaths'; Advocates ask why only 13 per cent of LTC COVID-19 patients got hospital care
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Table 1. Long-term Care Homes (nursing homes) by Province: Number of facilities, terminology, governing policy/legislation

Province	No. of Nursing Homes	Terms Used		
		Homes	Sector	Workers
Alberta	183 ²⁴	<ul style="list-style-type: none"> • Long-term care facilities⁹ • Nursing home⁹ • Auxiliary Hospital⁹ 	<ul style="list-style-type: none"> • Long-term care⁹ • Nursing home⁹ • Auxiliary Hospital⁹ 	<ul style="list-style-type: none"> • Health Care Aide¹⁰
		<p>Legislation: Nursing Homes Act, Revised Statutes of Alberta 2000 Chapter N-7: https://www.qp.alberta.ca/documents/Acts/N07.pdf Hospitals Act, Revised Statutes of Alberta 2000 Chapter H-12: https://www.qp.alberta.ca/documents/Acts/H12.pdf</p>		
British Columbia	293 ²⁵	<ul style="list-style-type: none"> • Residential care facilities^{1,2} • Long-term care homes/facilities^{1,3} 	<ul style="list-style-type: none"> • Long-term care³ • Residential Care³ 	<ul style="list-style-type: none"> • Health Care Assistant⁴ • Care Aide⁴ • Health Care Worker⁵¹
		<p>Legislation: Community Care and Assisted Living Act, SBC 2002, CHAPTER 75, Assented to November 26, 2002: http://www.bclaws.ca/civix/document/id/complete/statreg/02075_01 *Note: Legislation governing some NHs (34% of all publicly funded beds) is regulated through The Hospital Act: http://www.bclaws.ca/civix/document/id/complete/statreg/96200_01</p>		
Manitoba	130 ²⁶	<ul style="list-style-type: none"> • Personal Care Homes^{5,12} 	<ul style="list-style-type: none"> • Long-term care^{13,14} • Personal care services¹¹ 	<ul style="list-style-type: none"> • Health Care Aide³⁸
		<p>Legislation: The Health Services Insurance Act (C.C.S.M. c. H35) - Personal Care Homes Standards Regulation: https://web2.gov.mb.ca/laws/regs/current/_pdf-regs.php?reg=30/2005</p>		
New Brunswick	68 ^{27,29}	<ul style="list-style-type: none"> • Nursing homes³⁴ 	<ul style="list-style-type: none"> • Long-term care³³ 	<ul style="list-style-type: none"> • Resident Attendant⁵³
		<p>Legislation: Nursing Home Act, RSNB 2014, c.125, Deposited December 30, 2014: http://laws.gnb.ca/en/ShowPdf/cs/2014-c.125.pdf</p>		
Newfoundland and Labrador	40 ²⁸	<ul style="list-style-type: none"> • Personal care homes¹⁷ • Long Term Care* 	<ul style="list-style-type: none"> • Long-term care¹⁸ 	<ul style="list-style-type: none"> • Personal Support Worker (PCH)¹⁷ • Personal Care Attendant (LTC)⁵⁴
		<p>Legislation: Newfoundland and Labrador Regulation 15/01. Personal Care Home Regulations under the Health and Community Services Act (O.C. 2000-626) (Filed January 30, 2001: https://assembly.nl.ca/Legislation/sr/regulations/rc010015.htm</p>		
Nova Scotia	88 ²⁹	<ul style="list-style-type: none"> • Nursing homes¹⁹ 	<ul style="list-style-type: none"> • Long-term care²⁰ • Continuing care²⁰ 	<ul style="list-style-type: none"> • Continuing Care Assistant³⁶
		<p>Legislation: Homes For Special Care Act. R.S., c. 203, s. 1.: https://nslegislature.ca/sites/default/files/legc/statutes/homespec.htm Long Term Care Program Requirements: https://novascotia.ca/dhw/ccs/policies/Long-Term-Care-Facility-Program-Requirements.pdf</p>		
Ontario	626 ³⁰	<ul style="list-style-type: none"> • Long-term care homes⁶ 	<ul style="list-style-type: none"> • Long-term care⁶ 	<ul style="list-style-type: none"> • Personal Support Worker^{7,8}
		<p>Legislation: Long-Term Care Homes Act, 2007, S.O. 2007, c. 8: https://www.ontario.ca/laws/statute/07l08 Regulation: O. Reg. 79/10: GENERAL: https://www.ontario.ca/laws/regulation/100079</p>		

