



ONA

Ontario Nurses' Association

“Are We in This Together?”:

The Voices of Ontario's
Long-Term Care Nurses

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Section 1: Introduction

“My question to everybody is, are we in this together?” ONA Survey (2020),
Anonymous Registered Nurse

For decades, Ontario’s registered nurses (RNs) and their trade union, the Ontario Nurses’ Association (ONA) have been warning that systemic underfunding and understaffing of the long-term care sector was negatively impacting the safety and quality of care to Ontario’s long-term care residents. A successive series of governments promised change that never came. The crisis in long-term care became real to the general public in the spring of 2020 with the first wave of COVID-19 and the carnage that ensued. Years of neglect erupted into a humanitarian crisis that is still being fought today.

In July 2019, ONA commissioned a report, *RNs in Long-Term Care: A Portrait*. In this report, an anonymous registered nurse (RN), who had 27 years of long-term care experience, voiced his frustration and concern about the state of long-term care. He stated:

“What is it going to take for them (Ministry of Health and Long-Term Care) to actually make a change that will help residents, and when is it going to happen? Because are you going to wait for some major case to happen where someone dies...because there was not enough staff, or are you going to be proactive and put the staff in there before that happens?”

At the time, no one could have conceived how catastrophic this “major case” would be.

The numbers are staggering. As of February 8, 2021 (Government of Ontario COVID-19 long-term care homes):

- 213 of the 626 long-term care homes in Ontario are in COVID-19 outbreaks;
- 14,820 long-term care resident cases of COVID-19 with 3,679 resident deaths; and
- 6,434 long-term care staff cases of COVID-19 and 11 staff deaths.

COVID-19 is not solely responsible for the crisis in long-term care. Multiple failures have led to the current situation, including a failure to:

- Fund appropriately;
- Regulate the sector in a balanced, whole systems way;
- Collect, verify and analyze crucial data to manage and improve the sector;
- Address the consequences of well-known population trends in aging, dementia, and caregiving by family members;
- Plan for the known shortage of RNs;
- Establish standards for appropriate levels of regulated health workers;
- Listen to the voices of the workers at the point of direct care;
- Build and support resilience of the long-term care workforce; and
- Adequately educate, regulate, and support the unregulated care workers who provide upwards of 90 per cent of direct care.

(Estabrooks et al., April 2020)

Put simply, long-term care has not been prioritized. In 2019, when ONA’s members were asked what they would tell the (then) Minister of Health and Long-Term Care, many nurses suggested that decision-makers should experience long-term care homes themselves. One ONA member offered, *“come experience what we do. Don’t read about it...Don’t hear about it. See it. Live it. Experience it.”* No one – not the Ministers, the Premier, or anyone else in government ever did.

In April 2020, the Canadian Armed Forces (CAF) were called in to temporarily support the seven long-term care homes which were deemed to be in the greatest need of assistance. They provided staffing support, helped with infection prevention and control measures, and performed other duties as required. In May, the CAF provided a report to the government of Ontario, setting out urgent concerns based on the observations of those on the ground.

The CAF report echoed concerns which had been presented by nursing professionals and others for decades: severe understaffing of Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), and RNs relative to resident needs, inadequate training of new staff, and unmanageable workloads which put staff and residents at risk (CAF, 2020). They also reported that many long-term care homes did not always have an RN in the building, with nurse-to-resident ratios as low as 1 RN for 200 residents, and unsafe PSW-to-resident ratios, such as 1 PSW per 30 to 40 residents, or in the worst case, no PSW staffing present for some shifts. (CAF, 2020).

The Ontario government responded to the findings in the CAF report by announcing an independent Long-Term Care COVID-19 Commission (The Commission) with Premier Doug Ford stating “...but it took the military to be there 24/7...it’s impossible to know the extent of the problems plaguing the system until you live, breathe, eat it...until you’re there around the clock at night time and during the day.” (Maclean’s, 2020).

This blatant disregard for our nurses’ voices over the past decades was summed up by Canadian Federation of Nurses’ Unions (CFNU) President Linda Silas:

As politicians of all stripes scramble to thank the military for their whistleblower report on long-term care, front-line health-care workers are left wondering why, when we voiced these same concerns, we were ignored or met with callous inaction. Nurses, health-care workers, and the unions that represent them, have been sounding the alarm on long-term care conditions literally for years. Maybe now we will finally be heard (Silas, Email, May 29, 2020)

In the fall of 2020, ONA conducted a survey of members working in long-term care during the first wave of COVID-19, including RNs from other sectors who were redeployed to assist in the hardest hit long-term care homes. The survey was sent to approximately 3,300 members: 1,185 answered at least part of the survey and 766 completed it. ONA also conducted individual interviews with about 200 long-term care ONA members.

The survey paints a compelling picture of the registered nurses’ experiences during the first wave of the pandemic. Their answers reflect the chilling conditions RNs endured while they were physically and emotionally battling the devastation of COVID-19 within their long-term care homes and their sense of abandonment, as reflected in the title of this paper.

The duality of the long-term care home as both a home environment for the residents and a health-care facility allows for the development of a unique therapeutic nurse-client relationship. Despite arduous workloads, RNs working in long-term care described how they often come to see themselves as family to their residents and their residents see them the same way (ONA, 2019). As one RN said:

“My residents are like family to me. I love the interaction with them. We get to know them on a personal level because they stay longer. In fact, we’ve had some residents in our home for more than 20 years.” Shelley, RN, long-term care (ONA, 2019)

The intent of this report is to present their voices, describing their experiences during COVID-19, in the hopes that this time their voices will be heard.

From a nursing and quality of care lens, this report presents a background on pre-pandemic issues within Ontario's long-term care sector, and the impact that these and additional COVID-19 pressures had on the professional and personal experiences of ONA members. We make recommendations to repair a broken sector into one to be proud of, a system that values the dignity, respect and health of both residents and staff, preventing this tragedy from ever being repeated.

Section 2: Background on Long-Term Care Staffing

“The most critical factor in improving conditions of care and work in long-term care is enough staff....The data show that daily hands-on care levels for Ontario long-term care residents are far too low and has actually declined as levels of acuity have increased.” (Ontario Health Coalition, 2019).

Staffing and quality resident care are interconnected. Long-term care homes have long failed to staff appropriately, particularly in for-profit organizations. The Commission has heard from many front-line staff that staffing must be improved. As one participant stated, *“the resident needs much more than what they are getting, and I think the government needs to step in and start setting guidelines and make sure that they hire more staff.”* (Long-Term Care COVID-19 Commission Transcript January 21, p. 62).

This section reviews the role of the RN and the legislative and regulatory framework applicable to RN staffing in long-term care, highlighting the critical importance of RNs in providing care to increasingly acute and complex long-term care residents.

Determining the Appropriate Care Provider for LTC Residents

Long-term care homes hire a mix of PSWs, RPNs, and RNs to provide care to residents. Each plays an important role in the home. Effective skill mix decisions are essential to optimize timely access to safe and quality care, and outcomes for patients, organizations, and the health-care system. (RNAO, 2016).

The role of the RN in long-term care

Sufficient RN staffing is imperative in long-term care homes. The RN practice in long-term care entails a high level of critical thinking that enables care to be provided for residents with stable to highly critical and rapidly changing needs. The RN has significant accountabilities and responsibilities including (ONA, 2019; McGilton et al., 2009; Saskatchewan Registered Nurses' Association (SRNA), 2015):

- Resident assessments on admission using the nursing process (assessment, planning, implementation and evaluation);
- Development of a holistic, individualized, care plan that is evidence-based and current;
- Ensuring appropriate assignment of staff to resident care needs, and reassigning residents to the appropriate care provider as care needs change;
- Providing leadership to the interprofessional team, and supervision over the provision of care to residents by that team;
- Being available for consultation and collaboration with other team members, and taking over care of residents whose condition has become unstable or unpredictable;

- Administering medications, providing skilled interventions such as complex wound care, peritoneal dialysis, gastric tube feedings, intravenous therapy;
- Assisting with personal care of residents when required;
- Participating in physician rounds and following up on physician and pharmacy orders;
- Expected to form therapeutic relationships that may involve working with challenging family dynamics, residents with impaired decision-making abilities and other situations;
- Administrative tasks such as answering phones, finding replacement staff for sick calls;
- Filling in for the absence of other staff including housekeeping and security;
- Often acting in the role of home supervisor responsible for ensuring the safe operation of the facility and a safe environment for residents and staff;
- A required understanding of the complex long-term care regulatory environment and ensuring compliance with numerous standards and regulations that are intended to support the provision of safe, ethical and resident-centred care; and
- Documentation to meet CNO standards and long-term care regulatory requirements.

Consequently, RNs working in long-term care have great responsibilities, heightened by the fact that they are often working as the sole RN in the building with limited on-call support. This places residents' well-being and the RN's ability to meet legal and professional accountabilities in jeopardy. (McGilton et al., 2009)

RNs, RPNs and Nurse Practitioners (NPs) are regulated by the College of Nurses of Ontario (CNO) and are accountable to, and practice under, relevant laws, and CNO's Standards of Practice (CNO, 2019). While RNs and RPNs study from the same body of nursing knowledge, RNs graduate with a baccalaureate degree (BScN or BN) which is eight semesters in length. This longer period of study allows "for greater foundational knowledge in clinical practice, decision-making, critical thinking, leadership, research utilization and resource management." In contrast, RPNs graduate from a two-year (four semester) diploma program.

The CNO Practice Guideline, "RN and RPN Practice: The Client, the Nurse and the Environment," (2018) focuses on those three factors – the client, the nurse and the environment "to support nurses and nursing employers in decision-making specific to nurses intraprofessional responsibilities, the utilization of individual nurses in the provision of safe and ethical care and identify attributes of practice environments that lead to improved client outcomes and public protection" (CNO, 2018). The CNO clearly delineates that RNs care for complex and unpredictable patients, while RPNs care for less complex and predictable patients, and unregulated providers provide care as delegated by nurses (RNAO, 2016).

The Client

In long-term care, the client is the resident. Resident acuity has been steadily increasing over the years, with no corresponding changes in staffing levels or skill-mix.

Since 2010, the Method for Assigning Priority Levels (MAPLe) decision support tool, has been used by Local Health Integration Networks (LHINs) to standardize the process of identifying home care clients in most urgent need of community or facility-based services, including admission to long-term care homes, prioritizing their access (CIHI, 2013; Hirdes et al., 2008). A MAPLe priority level from 1 (low risk of adverse outcomes) to 5 (very high risk of adverse outcomes) is assigned to each client based on the assessment of approximately 20 functional, medical, social, and psychological measures (Hirdes et al., 2008).

In 2019, at the time of admission to long-term care, the MAPLe score of 87 per cent of residents was 5 (very high) compared to 76 per cent in 2010 (Ontario Health Coalition, 2019; Government of Ontario, 2020).

The following statistics from the Ontario Long-Term Care Association (OLTCA) (2019) of Ontario's long-term care residents reflect an increasingly complex resident population:

- 90% have some form of cognitive impairment;
- 86% of residents need extensive help with daily activities such as getting out of bed, eating, or toileting;
- 80% have neurological diseases;
- 76% have heart/circulation diseases;
- 64% have a diagnosis of dementia;
- 62% have musculoskeletal diseases such as arthritis and osteoporosis;
- 61% take 10 or more prescription medications;
- 45% exhibit aggressive behaviour;
- 40% need monitoring for an acute medical condition;
- 21% have experienced a stroke;
- 79.2 % have bladder incontinence; and
- 58.9% bowel incontinence.

