LTC Lessons Learned – Feedback and Key Themes
Updated July 15th, 2020

Testing:

- Homes waited to receive swabs for testing. PHU didn't provide swabs until April 10th.
- Waiting up to 7 days for test results was challenging, as is having to wait for weekends. Proposed testing centers offer extended hours for faster result turnover.
- There was inconsistency across PHUs regarding testing results, timelines, and the approach to false positives.
- When waiting for test results, homes went into outbreak measures when there had been a false-positive result, which was particularly challenging for staff and residents.
- Unclear guidance from PHU in terms of when LTC Homes would officially "come out of outbreak" once they had a declared outbreak. It seemed like the rules changed part-way through.
- Receiving staff testing results could be stream-lined, right now homes must pull results from various areas in order to verify that all staff has been tested. A suggestion was made that the homes receive a summary list of all the staff test results from PH.

Partnerships:

- Partnerships were a great asset in stabilization of staffing in homes.
- The timing of a potential second wave is likely to be between mid-September to October. Given the limited lead time, a key focus should be on continuing to rely upon and formalize partnerships and collaboration that have supported the sector during COVID-19 (including with hospitals, OH and others).
- Issues arose related to the role of public health and the ability of public health both locally and centrally to share IPAC and other expertise. There was confusion and lack of role clarity as well as slowness to respond, in some instances.
- Roles were unclear in partnerships, it was not clear which organization/teams would take on which tasks. Generally, roles were decided by each region and by local organizations. Lack of role clarity also led to accountability issues, it was unclear who would be held accountable for keeping homes outbreak-free. OH

stepped in significantly due to need – however this relationship and role requires codification/formalization going forward.

- A local-level structure of a daily response table was put in place in Central region Ontario Health, based upon a framework of key categories of need. This structure was co-chaired by Public Health. This structure assisted in forming a collaborative relationship.
- Partnerships that are more community-based seem to have gone better.
- PHO became involved early on – they provided the IPAC extenders – this was an excellent partnership.
- Homes seemed to have a level of suspicion towards Ontario Health teams due to a relationship of compliance. The homes were reluctant to accept help because they did not want people to "report back on them."
- Larger hospitals may have been more challenged in terms of understanding the sector and the resources they were able to share, such as IPAC support, testing, and PPE.
- Hospitals need to understand the LTC sector better if there is going to be a more long-standing, ongoing partnership. The hospital staff needs to understand that they are running a home, not a hospital.
- Hospital support does not always follow the same standards of staff testing as LTC Homes do, some hospitals do not test employees as frequently as LTC does while having multiple employers.
- There does not currently seem to be a way for LTC homes to alert the Ministry to their investment needs without the LHINs brokering deals on a case-per-case basis. Proposal of some sort of formal submission and reporting process for provincial and not for profit homes.

Staffing:

- The one employer/one home order and staffing flexibility helped. Some homes have extended the one employer order to include all sectors, not just healthcare (ie. staff cannot work in grocery stores, retail, etc).
- For successfully managing/preventing virus spread in homes, staffing levels were one of the most notable factors.
- Some homes offered full-time contracts for three months, which stabilized staffing. However current funding isn't enough to allow them to continue to do so.
- Money has been a significant motivator for staff – the level of compensation has been a significant challenge. Staff have chosen to go somewhere where they will be paid more – this will be true in a second wave as well.