Prince Edward Island	19 ^{23,29}	<ul style="list-style-type: none"> • Care homes⁵⁶/nursing homes³¹ • Manors²³ 	<ul style="list-style-type: none"> • Long-term care²³ 	<ul style="list-style-type: none"> • Resident Care Worker³⁷
		<p>Legislation: Community Care Facilities and Nursing Home Act: https://www.princeedwardisland.ca/sites/default/files/legislation/C-13-Community%20Care%20Facilities%20And%20Nursing%20Homes%20Act.pdf Facilities and Nursing Home Act Regulations: https://www.princeedwardisland.ca/sites/default/files/legislation/C%2613G-Community%20Care%20Facilities%20and%20Nursing%20Homes%20Act%20Regulations.pdf</p>		
Quebec	412**	<ul style="list-style-type: none"> • CHSLD (centre d'hébergement et de soins de longue durée)¹⁵ • CHSLD privé conventionné⁵⁷ • Privé non-conventionné⁵⁷ 	<ul style="list-style-type: none"> • Residential and long-term care¹⁵ 	<ul style="list-style-type: none"> • Le préposé aux bénéficiaires (PAB)⁴⁰ • Orderly
		<p>Legislation: Bill 120 (1991, C. 42): An Act Respecting Health Services and Social Services and Amending Various Legislation: http://collections.banq.qc.ca/ark:/52327/bs57416 S-4.2, r. 5.01: Regulation respecting the conditions for obtaining a certificate of compliance and the operating standards for a private seniors' residence: http://legisquebec.gouv.qc.ca/en/pdf/cr/S-4.2,%20R.%205.01.pdf</p>		
Saskatchewan	236 ³²	<ul style="list-style-type: none"> • Special care homes or nursing homes²² • Personal Care homes²¹ 	<ul style="list-style-type: none"> • Continuing care⁵⁰ 	<ul style="list-style-type: none"> • Continuing Care Assistant³⁹ • Special Care Aide³⁹
		<p>Legislation: R-8.2 Reg 8 - The Special-care Homes Rates Regulations, 2011, under The Provincial Health Authority Act (P-30.3): http://www.qp.gov.sk.ca/m/index.cfm?action=browse&p=33130 Facility Designation Regulations, section 17 23: http://webcache.googleusercontent.com/search?q=cache:qO6F-rdcSGEJ:www.qp.gov.sk.ca/documents/English/Regulations/Regulations/R8-2R6.pdf+%&cd=1&hl=en&ct=clnk&gl=ca&client=firefox-b-d Program Guidelines for Special Care Homes: https://www.ehealthsask.ca/services/resources/Resources/Program-Guidelines-for-Special-Care-Homes.pdf</p>		
Yukon	5 ⁴²	<ul style="list-style-type: none"> • Long-term care homes⁴² • Continuing Care Facilities⁴⁵ 	<ul style="list-style-type: none"> • Continuing care⁴¹ 	<ul style="list-style-type: none"> • Health Care Assistant⁴³ • Health Care Aide³
		<p>Legislation: Yukon Continuing Care: Bill of Rights for Residents Living in Yukon Continuing Care Facilities: http://www.hss.gov.yk.ca/pdf/cc_billofrights.pdf</p>		
Northwest Territories	9 ⁴⁴	<ul style="list-style-type: none"> • Long-term care homes⁴⁴ 	<ul style="list-style-type: none"> • Long-term care⁴⁴ 	<ul style="list-style-type: none"> • Personal Support Worker⁴⁶
		<p>Legislation: Northwest Territories Continuing Care Standards, 2015: https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/continuing-care-standards.pdf Proposal of new regulations for Continuing Care Facilities: https://www.hss.gov.nt.ca/sites/hss/files/resources/what-we-heard-continuing-care-facilities-legislation-nwt.pdf https://www.hss.gov.nt.ca/sites/hss/files/resources/continuing-care-facilities-legislation-nwt-discussion-paper.pdf</p>		
Nunavut	5 ⁴⁷	<ul style="list-style-type: none"> • Continuing care centers⁴⁷ • Elder homes⁴⁷ 	<ul style="list-style-type: none"> • Long term care⁴⁷ 	<ul style="list-style-type: none"> • Continuing Care Worker⁵⁵
		<p>Legislation: Currently there is no legislation in Nunavut to provide a framework for Continuing Care services⁴⁸</p>		