Source: Excerpted from This is Long-Term Care 2019 by the Ontario Long Term Care Association.

The client factors – complexity, predictability and risk of negative outcomes – combine to create a representation of the client on a continuum. As resident factors become more complex and unpredictable, there is a higher risk for negative outcomes and increasing need for consultation/collaboration with and care provision by RNs (CNO, 2018).

The rise in prevalence of many health conditions in long-term care residents has resulted in higher overall care needs, requiring more frequent and more types of interventions, for example peritoneal dialysis, IV medication administration, G-tube feedings. This creates a corresponding need for RN staff who have the decision-making, analytical, critical thinking,, and leadership abilities to provide the complex care required by long-term care residents. (Ontario Association of Non-Profit Homes and Services for Seniors, 1998).

The Nurse

The “nurse factors” to be considered include leadership, decision-making and critical-thinking skills, knowledge, and the ability to consult as needed. The individual competence and practice of the nurse must also be considered. Nurses may enhance their knowledge and competence through ongoing learning, education and experience, and become experts in an area of practice *within their own nursing category*. An RPN, however, cannot acquire the same foundational competencies as an RN simply through continuing education. The only way to acquire the same foundational knowledge and competencies is through the formal education and credentialing process of an RN (CNO, 2018).

While RPNs assume similar roles and responsibilities as RNs within long-term care settings (RPNAO, 2018), as per CNO Guidelines (CNO, 2018), their autonomous practice is limited to providing care to residents who are less complex, more predictable with a low risk for negative outcome(s) in a stable, predictable environment which has practice supports and consultation resources available.

The Environment

Environmental factors to be considered when determining the appropriate category of nurse to provide care for resident groups include practice supports and consultation resources to support nurses in clinical decision-making, and the stability/predictability of the environment (see Appendix 4). The less stable these factors are, and the less available the practice supports and consultation resources are, the greater the need for more in-depth nursing competencies and skills in clinical practice, decision-making, critical thinking, leadership, research utilization and resource management, and the greater need for RN staffing (CNO, 2019).

Environment Factors	More Stable	Less Stable
Practice Supports	<ul style="list-style-type: none"> • Clear and identified procedures, policies, medical directives, protocols, plans of care, care pathways and assessment tools • High proportion of expert nurses or low proportion of novice nurses • High proportion of nurses familiar with the environment 	<ul style="list-style-type: none"> • Unclear or unidentified procedures, policies, medical directives, protocols, plans of care, care pathways and assessment tools • Low proportion of expert nurses or high proportion of novice nurses and unregulated staff • Low proportion of nurses familiar with the environment
Consultation Resources	<ul style="list-style-type: none"> • Many consultation resources available to manage outcomes 	<ul style="list-style-type: none"> • Few consultation resources available to manage outcomes
Stability and predictability of the environment	<ul style="list-style-type: none"> • Low rate of client turnover • Few unpredictable events 	<ul style="list-style-type: none"> • High rate of client turnover • Many unpredictable events

Source: CNO, 2018

The long-term care environment is one in which RNs work very independently. They have few practice supports. Consultation resources are limited. This is particularly true on evenings, nights and weekend shifts, when there is often only one RN in the home.

Retention and Recruitment Challenges

Given the staffing challenges and associated heavy workload, it is not surprising that retention and recruitment in long-term care has been a long-standing problem. The Long-Term Care Staffing Study (2020) noted that working conditions and a negative public image have contributed to recruitment and retention issues in long-term care, worsening the already existing staffing shortages, and reducing continuity of care and the risk of increased harm to residents. (O'Brien et al., 2010; Colwell, 2019)

Long-term care is unfairly regarded as a less desirable workplace for RNs than other sectors due to significant workload and responsibility, fewer resources and lower remuneration. (Colwell, (2019), McGilton et al., 2020). RNs working in for-profit long-term care homes receive lower wages and inferior benefits compared to RNs working in municipal homes and the hospital sector. This contributes to the misguided perception that long-term care nursing is less skilled than that in other sectors.

Additional factors such as job training, acknowledgement of accomplishments, career advancement, and management style affect retention and recruitment. Management staff are

instrumental leaders for change, and positive leadership styles can improve satisfaction rates, decrease turnover rates, and improve recruitment of qualified staff (O'Brien et al., 2010).

Compounding all of this is an ongoing and worsening nursing shortage in Ontario. While we have the largest population in Canada, Ontario also has the lowest provincial ratio of RNs per capita, with 15 per cent fewer RNs per capita than each of the other provinces and territories. Fewer graduates are staying in the profession after a few years of practice, and RNs are retiring earlier than ever. The proportion of RNs in the long-term care sector has decreased between 2013-2018, while the proportion of RPNs and PSWs has increased (Long-Term Care Staffing Study, 2020). There is evidence that the stressful and unsafe working conditions for RNs during the pandemic has only deepened job dissatisfaction, burnout, and will negatively impact recruitment and retention. According to the ONA 2020 Survey, COVID-19 and the response to it changed 47 per cent of respondents' attitude toward the nursing profession, and 45 per cent of respondents' attitude toward long-term care. Members provided comments to support this:

"I left my job as an RN in long-term care as a result of how my employer handled the COVID-19 outbreak. I felt like a lamb being led to slaughter."

"I want to get out of this profession as soon as possible."

"My anxiety is high, and I am looking at leaving LTC. At multiple times, I have thought about taking a break from nursing altogether."

Despite the importance of having adequate RN staffing in long-term care, it was difficult to recruit RNs to work in the sector prior to COVID-19. Results from ONA's survey suggest that this will be a continuing challenge unless significant change is made to improve staffing levels of RNs, their workload and working conditions.

Legislative Requirements

The *Long-Term Care Homes Act, 2007* ("LTCHA") has been criticized for being too prescriptive. There are more than 200 regulations with which homes are required to comply. Yet despite this, there is very little in the *Act* that speaks to front-line staffing. There are no ratios setting out how many residents should be assigned to care providers. There are almost no minimum staffing requirements, with the exception of s.8(3) of the *Act*, which requires that there be one RN, who is a regular member of the staff, in the home at all times:

24-hour nursing care

(3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

This requirement is not dependent on the size of the home: it is the same whether the home has 60 beds or 320 beds. The failure to meet this requirement is not mandatorily reported to the Ministry of Long-Term Care (MLTC).

Section 31(2) of Regulation 79/10 of the LTCHA requires that every licensee have a written staffing plan for nursing and personal support services. That plan must provide "for a staffing mix consistent with residents' assessed care and safety needs". Aside from these minimal requirements, the licensee is entrusted with the responsibility to staff the home in accordance with the needs of residents.

Inadequate Overall Staffing Levels

The Ontario Staffing Study, which was released in July 2020, indicated that as of 2018, long-term care homes across Ontario employed more than 100,000 people: 58 per cent of which were personal support workers and 25 per cent of which were RNs/RPNs. Of the 25 per cent of registered staff, 62.9 per cent were RPNs and 36.5 per cent were RNs (Nurse Practitioners account for the additional 0.6 per cent).

Staffing at all levels – PSWs, RPNs and RNs – has long been inadequate. Recommendations from independent studies and reports to increase staffing levels have been ignored for more than 20 years. A chart summarizing these reports and their relevant recommendations is attached as Appendix A.

Hours of care per resident day

A core recommendation from these reports is to increase the hours of care provided to residents from its current level of approximately 2.7 hours of care per day to at least 4.0 hours. Numerous studies of long-term care reveal that staffing characteristics are important predictors of quality of care and quality of life of residents. Appropriate staffing levels can lead to less staff turnover; and higher staff retention rates (Collier & Harrington, 2008; Harrington et al., 2020; Boscart et al., 2018). There is a strong positive relationship between the number of staff providing direct care on a daily basis and improved resident outcomes (Collier & Harrington, 2008; Harrington et al., 2020).

A 2001 study by the Centers for Medicare & Medicaid Services (CMS), established the importance of having a total of 4.1 nursing hours per resident day (HPRD) to “prevent harm or jeopardy” to long-term care residents which should include the following: 0.75 RN HPRD, 0.55 Licensed Practical Nurse/Licensed Vocational Nurse/RPN AND 2.8 Certified Nurse Aide (PSW) (CMS, 2001). This study recommended minimum staffing ratios for **low acuity** nursing homes during day/evening/night shifts (Table 1).

Table 1

At least 1 RN on premises for every:	28 residents during the day (.29 hours per resident day (HPRD))
	30 residents during the evening (.26 HPRD)
	40 residents during the night (.20 HPRD)
	Total: .75 HPRD
At least 1 RPN for every:	40 residents during the day (.20 HPRD)
	40 residents during the evening (.20 HPRD)
	56 residents during the night (.14 HPRD)
	Total: .54 HPRD
At least 1 PSW for every:	7 residents during the day (1.14 HPRD)
	7 residents during the evening (1.14 HPRD)
	15 residents during the night (.53 HPRD)
	Total: 2.81 HPRD
Total Nurse Staffing	4.1 HPRD

Source: CMS, 2001, American Nurses Association, 2014; Coalition of Geriatric Nursing Organizations, 2013; Consumer Voice, 2013. Ratios and conversions made by the authors. Accessed via: Nova Scotia Nurses' Union (2020)

In 2007, the Registered Nurses' Association of Ontario (RNAO) made a submission to the Ministry of Health and Long-Term Care re: Staffing and Care Standards for Long-term Care (RNAO,

2007). Based on evidence and experiences in other jurisdictions, the RNAO expert panel recommended a staff mix which consisted of 20 per cent RN, 25 per cent RPN, and 55 per cent PSW.

The following year, in 2008, Shirlee Sharkey released *“People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes,”* in which she recommended that Ontario fund 4.0 hours of care by 2012. Despite committing to do so, the Ontario government has failed to come close to meeting that standard. In 2012, Gail Donner, in *“An Action Plan to Address Abuse and Neglect in Long-Term Care Homes,”* echoed the need for 4.0 hours of care.

Some experts are now recommending even higher staffing standards (a total of 4.55 HPRD) to improve the quality of nursing home care, with higher adjustments for higher resident acuity. (Harrington et al., 2020)

In 2018, staffing levels for Ontario long-term care were an average of 2.75 HPRD (Ministry of Long-Term Care, 2020), a shocking 1.35 HPRD less than what was recommended 17 years ago. Almost three years later, in January 2021, Villa Colombo Toronto reported to the Commission that only 2.39 HPRD was provided in that 395-bed home.

Quality, safe care for Ontario’s long-term care residents is simply impossible without adequate staffing. ONA recommends a minimum of 4.1 HRPD of direct care worked hours, with a skill mix of 20 per cent of registered nurses.

ONA’s members and other health-care workers have vividly described the impact of insufficient staffing in meetings with the Commission. Quantitative data support these reports, as demonstrated by quality indicators for Ontario long-term care homes. These quality indicators, described below, illustrate that homes, on average, were not meeting established benchmarks on four out of five key indicators of quality care.

Quality Indicators for Ontario Long-Term Care Homes

With the introduction of the provincial Residents First Quality Initiative (HQO, 2009) in 2009, Health Quality Ontario (HQO) began to publicly report on quality indicators (QIs) in long-term care. The QIs are “reflective of current evidence-informed practice” (HQO, 2015) and aim to evaluate the quality of care being provided to residents.