- Pandemic pay was significant and contributed substantively to stabilize staffing. There will likely be an expectation that this will continue in a/the second wave. The Ministry should confirm its approach to this as an immediate priority.
- Need to revisit regulation of PSWs. Need to better understand why they 'walked out'.
- The system needs "1000s" of PSWs- this is a chronic issue. Suggestion to look at the "Quebec" model of a 3-month accelerated PSW training program, as well as creating COVID swat teams. Suggested to look at David Lamb's work.
- Directive re: funeral directors – at the height of the pandemic they were not allowed in the home. This was distressing to staff – asking govt. to consider revisiting this decision.
- Need data on staffing level for acuity to prepare for higher level of staffing needed.
- The mental health of the LTC staff needs to be addressed, some homes held mental health debriefs in order to support their staff. A system to prevent burnout and protect staff's mental health should be invested in.
- Medical Directors and physicians in LTC were largely not visible in homes. Virtual care is not adequate for patients, many of which have complex needs. Virtual care can supplement onsite visits, but not replace.
- We had had such a push on virtual care – but this ended up being a risk. We needed people in homes – doing 'real' assessments and 'real care'.
- Supplying LTC Homes extra staff through Ontario Health may not be sustainable, need to give homes the support they require in order to be self-sufficient in staffing, such as more staff and better training.
- Mobile Medical Teams from hospitals were helpful for homes where physician staff were working virtually. Offered help with symptoms and improved comfort of patients.
- Organizational culture and leadership in Homes have been key challenges. Stability and effective performance in leadership is needed.

- Existing/available staffing must be stabilized – there are several key contributors to achieving this including effective leadership and management; clear communication; making staff feel safe, and compensation. An additional pool of staff for surge capacity will also be needed.
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Visitation:

- Moving forward can one family member be allowed to be an essential visitor? Many of them would normally be visiting regularly and providing much needed support in feeding and care.
- Mental health of residents should be considered when looking at visitation policy.
- Currently, visitation is not a welcoming environment for the guests, and this acts as a barrier to visitation.

LTC Home Design:

- The layout and design of different LTC homes can pose different challenges.
- Suggestion that going forward, all homes should have private rooms to facilitate easy isolation.
- Lack of resources for supportive housing in Campus of Care communities might increase risk of outbreaks in the LTC homes in these communities, due to the shared spaces.
- Asking about potential funding for negative pressure rooms – if this is coming it's needed right away in order to begin work with contractors before next wave.
- Conduct full assessment of all existing homes and planned redevelopments including reviews of equipment, furnishings and building layouts.
- It is suggested that the province allocate additional and specific funding for interior design and furnishings to improve IPAC within the current designs of homes.

LTC Home Design: Multi-bed rooms

- Multi-bed rooms have posed significant IPAC and social distancing challenges, an assessment of required capital and physical plant investments is recommended to maintain IPAC standards, meet occupancy targets, and contain the spread of infection. (e.g., minimize the use of ward rooms and other shared spaces, removal of carpeting, strategy for upholstered furniture, enhancements in cleaning technologies, etc.).
- New directive 3 guidelines will result in a substantive loss of capacity, which will be visible across the health care system. Alternate capacity is required immediately to facilitate the conversion of 3 and 4 bed rooms and the diversion of patients from hospital who require lower acuity care to prevent longer waitlists, wait times and escalating alternate level of care pressures in hospitals across the province.
- The redevelopment of 15,000 beds and building of 15,000 new beds by 2025 in the LTC sector is well underway. Assuming that the government does not want to continue to have older beds in older facilities operational for longer than needed,

the financial subsidy available to homes under the current capital development program needs to increase in order to expedite the process as well as secure funding for the remaining 15,000 beds that need to redevelop by 2025 (30,000 existing beds in total).

IPAC:

IPAC: PPE

- Lack of knowledge re: appropriate use of PPE was apparent very quickly, as well as supply. Issues included not understanding how to properly don and doff; and how to use and/or reuse PPE, where permitted/appropriate.
- Immediate action to prepare homes with enough adequate PPE should be taken.

IPAC: Conflicting Guidance

- lack of very basic IPAC knowledge including the basics of infectious disease transmission; as well as relatively basic/routine related processes such as commonly used checklists re: environmental cleaning; PPE use; resident management, etc.
- An issue with a mobile younger resident who was the index resident in both of their homes – raises issues re: appropriate placement of this kind of resident.
- varying direction and guidance from local PHUs. Additionally, Unions gave guidance to workers that conflicted with suggested PPE practises, which caused unease in workers.
- high volume of guidance from govt. and other sources; consolidation and/or clarification of key documents may be helpful.
- current guidance could be more sensitive to the variability in capacity, organizational maturity and resident population in homes. Guidance must be ‘realistic’ and feasible for Homes to implement.
- A key future task could be re-framing and clarifying guidance to articulate clear minimum requirements for specific/categorized ‘types’ of homes – meaning, more responsive to size
- Government should focus on developing a concrete operational playbook for homes – as immediately as possible - that addresses exactly what to do when a Home goes into outbreak.
- Requests for a more specific IPAC framework, with the suggestion of looking at accreditation standards to inform what to include. Possible topics to address are:

guidance; mechanisms; linkages to other expertise – (committees, etc). Education, ongoing training; etc.
- A risk-adjusted framework to identify issues and to manage them is needed – one that recognizes that all Homes are not the same and that the risk profile of Homes varies.

IPAC: Support required/Suggestions for support

- The pandemic demonstrated the fragility of the LTC environment, and how the design, age, and staffing levels of a home contribute to the success or failure of a home once it is put under stress.
- Homes have needed considerable support. As noted, many have lacked basic/foundational capacity; they have needed infection control advisory support/capacity; outbreak prevention and management capacity; support and shared capacity from other partners including OH, hospitals and others. They will need ongoing support and collaboration with key partners to prepare for a potential second wave (e.g. OH, IPAC committees, hospital partners and others).
- Need to begin Capacity Planning and preparedness assessments for the fall, and each home needs to have a specific plan. Ongoing capacity development and education are required; it must be accompanied by ongoing KT and QI initiatives to ensure improved organizational performance in this area. A related consideration is accreditation. It may be a potential approach to consider accreditation in IPAC – in collaboration with Accreditation Canada.
- IPAC tends to be a component part of a staff member's role – a potential approach could include dedicated IPAC staff in all homes.
- They need more funding – including to support possible new initiatives/commitments such as more IPAC capacity.
- The basic/foundational principles of IPAC will not vary – but a strategy should consider variability of homes – where appropriate.
- The culture in some homes was not welcoming to IPAC support, it felt as is the homes were "kicking out" their IPAC aide.
- Standards of good cleaning and adequate supplies in homes should be enforced and the homes should be supported to reach an appropriate level.
- Instead of "augmenting" IPAC with each outbreak, consider a continuous standard of IPAC in homes throughout the year with good surveillance throughout the year.
- Need to find a way to ensure compliance to IPAC standards.
- Infection Prevention and Control (IPAC) has been a key issue. Homes need both on-site and shared/advisory capacity in IPAC. It will take some time to develop

and train new IPAC FTEs, however, collaborative and shared support, including from hospitals and others, must continue. Regional/local IPAC communities of practice should also be explored.
- There needs to be an infrastructure for infection control in homes that deals with governance and oversight, with onsite resources, to ensure that IPAC standards are followed.

- As well, a 3-point plan is needed:
    1. Require every home in the province to complete a preparedness check list with gaps identified.
    2. For the gaps also identify required support(s).
    3. A Table Top Exercise with Homes to test plans/preparedness.

Inspections

Inspections: Communication/Collaboration

- The Ministry of Health and Long-Term Care should establish a formal communications policy and process to ensure that its inspectors share relevant information with the College of Nurses of Ontario (College) about members of the College who may pose a risk to residents.
- The Long-Term Care Homes Division within the Ministry of Health and Long-Term Care must communicate and collaborate with the Home and Community Care Branch and the Local Health Integration Networks (or successor organization) in providing healthcare services to older Ontarians
- Potential for developing a committee to form a more collaborative relationship between the Ministry and Public Health. This would give Public Health a means to direct any questions about directions and prevent confusion over guidance. It would be beneficial to establish some sort of communication between the Ministry and OH, they are aware that homes sent us a staffing report, but they cannot aide the homes without knowing what exactly is needed.
- Integrated response tables and reports are a key to success, in the beginning when each area had its own set of reports it was an extra layer of work.

Inspections: Culture of Quality

- A paradigm shift is needed in the sector to move it to a culture of Quality. The current paradigm is one of intensive regulation – a more explicit and active focus on quality is needed – focused on quality care for residents. Focus of inspections should be shifted to quality improvement and support – away from the current more ‘adversarial’ approach. Identify the Homes that are not performing well and

intervene aggressively – for those that are; support them with a focus on quality improvement.