* In NL there are 40 Long term care facilities are stand alone or part of an acute care facility.⁵⁴

** 1)Public CHSLDs (centre d'hébergement et de soins de longue durée) are managed entirely by the public sector and have approximately 29,668 beds; 2) Private funded CHSLDs (privé conventionné) are managed by private companies in partnership with the public sector. There are approximately 63 private funded CHSLDs in Quebec, with a total of 6,800 beds; 3) Private unfunded CHSLDs (Privé non-conventionné) are completely regulated by the private sector and operate with a permit from Quebec government but have little oversight.^{57,58}

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Table 2. Unregulated workers providing direct care in LTC homes

Province	Title(s)	Standardized curriculum*	Ave. Curr. Length (classroom + clinical)*	Minimum education**	Certificate required
Alberta	Health Care Aide ²	Yes ⁵	695 hours ¹⁵	Grade 11 English, minimum grade of 60% ¹⁵	No ¹⁵
British Columbia	Health Care Assistant/Aide ¹	Yes ²⁴	775 hours ³	Grade 10 English ³	Yes ²⁴
Manitoba	Health Care Aide ⁶	No ³	700 hours ³	Grade 12 English, Grade 12 Math, Grade 10, 11 or 12 Science ^{16,17}	No ¹⁹
New Brunswick	Resident Attendant ⁹	No ³⁰	818 hours ^{***3,30}	High school diploma ³	No ^{20,30}
Newfoundland and Labrador	Personal Care Attendant-LTC ²¹	Yes ³	840 hours ²¹	High school diploma, or equivalent ^{3,21}	Yes ²¹
Nova Scotia	Continuing Care Assistant ¹⁰	Yes ¹⁰	905 hours ³	Grade 12 or GED equivalent, or be a Mature Student (21+ with demonstrated skills) ¹⁰	Yes ¹⁰
Ontario	Personal Support Worker ^{7,8}	Yes ⁸	725 hours ^{****3}	Ontario Secondary School Diploma or equivalent, Grade 12 English ²³	Yes ⁸
Prince Edward Island	Resident Care Worker ¹¹	No	844 hours ³	High school diploma ³	No ²⁸
Quebec	<ul style="list-style-type: none"> • Préposé Aux Bénéficiaires (PAB)²⁵ • Orderly 	Yes ³	906 hours ³	Secondary school diploma or equivalent ²⁵	Yes ³
Saskatchewan	<ul style="list-style-type: none"> • Continuing Care Assistant^{4,18} • Special Care Aide^{4,18} 	No ^{3,29}	760 hours ³	High school diploma ³	No ^{*****18,29}
Yukon	Health Care Assistant ¹²	Yes ³	795 hours ³	Grade 11 English ²⁶	N/A ^{*****}
Northwest Territories	Personal Support Worker ¹³	No	820 hours ³	Grade 10 English ³	No ²⁷
Nunavut	Continuing Care Worker ¹⁴	No	745 hours ³	–	No ¹⁴

*These data are primarily from a Report by the Association of Canadian Community Colleges (ACCC) and the Canadian Association of Continuing Care Educators (ACCE), published in 2012 (Reference 3). As a result, some of this information may be outdated.

** Data reported represent the majority of programmes – there may be variation and Prior Learning Assessments applied.

*** ACCC and ACCE (2012 See Reference 3) reports 818 hours for NB however this was deemed inaccurate³⁰ and the training programs are under review³⁰

****In the Provincial Regulations (See reference 8 below), Ontario indicates that the PCW worker Program minimum duration is 600hr (class + clinical). The issue is complicated by three separate programs and curriculums in the Province. The Report by ACCC and ACCE (2012 See Reference 3) reports there are three delivers of the PCW program 1) Public Colleges; 2) Private Collages and 3) District School Boards.

***** While individual health regions such as Saskatoon Health Authority may require certification⁴ this is not consistent across the province¹⁸

***** Yukon University's HCA program states they use BC licensed curriculum: <https://www.yukonu.ca/programs/health-care-assistant>

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