There are currently five QIs reported (Table 2), each with a benchmark value (a point of reference against which others may be measured) that allows for comparison of performance of long-term care over time, across regions and between homes. The benchmark for each QI represents an upper limit value of acceptability, therefore when a long-term care home scores below the established benchmark for a QI, it is a marker that the homes are providing high quality of care for the QI” (HQO, 2017).

Table 2

Quality indicator	Ontario provincial benchmark	2018-2019 Provincial average across all Ontario long-term care	Maximum score reported from individual homes
Residents Not Living with Psychosis Given Anti-Psychotic Medication	19%	19%	30.6%
Residents who Fell	9%	16.6%	22.1%
Residents who were Physically Restrained	3%	3.9%	15.7%

Residents with Pressure Ulcers	1%	2.6%	5.6%
Residents with Worsened Symptoms of Depression	13%	22.8%	37.1%

Data Source: HQO website <https://www.hqontario.ca/System-Performance/Long-Term-Care-Home-Performance>. Accessed January 10, 2021.

As noted in Table 2, reported results show the provincial average score is higher than the benchmark in four out of the five QIs (indicating inadequate quality of care), while one is at benchmark level. Column four shows the highest score reported by an individual home in each QI category, indicating significantly inadequate quality of care.

HQO results reported in Table 2 support the need for increased RN, RPN, and PSW staffing hours in all long-term care homes in Ontario. They particularly highlight the need for more RN staff. Research has demonstrated that the QIs associated with pressure ulcers and falls are nursing-sensitive adverse outcomes, significantly associated with “a larger number of patients per nurse and a poor working environment.” (Hughes, 2008) Studies have demonstrated that higher RN staffing and care hours are associated with better resident care quality: fewer pressure ulcers; fewer catheterizations; decreased urinary tract infections; less weight loss and dehydration; improved independence with activities of daily living (ADLs); less declines in ADLs; lower use of physical restraints; less improper and overuse of antipsychotics; less hospitalizations, increased resident satisfaction; and lower mortality rates (Harrington et al., 2020; Boscart et al., 2018).

Section 3: The Impact on Staffing During the COVID-19 Pandemic

Staffing was inadequate before the pandemic: it then became catastrophic.

As ONA members indicated on the survey:

“We were short staffed almost every day before the outbreak. When COVID hit, we were down to a bare minimum or below....3-4 staff were taking care of 72 residents, which was an impossible task.”

“At one point we were operating at 50% staffing capacity.”

“We lost more than 42% of our staff. Daily there are at least 3-5 staff members that are working doubles (16 hours total).”

“We had ongoing staffing shortages before COVID – made even worse – catastrophic proportions during COVID outbreak.”

Adequate staffing is a crucial ingredient in the fight against COVID-19 in long-term care. This section examines the extent of staffing shortages during the pandemic and reviews a number of recent academic studies exploring the connection between RN staffing levels and resident outcomes during COVID-19 outbreaks. We describe, based on reports from ONA members, the actual impact low staffing levels had on the ability of RNs to assess and provide care while mitigating the spread of COVID-19.

Extent of Staffing Shortages during Pandemic

During the pandemic, staffing levels in long-term care homes were further compromised with 50 per cent of ONA survey respondents reporting a reduction in staffing levels of RNs, RPNs and PSWs. This was due in part to the emergency orders requiring employees to only work in one health-care facility, and in part to the disproportionate number of staff who became ill with COVID-19 or other conditions. Stuningly, only 57 per cent of respondents cited always having an RN

employee who was a member of regular nursing staff present and on duty. Table 3 is a breakdown of ONA Survey respondents' experiences with staffing during COVID-19.

Table 3

ONA Survey Question: During the pandemic, within your long-term care facility, how often did you work below baseline staffing for the following health-care providers?	Never	Rarely (less than once a month)	Occasionally (every few weeks)	Frequently (once every week)	Often (several times a week)
RNs	12%	14%	22%	20%	32%
RPNs	11%	13%	22%	23%	31%
PSWs	3%	5%	11%	14%	67%

The ability of registered nurses to assess and provide care for residents, follow best practices, supervise and support other team members, comply with IPAC measures (including the requirement to cohort staff), all while meeting CNO standards was compromised. These staffing challenges impacted resident outcomes and resulted in an increased, untenable workload.

(Figueroa et al., 2020; Gorges & Tamara, 2020; Harrington et al., 2020; Nova Scotia Nurses' Union, 2020)

Review of Studies: Positive Link between Staffing and COVID-19 Outcomes

Several empirical studies have demonstrated the relationship between staffing and COVID-19 outcomes in long-term care homes. Gorges & Konetzka (2020) found that compared to long-term care facilities with COVID-19 outbreaks, those without outbreaks had higher staffing ratings, as well as higher Nurse Aides (PSWs), total nurse and RN/total nurse hours. Thus, more staffing and more total nursing hours were found to be related to fewer COVID-19 outbreaks in the long-term care facilities studied (Gorges & Konetzka, 2020). It also suggested that in facilities with at least one COVID-19 case, higher PSW and total nursing hours are related to a lower probability of a COVID-19 outbreak, as well as fewer COVID-19 deaths.

Similarly, in a study by Harrington et al. (2020), a higher proportion of nursing homes with COVID-19 residents had decreased total RN staffing levels (less than the minimum recommended 0.75 hours per resident per day), as well as decreased total nurse staffing levels (less than the minimum recommended 4.1 hours per resident per day). Nursing homes with COVID-19 were twice as likely to have low RN hours (less than 0.75 hours per resident per day) compared to those without COVID-19 residents (Harrington et al., 2020). The findings from this study also demonstrate that staffing measures, and particularly RN hours, were the strongest predictors of nursing homes having COVID-19 positive residents (Harrington et al., 2020).

In a study by Spurlock et al. (2020), higher nurse staffing levels were found to be a protective factor against COVID-19 cases and deaths in California nursing homes. Homes with more total nursing staff hours and RN staffing hours were noted to have reduced COVID-19 cases by almost half (Spurlock et al., 2020). Further, nursing homes with higher RN staffing levels also had reduced COVID-19-related resident deaths by approximately half (Spurlock et al., 2020). Interestingly, total staffing was found to be the most important factor associated with fewer

COVID-19 infections, deaths, and outbreaks earlier on in the study, while RN staffing emerged as the most important factor as the pandemic continued (Spurlock et al., 2020). Spurlock et al. (2020) hypothesize that this might be because RN staff have the knowledge, skills, and judgement to provide training, supervision, and infection control management within homes to mitigate the spread of COVID-19 in nursing homes. Notably, Spurlock et al. (2020) also found a correlation between higher nursing turnover and higher COVID-19 case rates within nursing homes, which provides huge implications for effective recruitment and retention of nursing home staff.

In a study by Li et al. (2020), higher RN staffing in Connecticut nursing homes was found to be associated with fewer confirmed COVID-19 cases:

- In nursing homes with at least one COVID-19 case, each 20-minutes per resident day *increase of RN staffing* was related to a *reduction of confirmed COVID-19 cases by 22 per cent; and*
- In nursing homes with at least one COVID-19 related death, each 20-minute *increase in RN staffing* was associated with a *reduction in COVID-19 related deaths by 26 per cent.*

Ultimately, Li et al.'s (2020) findings demonstrate the importance of RN staffing in mitigating the spread and death toll of COVID-19 in nursing homes. Similarly, a study by Figueroa et al. (2020) of nursing homes across eight states indicate that nursing homes with higher nurse staffing ratings were less likely to have greater than 30 COVID-19 cases and had fewer COVID-19 cases compared to nursing homes with lower staffing ratings.

Overall, these studies provide evidence to support that sufficient staffing is a crucial protective factor in mitigating the spread and death toll of COVID-19 in long-term care homes.

Impact on the RNs' Ability to Assess and Provide Care

ONA members provided ample information about the challenges caused by low staffing during COVID-19 outbreaks. In addition to their usual work, they had to conduct twice daily assessments on every resident in the home, provide care to sick residents, some of whom were very ill and would otherwise have been hospitalized. Donning and doffing PPE before and after every resident encounter was time consuming.

Members provided comments on the negative impact of staffing on their ability to provide care:

"Staffing and access to staff decreased significantly, leading to shortages, burnout and overall staff were not able to consistently provide effective or appropriate care."

"I believe COVID reduced the already limited ability to provide quality resident care in a home with 140 residents and one RN. Much time had to be spent with the acutely ill COVID residents which drastically limited time spent with other residents as there is also a concern about potential transmission even with appropriate PPE."

"Poor registered staffing levels, with increased workload led me to feel I was not at point of care as consistently as I should be; COVID signs and symptoms could be easily missed in our environment."

In contrast, some members provided accounts demonstrating the positive outcome of adequate staffing within their homes:

"We had increased staff hours with cohorting all through the worst of it and we had a few CUPE temps to help. This covered the staff who could not work and helped immensely to be able to be on top of things and prevent a serious outcome. Our

staff were treated well by management and our community and this increased the will to all do our best to follow the rules to prevent an outbreak. We were well prepared before with infection control measures. Because we are a municipal home we do not scrimp on regulated practices.

“We had more staffing and it was great, because we were able to contain the spread much quicker than anticipated!”

The importance of adequate staffing is crucial in the nursing process of assessment, (nursing) diagnosis, care planning, implementation of care, and evaluation of outcomes.

Low staffing levels often lead to deferred, infrequent, or rushed assessments of residents, contributing to the delayed recognition and response to COVID-19 (Nova Scotia Nurses' Union, 2020).

Upstaffing during infectious disease outbreaks, including COVID-19 outbreaks, is essential in order for RNs to perform the additional workload associated with minimizing the spread of disease, such as additional screening, assessing, and monitoring residents. These tasks are critically important yet cannot be safely placed upon overburdened staff already struggling to meet the basic care needs of residents. Staffing changes are immediately necessary to promote a robust long-term care workforce that can safely provide basic care to residents, in addition to COVID-19 related care activities.

Impact of Staffing Levels on Compliance with Infection Prevention and Control (IPAC) guidelines

The expectation for RNs to perform point of care risk assessments (PCRAs) and identify the appropriate PPE/infection control measures to be implemented with each resident and throughout the facility, is a process that requires adequate time and resources, two scarce commodities in Ontario long-term care homes.

Sufficient staffing levels allow for earlier identification of residents with an infectious disease (such as COVID-19), prompting early testing, isolation, environmental controls, and appropriate establishment of protocols. (Nova Scotia Nurses' Union, 2020)

Members reported the risks inherent in being short-staffed during the pandemic:

“Shortage of staff significantly affected our ability to provide safe resident care while also putting us at risk for not following infection control procedures well due to increased workload.”

A key infection prevention and control strategy in long-term care is to group, or cohort, staff to care for a specific group of residents in a zone/wing (Gilbert, 2020). The inability to do so, resulting in staff moving between resident rooms/zones, is a barrier to outbreak control (Gilbert, 2020).

Only 44 per cent of ONA members confirmed that cohorting of staff to care for specific resident groups took place in their organization. This can largely be attributed to staffing deficiencies in long-term care homes.

“Grouping of staff to isolated residents didn't often happen as there was not enough staff to cover the floor...”