- inspectors are strictly limited in their capacity to advise and support staff teams in addressing identified areas needing improvement and to focus on areas of highest risk. The Ministry of Long-Term Care should provide support and coaching to ensure that shortcomings/underperformance can be addressed constructively
- The Ministry of Health and Long-Term Care should encourage, recognize, and financially reward long-term care homes that have demonstrated improvements in the wellness and quality of life of their residents.

Inspections: Addressing Non-compliance

- Ministry of Health and Long-Term Care should ensure that all Critical Incident reports and complaints relating to high-risk incidents are given the highest priority and inspected as quickly as possible to ensure that any ongoing risk to residents is immediately remedied.
- When a finding of non-compliance has been issued to a licensee for failing to report as required by section 24(1) of the Long-Term Care Homes Act, 2007, those in the Ministry of Health and Long-Term Care responsible for coordinating inspections in long-term care homes should ensure that the next resident quality inspection (RQI) conducted in that home is the intensive RQI, regardless of the performance level assigned to the home. Before beginning an inspection involving either missing narcotics or allegations of staff-to-resident abuse, those in the Ministry of Health and Long-Term Care responsible for coordinating inspections should ensure that the assigned inspector reviews previous Critical Incident reports to determine whether the staff member involved in those incidents is named in earlier reports
- What are the consequences for not meeting standards (resident care, cleanliness)?

Inspections: Inspections Process

- There needs to be more consistency with red/yellow/green definitions of homes, and consistency across organisations. Public Health and MLTC have two separate lists of “Red” homes, and there were only a couple of homes that appeared on both lists, resulting in confusion and missing information as to why homes appeared on one list and not the other.

- The Ministry should refine its LQIP Performance Assessment to better identify homes struggling to provide a safe and secure environment for residents by giving more weight to findings of non-compliance relating to high-risk areas for residents than to findings of non-compliance less likely to impact resident safety or security. For example, a finding of non-compliance for failing to report suspected abuse or neglect is more significant than a finding of non-compliance for failing to ensure that planned menu items are available at each meal and snack.
- It is difficult to assess homes virtually- virtual assessments could be a supplement to onsite visits but alone they are not adequate. When a home or a resident is in crisis, their environment cannot be assessed fully without an onsite visit.
- There's really no place in the system for regular monitoring and development around quality (IPAC, skin and wound, medication administration, use of anti-psychotics) … who is monitoring these features? Ontario Health is requesting clarity on the inspections process and who makes those decisions.

Ministry Response:

- The Ministry was very responsive in getting new licenses in place.
- Speed of decision making by government was an issue initially. Felt that Ministry response was too slow, and that there needs to be a process in place to prevent delays in the future.
- OH, and PH would report on conditions in homes in various leadership tables, including IMS, but there was no response until the CAF report. Overall feeling that the Ministry was prioritizing publicity and politics, since areas that received media attention were supported more quickly.
- Lack of guidance on the Provincial level for Capacity Planning going into the fall.
- Lack of guidance from the Ministry for the roles of each organisation and team, causing a lack of accountability for who is responsible in getting homes back on track.
- OHTs felt the Ministry overlooked the help of LHINs in sending staff to homes, instead only asked about numbers sent from hospitals. Felt like the Ministry was more concerned with making the hospitals look good then actually learning about staffing levels.
- Taking time away from the front-line staff to give information "for politics" was a waste of time and capital.
- Concerns over inspectors and the Ministry "staying at home," when homes were struggling and did not have staff. Felt that LTC wasn't seen as a priority.

- The Ministry of Health and Long-Term Care (Ministry) must play an expanded leadership role in the long-term care system by: establishing a dedicated unit within the Long-Term Care Homes Division to: support long-term care (LTC) homes in achieving regulatory compliance; identifying, recognizing, and sharing best practices leading to excellence in the provision of care in LTC homes; providing bridging and laddering programs in LTC homes; and encouraging innovation and the use of new technologies in the long-term care system.