When there is only one RN in the building, they must attend to all the floors, making cohorting impossible. The inability to cohort staff ultimately had major implications on the spread of COVID-19 in long-term care homes, affecting both staff and residents.

Some ONA survey respondents did report that they were able to cohort staff because they were permitted to upstaff and bring in additional staff.

“We managed to upstaff during the pandemic which helped us immensely. Staff could be cohorted to working on one wing of the home.”

“When it was adequate staff we could keep same staff on each unit without floating between units.”

Staffing levels greatly impacted the ability of long-term care to prevent and contain outbreaks. RNs were under increased pressure due to the decreased staffing levels. Compounding this was the failure to implement adequate infection prevention and control measures. The importance of such measures is discussed in the next section.

Section 4: Impact on Infection Prevention and Control (IPAC)

In congregate care settings like long-term care, rigorous application of infection prevention and control measures is key to preventing and containing the spread of infections.

The incidence of COVID-19 infections within long-term care settings represents a serious risk for the following reasons:

- the accessibility of resources is scarcer than in hospital settings (Tumlinson et al., 2020);
- long-term care are communal living spaces, which are much more susceptible to infectious disease outbreaks and spread (Gilbert, 2020);
- the potential for negative outcomes from an infectious disease outbreak is further intensified by the vulnerability of long-term care residents, given their typical advanced age and comorbidities (Gilbert, 2020).

While infectious disease outbreaks are commonplace in long-term care settings, many homes were unable to meet the challenge posed by COVID-19. In this section, we will explore how insufficient staff education in IPAC, the absence of dedicated IPAC practitioners, delayed action on the part of leaders in the homes, and the aging, crowded buildings that house so many residents all contributed to the devastating impact COVID-19 has had in the long-term care sector.

Lack of Staff IPAC Education

Adequate IPAC training in long-term care is necessary not only during the context of COVID-19, but for everyday routine care activities (Gilbert, 2020). According to Gilbert (2020), there can be a considerable lack of confidence, proficiency, and support in infection control measures among health-care staff in long-term care settings, particularly when confronted with an infectious disease crisis such as COVID-19. Similarly, Lipsitz et al. (2020) state that nursing homes are generally not as well equipped with strong infection control expertise, training, policies/procedures, and supplies, compared to other health-care settings.

According to ONA's survey, some respondents indicated that staff in their long-term care homes were not provided with training on the use of PPE or, if they were, the training was not specific to COVID-19:

“Never received proper PPE and training till after things were at its worst point.”

“Training provided was the standard yearly PPE online education. Videos on donning and doffing, which PPE to wear when. Nothing geared to limitations or anything to do with COVID. Nothing more!”

“No new training provided since pandemic declared. Just routine IC annual training.”

Similar findings were uncovered through a study of Nova Scotia long-term care amidst the COVID-19 pandemic (Delorey, 2020). In this study, 52 per cent of long-term care facilities identified the need for additional IPAC training for staff, while 45 per cent reported inconsistencies in IPAC education (Delorey, 2020).

IPAC training inconsistencies in long-term care is a major concern, as inadequate or nonexistent IPAC staff training is a barrier to COVID-19 outbreak control (Gilbert, 2020). The American Geriatrics Society (2020) suggests that all long-term care staff caring for COVID-19 positive residents must receive appropriate training on infection control, personal protective equipment use, and detection of COVID-19 symptoms. Further, IPAC training should be on-site, and should specifically include topics such as COVID-19 transmission, point-of-care risk assessment, selection of personal protective equipment, and correct donning and doffing techniques (Stall et al., 2020).

It is also crucial that information is tailored for all staff, to ensure that infection control training is well understood (Gilbert, 2020). One ONA survey respondent emphasized the different learning needs of various long-term care staff members:

“Surge learning module is done yearly regarding donning and doffing. As an RN, I am familiar with infection control precautions, but PSWs and other departments like recreation, spiritual, didn’t have a proper training until it was too late.”

All staff must receive IPAC training specific to their roles and should receive consistent direction through IPAC policies and procedures within their facility (Gilbert, 2020). Staff members’ IPAC competencies must be assessed to ensure that they are following IPAC measures appropriately (Gilbert, 2020). Staff members’ adherence to proper IPAC protocols should be observed when they are providing resident care, and staff should also be required to demonstrate proficiency in donning and doffing PPE (Centers for Disease Control and Prevention, 2020).

Need for a Dedicated IPAC Professional

Widespread lack of IPAC education placed additional workload on long-term care RNs.

“Training was written down, but many staff were not following it properly and management instructed RNs that we have to referee that it is done properly. One RN per 40 staff should not be the one ensuring people are following protocol when we have to also be responsible for care of residents and run the building.”

Nova Scotia long-term care staff cited that their infection control designates often lacked formal IPAC training and were tasked with juggling multiple roles and priorities (Delaney, 2020). This is a problem in Ontario long-term care homes as well, with many homes not having an IPAC professional, or appointing one who does not have the appropriate certifications.

There is a need for a dedicated and credentialled IPAC professional in each long-term care home, due to the immense breadth of responsibilities associated with this role (Centers for Disease Control and Prevention, 2020; Gilbert, 2020). IPAC professionals, who should be registered nurses, are necessary to provide IPAC leadership and guidance, staff training, as well as advice on IPAC measures and outbreak control (Gilbert, 2020; Ouslander & Grabowski, 2020). Ultimately, appointing a full-time IPAC professional to each long-term care home is a crucial strategy to help prevent and control future outbreaks and prevent the devastation experienced in the COVID-19 pandemic from ever occurring again. This was a recommendation made during the Central Park Lodge Inquest in 1999 – it is time for that recommendation to be implemented.

ONA recommends that the IPAC practitioner must be a registered nurse, trained and certified in IPAC Canada-endorsed courses. Ideally, the IPAC professional will be or will agree to be Certified in Infection Control (CIC). They must be given authority to make effective decisions about infection prevention and control in the workplace.

Delayed Implementation of IPAC Measures (Screening, Testing, Isolating)

Inadequate infection control measures increase the susceptibility of long-term care to COVID-19 infections (Harrington et al., 2020). With substandard or non-existent IPAC education, skeletal staffing, increased job demands, scarce resources, and a lack of IPAC leadership within most Ontario long-term care homes, residents and staff were increasingly vulnerable to COVID-19.

According to Gilbert (2020), barriers to outbreak control in long-term care include: inadequate COVID-19 source control, failure of staff to follow IPAC precautions, delayed identification and isolation of COVID-19 cases, and/or failure to activate a prompt outbreak response.

According to Ouslander & Grabowski (2020), strict IPAC measures must be observed in long-term care during COVID-19 such as: rigorous screening of all people who enter the facility, regular COVID-19 testing for staff, residents, and all other employees, prudent monitoring and isolation of all newly admitted residents as well as any resident who demonstrates any change in condition (for 14 days), as well as careful reopening of long-term care to visitors. Long-term care must carefully monitor roommates and other residents who have been exposed to a COVID-19 positive case and should avoid placing unexposed residents with COVID-19 positive residents (Centers for Disease Control and Prevention, 2020).

Ultimately, Lipsitz et al. (2020) demonstrated that there is a significant relationship between strong IPAC adherence and decreased COVID-19 infections and deaths. Prudent infection control measures and early testing, monitoring, and treatment protocols are of the utmost importance within nursing homes to mitigate the spread of COVID-19 (Tumlinson et al., 2020). These infection control measures were made nearly impossible for our front-line members to follow in many cases, as they were stretched far beyond capacity, with limited resources and supports. More concerning, in many cases, RNs were advised by their managers that they were not permitted to put in place certain IPAC measures, particularly isolating and cohorting of residents and staff.

The failure of long-term care to rapidly implement infection controls is evidenced in the responses to the ONA survey. For example, it was reported that symptomatic and asymptomatic residents were either not separated at all, or only after testing positive for COVID-19 were positive residents isolated.

“There were many positive residents and often grouped with negative.”

“Home did not isolate residents that were symptomatic or implement isolation precautions of those that were symptomatic until positive test results.”

“Isolation and swabbing did not occur for a few residents for 24 hours and residents are not grouped together who are sick. They have remained on their own units.”

These reports highlight the inconsistencies and delays that occurred with respect to isolating residents who had tested positive from the rest of the facility, contrary to Directive 3 issued in March 2020 by the Chief Medical Officer of Health.

Many of the practices reported are also contrary to the recommendations of the Centers for Disease Control and Prevention (2020), which provide that it is crucial for long-term care facilities to identify a specific floor, unit, or wing to cohort/isolate residents that are positive with COVID-19.

Again, these issues can be attributed to systemic failures, and warrant the need for extra IPAC supports and increased staffing levels in long-term care homes.

Infection control deficiencies in some Ontario long-term care homes are further illustrated in the following quote from an ONA survey respondent:

“A COVID positive patient was sharing a bathroom with a negative patient. Staff were not clustered to care only for positive or negative patients. The same food cart was used to distribute meals and drinks to both positive and negative patients. This made it harder for staff not to contaminate the cart. PPE was in low supply, especially cleaning wipes.”

In addition to overall IPAC compliance difficulties, our findings suggest that isolating residents and cohorting was a particular IPAC challenge faced in most Ontario long-term care homes. When our ONA survey respondents were asked if their long-term care home isolated residents who showed symptoms of COVID-19:

- only 19% said residents were isolated as soon as there was a known resident exposure to the virus;
- 40% said residents were isolated as soon as they showed symptoms;
- 6% said residents were isolated as soon as they tested positive for COVID-19;
- 7% said residents were isolated but there was a delay;
- 20% said residents were not grouped; and
- 8% did not know.

Similarly, when asked if their long-term care home separately grouped symptomatic and asymptomatic residents:

- 19% said residents were isolated as soon as there was a known resident exposure to the virus;
- 39% said residents were isolated as soon as they showed symptoms;
- 5% said residents were isolated as soon as they tested positive for COVID-19;
- 7% said residents were isolated but there was a delay;
- 23% said residents were not grouped; and
- 8% did not know.

This data suggests vast inconsistencies in the cohorting and isolating of residents in Ontario long-term care homes, attributable to a lack of consistent IPAC leadership, support, and resources in many long-term care homes.

RN Expertise

Aligning with Davidson and Szanton's (2020) assertion that RNs possess the necessary knowledge, skill, judgment, and resources to navigate the care needs of COVID-19 residents in the context of a pandemic, RNs in Ontario long-term care home played a pivotal role in cohorting residents.

“One of my colleague RNs took it upon herself to start to cohort residents with symptoms after we had already lost many residents.”

“One of the nurses took it upon herself to cohort residents after a majority of the COVID residents with symptoms died leaving many empty beds.”

To the best of their ability, RNs took the initiative to follow IPAC procedures even where the leadership in their homes failed to do so. It can be inferred that if RN and overall staffing was

adequate in Ontario long-term care during the COVID-19 pandemic, improved resident cohorting and IPAC measures would have occurred.

Infrastructure

The physical infrastructure of long-term care homes is a significant barrier to cohorting and isolating residents. Specifically, ONA survey respondents recognized the challenges of having four-person ward rooms within their long-term care homes:

“We still have four-bed wards. All rooms in this long-term care home are extremely small and do not come close to meeting current standards. The beds are so close together that residents can touch the bed beside them. If a resident displayed any symptoms, the resident was isolated in their room by having the curtains pulled and the resident would remain in their small, curtained area for 14 days, with a commode being taken in and out when required. The other three residents remained in the room.”

“All they did to isolate a patient was pull a curtain. They were left in four-person ward rooms. Residents were never grouped while I was there.”

These findings are similar to the experiences reported by staff in Nova Scotia long-term care homes, who indicated that older buildings with poor infrastructure made it difficult to control the spread of COVID-19 (Delorey, 2020).

It is seldom possible for long-term care homes to effectively isolate residents, as there are often rooms with multiple occupants and/or shared bathrooms, which facilitates the spread of COVID-19 (Davidson & Szanton, 2020; Ouslander & Grabowski, 2020). Gilbert (2020) also indicates that these factors, in addition to intermingling and crowding, act as significant barriers to outbreak control in long-term care homes.

In a study of Ontario long-term care by Brown et al. (2020), resident crowding was associated with higher incidences of COVID-19 infections and mortality. Specifically, homes with higher crowding index scores were found to have a mortality rate of 2.7 per cent compared to 1.3 per cent those with a lower crowding index.

Multiple authors suggest the need to decrease occupancy standards to a maximum of 2 residents per room (Brown et al., 2020; Delorey, 2020). According to Brown et al., if all four-bed ward rooms in Ontario long-term care had been converted to two-bed rooms prior to the pandemic, 988 COVID-19 resident infections and 271 COVID-19 related deaths could have been prevented. New builds must meet design standards that are more amenable to effective IPAC measures, including single resident rooms, private bathrooms, and zones that could be separately isolated (Gilbert, 2020).

Resident Responsive Behaviours

Another challenge to cohorting and isolating long-term care residents, is the increased incidence of resident responsive behaviours.

“The COVID-positive residents were wandering throughout the unit going into all of the rooms and so the staff and the COVID negative residents were continually unprotected and exposed to COVID-19.”

“Some residents were high risk for falls, or wanderers, and did not stay in their room and therefore were technically isolated but never stayed in their room.”

It is extremely challenging to implement infection control procedures such as cohorting and isolating with residents, particularly those with cognitive impairments, who often wander (Lipsitz et al., 2020; Ouslander & Grabowski, 2020).

Effective management of resident responsive behaviours requires time and a consistent approach by staff who know, and who are known by the resident. Responsive behaviours can be triggered by any changes to the residents' usual routine or environment, for example unfamiliar staff, changes to regular meal times etc. During "regular operation" managing these behaviours safely and appropriately requires increased staffing, however during times of crisis, such as during the pandemic, further upstaffing needs to be in place.

As an ONA member stated in the survey:

"Some residents that were supposed to be isolated were not because they were non-compliant and would have required to be physically restrained and 1:1 monitoring. We do not have the staff for this."

Increased staffing is necessary to appropriately isolate responsive residents safely.

Section 5: Personal Protective Equipment

Personal protective equipment (PPE) is the last line of defense for long-term care workers who must work in close proximity to suspected, probable and confirmed COVID-19 residents. It is of critical importance protecting both residents and staff from COVID-19. PPE includes a range of equipment, including but not limited to, gloves, gowns, surgical masks, N95 respirators, face shields and goggles. A shortage of PPE and restrictions around PPE access and use, has been a persistent, urgent issue during the COVID-19 pandemic. Particularly, the availability of necessary personal protective equipment supplies within long-term care has been an ongoing concern (Gilbert, 2020). Montoya et al. (2020) emphasize the importance of having extra PPE available when caring for COVID-19 patients.

Front-line workers within Ontario long-term care homes have faced considerable challenges with PPE during COVID-19. A key issue of debate has been whether front-line workers are sufficiently protected with droplet and contact precautions, or whether, in the face of a novel and largely unknown pathogen, the precautionary principle should have been applied, meaning health-care workers would use enhanced protections required for an airborne (or potentially airborne) virus. Nearly a year in to the pandemic, the science has continued to mount in support of RNs, ONA, and other voices who have advocated for airborne precautions from the beginning.

PPE Accessibility

According to the Centers for Disease Control and Prevention (2020), necessary PPE must be made readily available within long-term care homes, specifically in areas where direct resident care is provided. Ouslander and Grabowski (2020) acknowledged the importance of adequate PPE supplies in long-term care homes, within the context of COVID-19.

Countless ONA survey respondents reported inadequate PPE access, and that PPE was locked up, far away from the point-of-care:

"PPE was not readily available. Management hoarded."

"PPE was not readily available. It was locked up and I did not have access to it when I needed it during my night shift."

"We asked for more PPE, they changed the locks on the doors where the PPE was kept."

PPE supplies were sometimes so scarce in long-term care homes that some ONA members reported purchasing their own supplies:

“We brought our own. Some were donated to the home and we were not denied access to those. We used our own N95 masks if we were fortunate enough to find some. We were absolutely denied access to the N95 mask supply in the home, in fact they were locked in the office of the ED.”

The unavailability and inaccessibility of PPE reported by our ONA members is unfathomable. Readily available PPE aids in the prevention of COVID-19 transmission and allows workers to feel safe in continuing to work (Fisman et al., 2020). Both caregivers and residents are protected when health-care workers have proper PPE. Access to adequate PPE and hand sanitizer at the point of resident care has been shown to contribute to improved IPAC compliance in long-term care homes, leading to decreased COVID-19 spread (Delorey, 2020). The shortage of PPE in many Ontario long-term care homes has been a serious concern with respect to COVID-19 transmission.

Directive 5: Failure to Require Airborne Precautions

Directive #5 issued by the Chief Medical Officer of Health, requires health-care providers to perform a point of care risk assessment (“PCRA”) to determine whether an N95 respirator was required for patient care. Despite the Directive leaving that assessment to health-care workers, RNs were actively discouraged from using N95s, and in some cases, were prohibited from using them. According to ONA survey respondents, when asked if they experienced restrictions in utilizing N95 respirators in their long-term care homes:

- 13% indicated they were required to reuse their N95 respirators;
- 9% indicated they were required to use their N95s for extended use;
- 12% indicated they were provided a limited number of N95s for use during their shift;
- 28% indicated they required permission to access N95s;
- 14% indicated they were prohibited from using N95 respirators;

When asked if they were ever denied an N95 respirator:

- 24% were denied the use of an N95, and;
- 35% were required to use the same mask while treating both healthy and COVID-19 positive residents.

When asked whether any manager from their long-term care home interfered with the outcome of their PCRA, 29 per cent of ONA survey respondents said yes.

“Once directed to utilize PCRA, N95s weren’t readily distributed in the home at that point. I do not recall it being that far apart from the point at which N95s were no longer distributed.”

“Yes. My assessment and requirements would not always meet with management’s. They would insist that N95 was not necessary and a surgical mask would suffice.”

Additionally, 30 per cent of ONA survey respondents indicated that they provided care to residents who exhibited aerosol generating behaviours such as spitting, uncontrolled coughing, or sneezing without being provided with an N95 respirator.

“The administrator did not feel that all PPE was required when I had assessed that I wanted to wear the N95, goggles & shield knowing the residents I was going to assess had history of being resistive, at times spit, etc.”

Circumstances related to PPE accessibility and PCRA completion ultimately became so bad in some long-term care homes that ONA was forced to seek a court injunction to address serious health and safety concerns. This injunction resulted in the four Ontario long-term care homes in question being ordered to provide nurses with fitted N95 respirators and the necessary PPE when assessed by a nurse at the point of care to be necessary.

Airborne precautions not taken when caring for suspected, probable, confirmed COVID-19 cases

According to Tumlinson et al. (2020) health-care providers interacting with high-risk populations, such as nursing home residents, should be provided with maximal protection to reduce the risk of COVID-19 transmission. The Centers for Disease Control and Prevention (2020) indicates that health-care providers should wear an N95 respirator, eye protection, gloves, and a gown while caring for residents who are awaiting COVID-19 test results. When residents are known or suspected to have COVID-19, the Centers for Disease Control and Prevention (2020) recommends that airborne precautions (an N95 respirator or higher-level respirator, eye protection, gloves, and gown) are used. Many ONA survey respondents indicated that they were advised that the use of N95 respirators was unnecessary.

“I had questions about whether or not we should be using N95 masks. I was told they were unnecessary.”

“They insisted they would follow guidelines - but guidelines were insufficient and there was not enough PPE available. They were giving us one surgical mask for four days at the beginning and insisted we would not need N95 masks because guidelines were for droplet precautions and that we had no aerosolizing procedures. I insisted that if we were to have presumed or positive cases - that we would need better protection such as N95 and goggles - they insisted that surgical masks would be sufficient. As supply got better, they began changing their stories. It took way too long to change guidelines to allow a nurse to make their own judgement. And still, I think we all know that airborne precautions are needed but that they will never supply the necessary precautions. It is all about budget and not about safety.”

The precautionary principle was not followed in Ontario long-term care homes as a result of government directives.

The science around the transmissions of COVID-19 has continued to mount, pointing more and more to evidence that aerosols are an important mode of transmission. Although the World Health Organization, the Center for Disease Control in the United States, and the Public Health Association of Canada all now recognize airborne transmission, Ontario directives and guidance around PPE use in long-term care still fail to mandate airborne precautions.

Section 6: Impact of Leadership

The quality of leadership and management in long-term care homes had important implications in preventing the spread of COVID-19 and affected overall staff perceptions of support during the pandemic.

Montoya et al. (2020), found that effective nurse managers communicated daily with their staff, providing updates regarding policies, procedures and PPE use. Research studies note that during

the pandemic, it was important for long-term care leadership to be visible and approachable to staff, adjusting their COVID-19 strategies based on staff feedback (Maben and Bridges, 2020). Creating work environments in which staff are encouraged to communicate concerns and provide problem-solving strategies, while acknowledging occupational stressors that staff members experience and directing them to appropriate resources for emotional support when required, were identified as some key qualities of effective leaders. (Rangachari & Woods, 2020).

Rating their satisfaction with leadership during the pandemic, ONA survey results were as follows:

- 22% of respondents were “very satisfied”;
- 33% were “somewhat satisfied”;
- 14% were “neither satisfied nor dissatisfied; and,
- 31% were not satisfied.

Survey respondents identified the following positive leadership experiences during the pandemic:

“The leadership team has done a great job navigating through these very difficult times. Hopefully, we can keep on keeping on.”

“Strong leadership. - strong nursing knowledge made the difference.”

“Management has never denied us what we need in the home to keep staff safe while working, orders were followed and implemented.”

“Our former Administrator worked tirelessly, I thought she did an excellent job keeping us educated, informed, provided for and supported!!”

“They were excellent. Supportive and checked in with us daily to see if we needed any supplies or anything at all.”

“They were here throughout the pandemic and had a manager on every Saturday/Sunday 8 hours to assist.”

Respondents also commented on negative experiences with leadership during the pandemic:

“Terrible leadership. No education, no training is ever done. They sit in one office together and never leave the office or they are angry.”

“Leadership was not clear enough and was not as proactive as they should have been in a pandemic.”

“Leadership is very focused on their own jobs and do not help the nurses with front-line care. Workload has greatly increased with no assistance.”

“I find that management only does what they are ordered to do. They do not do anything extra and do not seem concerned about staff. Everything comes down to money.”

“Leadership has been isolating themselves in their offices. They explained that this was to limit their exposure to COVID-19; however, it made front-line staff feel as if members of management were hiding in their offices while front-line staff continued

to work and risk their health. It has created a “them and us” environment between front-line and management staff with the RNs being the go-between.”

“They did not provide staff any support when the outbreak started. Hid in their offices so that it was difficult for staff to access them even by phone.”

“Managers ran and hid during pandemic and were never seen.”

“They were closed off. They spent minimal time on any given unit and when they did go to a unit, they were fast leaving.”

In a study by Siu et al. (2020), staff in Ontario long-term care reported:

- a need for improved engagement opportunities with long-term care leadership, to better plan a coordinated COVID-19 pandemic response;
- that communication structures were not efficient, and;
- that individuals in leadership positions could have strived to disseminate crucial knowledge to front-line workers more effectively.

This section will explore the impact of leadership on infection prevention and control, communication and staffing levels.

Leadership and IPAC

The correlation between effective leadership and IPAC is noted both in the academic literature and the responses to ONA’s survey of long-term care members. Gilbert (2020) posits that in order to prevent COVID-19 infections and outbreaks in long-term care homes, decisive leadership from managers is necessary.

Long-term care administrators should ensure that their long-term care facilities are equipped with facility-specific policies and procedures associated with infection prevention and control, including robust COVID-19 risk assessments and screening measures (Gilbert, 2020). Administrators should also ensure that all long-term care staff members are trained and proficient in proper IPAC practices and should conduct regular assessments of staff IPAC competencies (Gilbert, 2020; Tumlinson et al., 2020). Moreover, they must oversee that their facility has established proper infection control measures and an outbreak preparedness plan, which should include plans for a surge workforce (Gilbert, 2020; Tumlinson et al., 2020).

Outbreak preparedness plans should be regularly reviewed by long-term care administrators, as failure to possess a response plan, or efficiently implement an outbreak response, is described by Gilbert (2020) as a barrier to effective COVID-19 outbreak control.

According to Possamai (2020), administrative and workplace practice controls are paramount for the appropriate placement of infectious residents, outbreak surveillance measures, cleaning and disinfection processes, education programs, and risk management procedures. Rangachari and Woods (2020) indicate that leaders of health-care organizations must take an active role in ensuring that their staff have adequate access to PPE and all other necessary resources. Health-care organization leaders should facilitate employees’ access to proper training, to ensure that staff are equipped with the knowledge base to meet any unfamiliar patient care needs associated with COVID-19 (Rangachari & Woods, 2020).

ONA members noted in the survey how leadership made a difference in implementing effective IPAC measures.

Some positive observations made by ONA members include:

"I'm thankful that leadership made good decisions early on to require staff screening, mandated wearing of surgical masks, and limited visitors to help reduce the risk."

"It is my belief that having a strong leadership team and dedicated team members in protecting our residents and each other has made all the difference by following the guidelines given to long-term care from the Ministry of Health in the home and also when in our own homes."

Some negative observations made by ONA members include:

"Leadership at the LTC home contributed to the ineffective use of PPE, locking up of PPE, limiting access and not providing adequate training to staff. Also not following up with staff who were not using PPE as it was intended."

"Feel like they needed to move clients out of ward rooms earlier than they did and to designate a ward/wards to COVID patients that they needed to sound the alarm for help much earlier."

"Management not informed, not practicing appropriate infection control, lack of leadership knowledge."

"I have had problems sleeping and find myself to be more anxious at times when I did not feel that matters were being handled consistently. The lack of leadership resulted in increased anger and resentment towards my management team. Lack of knowledge I could understand as we were going through this together for the first time. However, the lack of critical thinking and the willingness do only the minimal that was required was unnerving. Not to mention hearing the Administer state over and over 'we are not in an outbreak' in an attempt to justify not taking steps beyond recommendations and directives made me concerned that there was little understanding that we were part of a pandemic."

Leadership and Communication

Effective communication by leaders is also of critical importance and yet was lacking during the pandemic.

Only 64 per cent of ONA survey respondents indicated that they received training sessions or meetings from management about updates on COVID-19 hazards, new developments and measures, and health-and-safety procedures. This experience was confirmed by the Canadian Armed Forces report (2020), which reported that facility-specific COVID-19 policies and procedures were not shared with staff members in some Ontario long-term care homes.

Additionally, long-term care home staff were not always provided with updated information about the COVID status of residents and staff in their long-term care home (Canadian Armed Forces, 2020).

In a study by Montoya et al. (2020), effective nurse managers communicated daily with their staff members, providing updates regarding policies, procedures and PPE use. They also checked in with staff frequently to monitor residents' status, identify necessary resources, and to generally

provide support to staff. Moreover, Maben and Bridges (2020) identify the value of daily communication between managers and staff members, to ensure that staff feel well informed about changes related to COVID-19.

In an Ontario study by Siu et al. (2020), staff clinicians reported a need for improved engagement opportunities with long-term care leadership, in order to better plan a coordinated COVID-19 pandemic response. Respondents indicated that communication structures were not efficient, and that individuals in leadership positions could have disseminated crucial knowledge to front-line workers more effectively (Siu et al., 2020).

Leaders of health-care organizations need to create work environments that encourage staff to communicate about concerns and provide problem-solving strategies for workplace limitations (Rangachari & Woods, 2020). Employees are more likely to communicate patient safety concerns to managers if they feel trusted, safe, and empowered (Rangachari & Woods, 2020).

The responses to ONA's survey of long-term care members illustrate the differences between homes where leaders communicated well with staff, and those that did not.

Some of the positive experiences:

"Our administrator has been wonderful throughout this pandemic. Staff were always kept up to date on all the changes, she was always one step ahead of providing safety that the government initiated."

"Our leaders were very proactive in following orders from the health unit as well as putting the suggestions in action before they had to. Allowed health-and-safety team to meet twice weekly so we can keep up with new directives as well as monitor how many PPE we had. Did meetings at each shift change to keep all staff up on the daily changes at first and continue as changes are made."

Some of the negative experiences:

"They did not include the staff in their decisions, they do not inform staff in a timely manner of decisions that will impact them."

"Serious lack of communication between levels of management and staff and all information was given via an over abundance of daily emails. They refused to look at the causes and contributing factors to our staff shortages and fix the main problems."

"They were looking through rose-coloured glasses and not hearing what we were saying."

"Something greater than us."

Leadership and Staffing

The staffing crisis experienced throughout Ontario's long-term care sector during COVID-19 is also directly linked to leadership. Directors of Nursing and Administrators are responsible for ensuring that their home has adequate nursing staff and a robust staffing contingency plan to combat staff absenteeism and staff shortages (D'Adamo et al., 2020). Staffing plans must ensure

that the staffing complement allows for proper shift lengths and adequate recovery time between shifts, an issue that became a problem during COVID-19 outbreaks (Maben & Bridges, 2020).

It is a failure on the part of home leadership that contingency plans for being short-staffed were not developed in the period leading up to the first outbreaks in long-term care homes. Without a plan, nurses were required to work longer shifts, many days in a row. As we describe in Section 3, these dire staffing shortages compromised the ability of remaining staff to meet the care needs of residents, and hindered the ability of staff to implement proper IPAC measures.

ONA members described in the survey the impact leadership had on staffing and the corresponding ability to meet the needs of residents during outbreaks.

Some positive observations:

“Our leadership team was/is amazing. Once we had a CONFIRMED COVID case, the management exclusively staffed that segregated isolation unit...allowing the RNs and other staff to staff the rest of the home - without any risk of staff working in “the home” and “the isolation unit.”

Some negative observations on the impact of poor leadership on staffing:

“Management also could have helped on the floor when we were and continue to go short all the time, but that has not happened. Management has not hired adequate staffing levels in which is putting major stress on ALL employees. Policies changing frequently and no consistent manner of informing staff. Staff not aware of new policies related to this inconsistency and then management would penalize even though we weren’t aware or notified of policy changes.”

“We were short PSWs. RPNs, RNs every day every shift with no assistance from management whatsoever. They ran and hid in their office and only contacted us by phone to bark our orders.”

Better Leaders, Better Homes

Throughout the pandemic, ONA members identified that effective leaders planned for the worst, implementing strong IPAC measures, communicating with staff, and creating staffing contingency plans, upstaffing where possible. Strong leadership is necessary to lead homes through a crisis such as that posed by COVID-19.

Section 7: Profit Status of Ontario long-term care homes

For-profit homes performed poorly during the pandemic. The factors discussed earlier – staffing, IPAC measures, PPE, and leadership – were all more challenging in the for-profit long-term care sector.

In this section, we review the increasing research examining the performance of for-profit, not-for-profit and municipal homes during COVID-19 outbreaks. This research supports that for-profit homes had worse outbreaks with more resident deaths than not-for-profit and municipal homes. Based on these findings, which are not surprising to those who have been working in the sector, ONA recommends that for-profit long-term care in Ontario must be eliminated.

Background

In Ontario, all long-term care homes, regardless of whether they are for-profit, not-for-profit, or municipally operated, are governed by the LTCHA and its regulations. They are all licensed by the Ministry of Long-Term Care and receive the same base funding from the provincial government. In addition, municipal and charitable not-for-profit homes receive supplemental funding: municipal homes from the municipality and not-for-profit homes through fundraising endeavors. Table 4 below sets out the share of the long-term care market held by each type of home, and the bodies to which they are accountable.

Table 4

Ownership	For-Profit Status	Accountability	Additional Accountability	Share of market
Private	For-Profit	Ministry of Long-term Care (MLTC)	Corporate board or owner/operator	58%
Charitable	Not-for-profit		Not-for-profit board or a charity, agency or cultural-religious group	26%
Municipal	Not-for-profit		Municipal councils, and/or charitable, religious, community agencies	16%

Data source: Stall et al., 2020, PODCAST

In terms of provincial funding, all long-term care homes in Ontario receive funding in four envelopes from the Local Health Integration Networks (LHINs) (who receive the funding from the Ministry of Long-Term Care):

- nursing and personal care;
- program and support services;
- raw food; and
- other accommodation.

While not-for-profit long-term care homes reinvest surplus funds from the “other accommodation” envelope to enhance services within their homes, for-profit homes are free to distribute this surplus to shareholders without reinvesting in the home (Stall et al., 2020, PODCAST).

Historically, studies have suggested that the majority of for-profit long term care homes have inferior staffing levels and deliver a lower quality of care to residents than not-for-profit homes (Amirkhanyan et al., 2008; Comondore et al., 2009; Grabowski et al., 2013; Grabowski et al., 2016; Harrington et al., 2012; McGregor et al., 2005).

An ONA member remarked on the difference between for-profit and not-for-profit homes, having been redeployed to work in both during outbreaks:

“There was a very stark contrast between the conditions in private, for profit Long-term care and not-for-profit homes, and I was redeployed to both.” ONA Survey (2020), Anonymous RN

COVID-19 Statistics in For-Profit vs. Not-For Profit Long-Term Care in Ontario

Numerous studies have suggested an association between for-profit long-term care home status and COVID-19 outcomes for residents (Abrams et al., 2020; Chown Oved et al., 2020; Li et al., 2020; Ontario Health Coalition, 2020). For-profit home status was significantly related to worse

COVID-19 outbreaks (more total resident cases) in Ontario long-term care homes, compared to not-for-profit homes (Stall et al., 2020). Abrams et al. (2020) indicates that for-profit home status is significantly associated with COVID-19 outbreak size, while Li et al. (2020) posits that nursing homes with increased confirmed cases/deaths were more likely to be for-profit.

During both the first and second COVID-19 outbreaks, while all classifications of **long-term care homes** were confronted with outbreaks at the same rate (Tubb et al., 2020):

- **residents in for-profit homes were 60% more likely to contract COVID-19 and 45% more likely to die of COVID-19 than residents in not-for-profit homes.** (Chown Oved et al., 2020)
- **12 of the 15 Ontario long-term care homes with the highest incidence of COVID-19 were for-profit.** (Stall et al., 2020)
- **7 of the 10 Ontario long-term care homes with the highest death rates from COVID-19 were for-profit.** (Stall et al., 2020)

An analysis by the *Toronto Star* of the first and second COVID-19 outbreaks in Ontario corroborated these findings.

According to Stall et al. (2020), among Ontario long-term care homes with a COVID-19 outbreak, an average of 6.5 per cent, 5.5 per cent, and 1.7 per cent of all residents died COVID-19 in for-profit homes, not-for-profit homes, and municipal homes respectively.

Similarly, according to a research analysis done by the Ontario Health Coalition (2020), the rate of COVID-19-related resident deaths in long-term care was: 9 per cent in for-profit homes, 5.25 per cent in not-for-profit homes, 3.62 per cent in municipal homes. Additionally, for-profit homes were found to exhibit resident death rates that increased more rapidly than not-for-profit and municipal homes (Ontario Health Coalition, 2020). Therefore, the data strongly demonstrates that Ontario for-profit long-term care have had far worse resident outcomes with COVID-19.

These findings are disturbing and should be unacceptable to all Ontarians. Immediate change is required to make for-profit care safer for residents and staff.

Outdated Infrastructure

One factor that may not immediately seem to be linked to the for-profit status of a long-term care home is the outdated facility infrastructure that contributes to the spread of COVID-19 (Brown et al., 2020; Stall et al., 2020). The Commission has heard that a significant risk factor during the pandemic were older, more crowded homes, where multiple-bed “ward rooms” were prevalent. Those older homes tended to experience the most severe outbreaks.

In a study of Ontario long-term care by Stall et al. (2020), it was found that Ontario for-profit homes typically have older design standards, compared to not-for-profit and municipal homes. Moreover, older home design standards were associated with increased odds of a COVID-19 outbreak in Ontario long-term care (Stall et al., 2020).

Newer design standards in long-term care have more private resident rooms, less crowding, and more contained common areas, as opposed to the ward-style rooms and central common spaces associated with older design standards (Stall et al., 2020). Further, newer design standards promote optimized infection control practices, as transmission within resident bedrooms and common areas is limited (Stall et al., 2020).

Similarly, Brown et al. (2020) examined the relationship between design standards and COVID-19 in Ontario long-term care homes. Half of Ontario nursing homes were found to be built according to pre-1999 design standards (which allowed for quadruple occupancy rooms) (Brown

et al., 2020). Crowded long-term care homes were found to be more likely to be operated by a private for-profit owner (Brown et al., 2020). It was also found that COVID-19 outbreaks in crowded nursing homes were larger, as there were nine COVID-19 outbreaks involving over 100 residents in more crowded nursing homes, compared to one COVID-19 outbreak involving over 100 residents in a less crowded home (as per the crowding index utilized in this study) (Brown et al., 2020).

For-profit long-term care operators have had many years to update their facilities, yet many failed to do so.

Voice of ONA Members on For-Profit Homes

RNs who responded to ONA's survey or who participated in interviews spoke strongly about their concerns about for-profit long-term care homes:

"Though I was never in favour of for-profit long-term care, I now firmly believe it should be eliminated as companies continued to pay out dividends while residents and staff died and were not properly supplied or cared for."

"Eliminate for profit LTC homes. Profit should never be a consideration over the lives of the people we care for."

"The for-profit homes don't care about the residents despite what they say. We have training on abuse – but by not providing sufficient staff THEY are in fact neglecting the residents, and neglect is a form of abuse."

"LTC needs to be taken over – no more privately owned homes...for-profit is all about money, not providing much needed care to residents. ...it has to change...workers cannot be held accountable...they need to make owners of homes accountable...for preventable deaths of our 100 residents."

ONA recommended to the Gillese Inquiry that for-profit homes be eliminated. The abysmal performance of for-profit long-term care homes during the pandemic reinforces ONA's longstanding view that there is no place for profits in the provision of long-term care.

Section 8: The Mental Health of long-Term Care Nurses is in Jeopardy

Prior to the COVID-19 pandemic, numerous studies demonstrated an increased risk for mental health issues among health-care workers (Reger et al., 2020). In a 2016 study, long-term care nursing staff were found to have significant occupational stress and high levels of burnout (Woodhead et al., 2016).

Nurses as front-line workers are disproportionately affected by COVID-19. Survey data from 34 countries suggest that front-line nurses have the highest risk of COVID-19 infection due to their close and frequent contact with patients/residents for long hours (Catton, 2021; Lai et al., 2020). This has added stress to health-care environments that were already strained pre-pandemic (Brophy et al., 2020.) As such, there is grave concern for the immediate and long-term psychological well-being of our front-line health-care workers who have bravely and tirelessly worked during the pandemic (Lai et al., 2020).

"My anxiety is high, and I struggle to sleep before work. On my days off I feel anxious knowing I have to go back to work in x number of days." ONA Survey (2020), Anonymous RN

COVID-19 Impact on the Mental Health of RNs

A study of Canadian health-care workers during the height of the pandemic (Smith et al., 2020) reported that 55 per cent of participants exhibited symptoms of anxiety and 42 per cent of participants exhibited symptoms of depression.

Similarly, in a study by Lai et al. (2020), 70 per cent of participants working on the front lines of health care during COVID-19 reported experiencing psychological distress, with a significant proportion reporting symptoms of anxiety, depression, and insomnia. It should also be noted that Reger et al. (2020) reported that preexisting psychiatric conditions among front-line health-care workers may be amplified by the difficult working conditions and emerging fears related to the pandemic.

"I have suffered insomnia, depression, severe anxiety, sleep disturbance, vivid nightmares, as well as concentration difficulties." ONA Survey (2020), Anonymous RN

"My stress level has increased. I already live with depression and anxiety and this pandemic has worsened my condition. I'm afraid of possibly making my husband sick (he's already compromised). I'm exhausted from working OT and I'm uneasy at work. There is so much more work to do with the residents during this time. Working short staffed makes it all worse. I don't feel proud to be a nurse anymore because you can't care for your residents like you should (or they deserve)." ONA Survey (2020), Anonymous RN

Factors Contributing to Intensified Personal and Professional Stressors

The following factors were reported in literature (Brophy et al., 2020; Jun et al., 2020; Reger et al., 2020; Santarone et al., 2020) and by respondents to the ONA 2020 survey:

- increased job demands such as: increase in hours worked; minimal (if any) rest periods, increased resident acuity, decreased staffing levels, increased workload;
- decreased ability to meet Professional Standards;
- issues with PPE such as: shortages/lack of accessibility; concern about the adequacy of protection for themselves and their residents;
- fear of transmitting COVID-19 to their families, and residents;
- inconsistencies and frequent changes to policies and directives (from both government and employers);
- silenced voices,
- traumatic experiences; and
- the need for support.

Increased Job Demands

"... "We signed up for this," we hear. No, I didn't sign up to work short-staffed every day, to have so much work I can't safely help my residents, to put my license on the line due to overworking, and to expose myself to deadly illnesses without PPE."

The unmanageable workloads that ONA's long-term care members have faced on the frontlines have contributed to feelings of defeat and disappointment. They do not always feel that they are able to provide their valued residents with quality care, which can be very morally distressing. The increased job demands placed upon health-care workers in long-term care have been exacerbated by new COVID-19 routines and the restriction of visitors to the long-term care homes. The absence of family caregivers at the bedside has warranted increased demands on long-term

care staff, as nurses and health-care workers have frequently had to stand-in for family to support residents, and facilitate remote communication between residents and family members (Brophy et al., 2020; Maben & Bridges, 2020). Additionally, violence against health-care workers has been on the rise in long-term care due to resident behaviours being triggered by lockdowns, isolation, and visitor restrictions (Brophy et al., 2020).

Concerns about adequacy of Personal Protection

“There was the fear I would catch COVID from the non-existent PPE, but I continued to work because if I didn’t stay, there would be no staff.” ONA Survey (2020), Anonymous RN

Concerns about the adequacy of personal protection against COVID-19 has been identified as a source of psychological distress for health-care workers. Brophy et al. (2020), state that health-care workers feel deterred from speaking out about their concerns regarding inadequate protection and working conditions, due to fear of reprisal. Ultimately, health-care workers have been aware of PPE shortages, and consequently worry about the adequacy of their own protection when caring for COVID-19 patients (Brophy et al., 2020).

Smith et al. (2020) found that Canadian health-care workers who perceived they had adequate access to PPE and effective infection control measures, had lower symptoms of anxiety and depression. Thus, robust infection control strategies could have important implications on front-line health-care workers’ mental health during the COVID-19 pandemic (Smith et al., 2020).

Fear of transmitting COVID-19 to their family and residents

In studies by Brophy et al. (2020) and Jun et al. (2020), the greatest fear that many health-care workers cited was the possibility of contracting COVID-19 at work and transmitting the virus to their family members (Brophy et al., 2020). Reger et al. (2020) also outline the ethical dilemma that many health-care workers have faced during this pandemic: whether to continue serving their sick COVID-19 patients, while simultaneously risking contracting and transmitting COVID-19 to their loved ones (Reger et al., 2020). Many health-care workers have opted to physically isolate from their families to reduce COVID-19 transmission risk, which has heightened their feelings of loneliness (Reger et al., 2020).

Similar to the findings in the above studies, several of our ONA members also reported intense fears of transmitting COVID-19 to their family members and fragile residents. ONA members reported isolating from their families to mitigate these risks as much as possible:

“I was very anxious the whole time. Scared to be around people, even outside. Scared for my family to be around people. I was started on medication for heartburn which was totally stress-related.”

“I was scared to go out anywhere because I was mortified of getting COVID and then bringing it to residents at the nursing home. This made me very isolated and stressed and alone and lonely.”

“I had to stay away from my family for more than a month, I have 2 little kids and my wife found it very difficult to manage them alone as they are just 1 and 2 years old. The job is very stressful, and I developed hypertension.”

“I isolated myself from family for 6 weeks in order to keep them and residents free from risk. I had feelings of loneliness and being abandoned to cope alone.”

Inconsistencies and frequent changes to Policy and Government Directives

Constant changes to policies, as well as contradictory directives from both the government and employers has significantly contributed to health-care workers' experiences of stress during the COVID-19 pandemic (Brophy et al., 2020). Rapidly changing practice environments, unfamiliar protocols, and an adjustment to a "new normal" within and outside of work have been challenging adaptations for health-care workers to cope with (Maben & Bridges, 2020; Shanafelt et al., 2020). Further, many health-care workers have felt let down by the government and their employers, as they sensed a lack of preparedness that contributed to inadequate PPE supply, confusing protocols and policies, and inconsistent communication (Brophy et al., 2020).

"I felt anger towards management for not listening to the needs of staff or being strict with the guidelines outlined by the government/public health authorities."

"Due to the reaction of the government, and of many employers that I have heard stories about...the profession is just undervalued, and that makes me sad. I would never recommend that anybody be a nurse in the future, although I always used to advise people my kids' age and younger that nursing is a good profession. I would never advise that now, in fact I would highly advise against it."

"The lack of appreciation for nursing, from site administration right up to the government level has been extremely disappointing."

Silenced Voices

"We put ourselves on the line to save lives, however, our voice is rarely heard, I feel people have forgotten us already..."

In addition to inconsistencies with policies and protocols, health-care workers have also experienced a sense of powerlessness, as they have felt that their voices have been silenced by their employers and/or the government (Brophy et al., 2020). Health-care workers have described facing "regulatory barriers" due to patriarchal structures, which have hindered the achievement of necessary changes and solutions to systemic issues faced on the front lines (Brophy et al., 2020).

Traumatic Experiences

In addition to ever-changing work environments and systemic barriers to quality care, nurses and health-care workers have also been confronted with traumatic work experiences. Front-line workers in long-term care have had to adjust to the "new normal" of providing end-of-life care to rapidly deteriorating residents on a frequent basis (Maben & Bridges, 2020). In many instances, long-term care residents have been cared for by staff over a duration of many months to years, which contributes to increased experiences of trauma and devastation for staff members.

Countless ONA members have shared the traumatic work experiences that they have endured during the COVID-19 pandemic:

"Seeing so many of our beloved residents die was very traumatic, 3 to 4 residents were dying a day. Putting their bodies in bags was not pleasant."

"The funeral home would bring the stretcher to the door – we took it from the door to the resident, put a name identifier on their toe and put them in a clear body bag resembling a garbage bag. I found this very upsetting – it felt like I was throwing the residents in the garbage...."

"...I now see how this can cause PTSD...at the end of their life, we are donned in PPE with the residents we have so lovingly taken care of, placing them in a body bag. NO honour guard, no family present to give our condolences to. Then we

push the gurney out to two waiting funeral attendants. So sterile and impersonal. Many times I cried.”

“I had to do the unthinkable as a nurse and that was to put the residents whom I cared for many years in a body bag. The body bags at the time were white, thin and not concealing. The stress of everything from my emotions of work and the potential exposure of my family was beyond stressful. I had been dealing with insomnia for 8 months prior to this and I truly believe the impact of my work experience exacerbated this. I went from having difficulty sleeping to no sleep at all....Putting my experience in words now brings back so many awful emotions and tears but I am truly grateful for the support from my colleagues and family that have helped me through this.”

The Need for Support

“Sleeplessness, anxiety. My doctor recommended counselling but they said I did not qualify.”

The ongoing support of health-care workers from managers and leaders is crucial for optimized mental health outcomes for front-line workers (Maben & Bridges, 2020). Leaders must strive to understand and address the concerns among health-care professionals and should work with their stakeholders to implement solutions to mitigate these concerns (Shanafelt et al., 2020).

When leaders are present and available to their front-line workers who regularly care for COVID-19 patients, it can provide a sense of reassurance (Shanafelt et al., 2020). Effective leaders must empower their team members to seek help, and should ensure that nobody feels alone, especially during the COVID-19 pandemic (Shanafelt et al., 2020). According to Greenberg (2020), health-care managers should pay attention to the mental health status of high-risk employees, such as those from ethnic minority groups, junior staff members, and/or newly hired employees.

Moreover, it is the responsibility of managers to actively monitor health-care workers who have been exposed to traumatic events during the COVID-19 pandemic, and guide them in navigating these experiences (Greenberg, 2020). There is considerable evidence that suggests managers of health-care workers play a crucial role in protecting the mental health outcomes of their staff members, through supporting them to seek and access mental health care (Greenberg, 2020).

Only 42 per cent of ONA survey respondents indicated that their employer offered any support to employees during the pandemic, such as Employee Assistance Programs and/or grief counseling. Nurses and health-care workers must receive practical and psychological support, to optimize their short-term and long-term mental health outcomes (Maben & Bridges, 2020). This is especially important due to the increased occupational stress levels in long-term care related to COVID-19.

Recommendations

Immediate interventions are necessary to promote the mental health and well-being of health-care workers who are confronted with COVID-19 (Lai et al. 2020). Specifically, health-care workers who work directly with patients infected with COVID-19 must be screened and monitored regularly for mental health issues, including depression, anxiety, and suicidal ideation (Braquehais et al., 2020; Smith et al., 2020). Preventive and early intervention strategies must be implemented, and health-care workers should receive short-term and long-term mental health services to support their needs (Jun et al., 2020). A range of supportive measures are warranted, including organizational, team, and peer supports (Maben & Bridges, 2020). The impacts of COVID-19 will be felt long after the immediate threat subsides, as health-care workers have been exposed to death and traumatic experiences (Reger et al., 2020). Thus, a systemic approach is

needed to facilitate priority access to mental health care for health-care workers (Reger et al., 2020). By supporting front-line workers, it will contribute to their mental well-being and ongoing resilience in performing their duties post-pandemic (Santarone et al., 2020).

Section 9: Conclusion

“To do what nobody else will do, a way that nobody else can do, in spite of all we go through — that is to be a nurse.” — Rawsy Williams

At the centre of the historical failures and neglect within Ontario's long-term care sector is inadequate staffing, and the devaluation of seniors and health-care workers, including RNs. It should not have taken such carnage and devastation and a damning military report to lead to action. The provincial government was warned – by RNs, ONA, other key stakeholders and independent experts and – if they had responded appropriately, the horrific impact of COVID-19 on long-term care homes could have been prevented or at least minimized. Lives could have been saved.

Even now, the government of Ontario and licensees of long-term care homes are not doing everything they can to minimize the risks associated with COVID-19 outbreaks, infections, and deaths and to make long-term care nursing safer for RNs and other health-care workers.

The government has not yet implemented all key interim recommendations issued by the Commission.

Early research linking improved COVID-19 outbreak response to RN care hours is promising. For RNs, these findings only reiterate what they already know – more RNs means improved resident care.

Decision-makers must recognize that RNs are the on-the-ground experts during the pandemic. RNs know what needs to be done to protect themselves and their residents, but they must have the resources and support behind them to do so. Creating a supportive, quality practice environment – by ensuring appropriate staffing levels, compliance with IPAC measures, including access to PPE, with strong effective leadership in the homes – is critically important.

The time is now to make monumental changes to Ontario's long-term care system to ensure that seniors receive the quality care and quality of life that they deserve.

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Appendix A

		Findings and Recommendations
Office of the Chief Coroner Inquest Central Park Lodge	1999	<ul style="list-style-type: none"> • All long-term care homes should have a provincially funded Infection Control Practitioner • Long-term care homes rely largely on part-time staff who work in more than one facility and could risk serving as a vector of spreading infection
Price Waterhouse Cooper Report	2001	<ul style="list-style-type: none"> • Ontario long-term care provided the fewest number of nursing hours per resident care compared to other settings • Ontario had the lowest amount of care provided by RNs 11%
<i>“Ownership Matters: Lessons learned from LTC Facilities”</i> (Ontario Health Coalition)	2002	<ul style="list-style-type: none"> • Survey of workers, family members and advocates for long-term care residents expressed concern about inadequate staffing levels and increasingly complex care needs • 80% of workers “did not have enough time to do their jobs, 79% reported working short staffed
<i>“Commitment to Care: A Plan for LTC in Ontario”</i> (Monique Smith)	2004	<ul style="list-style-type: none"> • “Very challenging” staffing issues • More full-time staff required • Recommended a public website that would track staffing levels and ratios, employee retention, inspection reports • Strategic efforts required to promote long-term care as a desirable career option • Administrator role and “philosophy of care” is critical” and makes a difference to quality of care delivered and impacts staffing • Tougher inspection regime
Office of the Chief Coroner Inquest into the deaths of Pedro Lopez and Ezzeldine El Roubi – Casa Verde	2005	<ul style="list-style-type: none"> • Ensure funding model takes into account the higher skill level of staff required for residents with dementia and other mental health problems • Evidence based study to determine appropriate staffing levels • Pending study results long-term care facilities should increase staffing levels to no less than .59 RN hours per resident day(hprd) and 3.06 hprd overall • Increase number of full-time RN positions and increase total % of full-time positions • RN staffing levels must be sufficient to allow RN to have time to adhere to the CNO standards • Staffing standards must ensure RN has sufficient time to collaborate with other health care professionals and sufficient time to adequately supervise teach and delegate to unregulated workers • Develop staffing standards for long-term care including number of RN hours of direct and indirect care per resident, the mix of registered and non-registered staff

		<p>and staff to resident ratios depending on complexity of care needs</p> <ul style="list-style-type: none"> • Track staff to resident ratios, the number of RN hprd and mix of registered and non registered nursing staff • Data regarding staffing, compliance reports should be public
<p><i>"People Caring for People: Impacting the Quality of Life and Care of Residents of LTC Homes"</i> (Shirlee Sharkey)</p>	2008	<ul style="list-style-type: none"> • Government should enhance funding within 4 years to achieve average of up to 4 hprd • Strategies be developed to increase recruitment and retention in long-term care sector
<p><i>"An Action Plan to Address Abuse and Neglect in LTC Homes"</i> (Gail Donner)</p>	2012	<ul style="list-style-type: none"> • Long-term care is a highly specialized area requiring "specialized leaders and skilled staff" to provide care • Need to develop effective leaders • Create a Leadership Development Strategy for the sector that focuses on the principles and practices of effective leadership and management • Increase the number of full time positions to increase continuity of care and consistent staff assignments
<p>Government of Ontario <i>"Aging with Confidence Ontario Action Plan for Seniors"</i></p>	2017	<ul style="list-style-type: none"> • Recognizing the needs of long-term care residents are becoming more complex, increase provincial average to 4 hours of direct care per resident day • Specialty training for health care professionals working with geriatrics and their unique needs
<p>Ontario Health Coalition</p>	2019	<ul style="list-style-type: none"> • Institute a regulated minimum care standard of an average of 4 hours of daily hands-on direct nursing and personal support care per resident
<p>Gillese, E. <i>"The Public Inquiry into the Safety and Security of Residents in Long-term care System"</i></p>	2019	<ul style="list-style-type: none"> • Enhanced training for administrators, directors of nursing and registered staff • Minimize use of agency nurses • Increase the # of registered staff in long-term care homes • Staffing increases over the years had not kept pace with increasing acuity of residents and the regulatory burden associated with implementing the LTCHA • Conduct a study to determine adequate levels of registered staff in long-term care homes on each of the day evening and night shifts
<p>Ontario Ministry of Long-Term Care Staffing Study Advisory Group</p>	2020	<ul style="list-style-type: none"> • Number of staff working in long-term care needs to increase and requires more funding **this includes a minimum daily average of four hours of direct care per resident • Workload and working conditions must get better to retain staff and improve the conditions for care • Excellence in long-term care requires effective leadership and access to specialized expertise

		<ul style="list-style-type: none"> • Staffing in the long-term care sector is in crisis and needs to be urgently addressed. • Requirement for one RN present and on duty at all times should be maintained but updated to consider home size as one RN is not sufficient to meet resident needs in larger homes • Effective leadership is integral to making long-term care a better place to live and work • Ensure access to strong IPAC expertise
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Sources: RNAO (2020); Government of Ontario (2020)