Report to
Rapport au:

Ottawa Board of Health
Conseil de santé d'Ottawa
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File Number: ACS2021-OPH-HPS-0001

SUBJECT: LESSONS LEARNED WORKING WITH LONG-TERM CARE HOMES (LTCHs) DURING THE COVID-19 PANDEMIC

OBJET: LEÇONS TIRÉES DU TRAVAIL EFFECTUÉ DANS LES FOYERS DE SOINS DE LONGUE DURÉE (FSLD) DURANT LA PANDÉMIE DE COVID-1

REPORT RECOMMENDATIONS

That the Board of Health for the City of Ottawa Health Unit:

1. **Receive, for information, key lessons learned from working with Long-Term Care Homes (LTCHs) during the COVID-19 pandemic, as described in this report;**

2. **Approve Ottawa Public Health's recommendations for strengthening the prevention and management of infectious disease outbreaks in Ontario's Long-Term Care Homes, as outlined in this report; and**

3. **Direct that the Chair of the Board of Health write to the COVID-19 Long-Term Care Commission, with a copy to the Premier of Ontario, to share the recommendations and request their consideration in implementing them.**

RECOMMANDATIONS DU RAPPORT

Que le Conseil de santé de la circonscription sanitaire de la ville d'Ottawa :

1. **prenne connaissance des leçons tirées du travail effectué dans les foyers de soins de longue durée (FSLD) durant la pandémie de COVID-19, comme décrites dans le présent rapport;**

2. **approuve les recommandations de Santé publique Ottawa visant à améliorer la prévention et la prise en charge des éclosions de maladies infectieuses dans les foyers de soins de longue durée de l'Ontario, comme décrites dans le présent rapport;**

3. **demande au président du Conseil de santé d'écrire à la Commission d'enquête sur la COVID-19 dans les foyers de soins de longue durée et d'envoyer une copie au premier ministre de l'Ontario pour leur faire part des recommandations et leur demander de réfléchir à leur mise en œuvre.**

EXECUTIVE SUMMARY

Long-Term Care Homes (LTCHs) provide critical care to adults whose needs can no longer be met in the community. The public health unit's role is to support the health and safety of residents and employees by providing Infection Prevention and Control (IPAC) education and outbreak management support to LTCHs. Ottawa Public Health (OPH) accomplishes this through surveillance, outreach/prevention and education, and

timely and effective detection, identification and management of exposures and support to people who test positive and their contacts.

Having identified key lessons learned from the challenges faced in LTCHs during the COVID-19 pandemic, OPH is putting forward a select number of recommendations to promote the safety and well-being of LTCH residents and workers going forward. Other lessons learned and recommendations, such as the importance of incorporating essential caregivers even in outbreak settings, and restricting staff to work at one location, have already been implemented by the province or locally.

Lessons Learned

Complexity in governance, accountability and oversight created challenges in mobilizing emergency response efforts to support LTCHs during outbreaks. Throughout the pandemic, LTCHs experienced unprecedented staffing shortages, which presented challenges in providing consistent care and support for residents and maintaining IPAC practices. In addition, residents with dementia, acquired brain injury (ABI) and memory loss often engaged in high-risk behavior such as wandering, which can pose a risk for spreading COVID-19. The ongoing redirecting of these residents back to their rooms during an outbreak magnifies staffing capacity concerns within LTCHs. Some LTCH workers faced challenging situations where they had to choose between continuing to work with mild symptoms or losing income required to meet basic needs.

LTCHs that successfully managed outbreaks share key factors critical to their success – the ability to cohort (group together) staff and residents that are positive /exposed /negative or isolate residents on-site, access to single rooms for residents, sound staffing practices, 24/7 IPAC oversight and accountability to implement and monitor IPAC practices, and staff's confidence in the facility's leadership to manage outbreaks.

Based on the lessons learned in working with LTCHs during the COVID-19 pandemic, OPH is putting forward four (4) recommendations at this time, aimed at strengthening the prevention and management of infectious disease outbreaks in Ontario's LTC sector:

- **Review governance structures and accountability measures** related to long-term care homes in order to clarify roles, responsibilities and accountability for each agency and service provider working in LTCHs;
- **Investigate ways to standardize and incentivize wages, benefits and employment conditions for health care workers in LTC** to address issues with

recruitment and retention of front-line LTCH employees, in order to maintain the staffing required for care and IPAC practices;

- **Require an adjustment to minimum thresholds of baseline staffing levels** that includes an appropriate mix of education, experience, and skill sets of workers in LTCHs and that is based on residents' needs; and
- **Require each LTCH to hire, train and retain at least one (1) in-house IPAC expert** and have mandatory comprehensive IPAC plans in place, with the means to implement them.

RÉSUMÉ

Les foyers de soins de longue durée (FSLD) fournissent des soins aux adultes dont les besoins dépassent la capacité de la communauté en général. Le rôle du bureau de santé publique est de protéger la santé et la sécurité des résidents et du personnel en fournissant de l'éducation pour prévenir et contrôler les infections, et un soutien pour gérer les éclosions. Pour ce faire, Santé publique Ottawa (SPO) fait de la surveillance, mène des activités de sensibilisation, de prévention et de formation, et prend des mesures pour détecter et prendre en charge rapidement et efficacement les cas d'exposition et le soutien aux personnes dont le test est positif et à leurs contacts.

Après avoir cerné les principales leçons tirées des défis auxquels les établissements de SLD ont été confrontés durant la pandémie COVID-19, SPO présente un certain nombre de recommandations visant à promouvoir la sécurité et le bien-être des résidents et des travailleurs des établissements de SLD à l'avenir. D'autres leçons apprises et recommandations, telles que l'importance d'intégrer les fournisseurs de soins essentiels même dans les contextes d'éclosion, et de restreindre le personnel à un seul endroit, ont déjà été mises en place par la province ou au niveau local.

Leçons tirées

La complexité de la gouvernance, de la responsabilité et du contrôle a créé des difficultés à mobiliser les efforts d'intervention d'urgence pour soutenir les FSLD pendant les épidémies. Tout au long de la pandémie, les établissements de soins de longue durée ont connu des pénuries de personnel sans précédent, ce qui a posé des problèmes pour fournir des soins et un soutien cohérents aux résidents et maintenir les pratiques de prévention et de contrôle des infections. En outre, les résidents atteints de démence, de lésions cérébrales acquises (LCA) et de pertes de mémoire ont souvent eu des comportements à haut risque, comme l'errance, qui peuvent constituer un risque

de propagation de la COVID-19. La réorientation constante de ces résidents vers leur chambre pendant une éclosion amplifie les problèmes de capacité en personnel au sein des FSLD. Certains travailleurs des FSLD ont été confrontés à des situations difficiles où ils ont dû choisir entre continuer à travailler avec des symptômes légers ou perdre le revenu nécessaire pour répondre aux besoins de base.

Les FSLD qui ont réussi à bien gérer les éclosions ont en commun certains facteurs clés : la capacité de créer des cohortes ou d'isoler les patients sur place, l'accès à des chambres individuelles pour les résidents, de saines pratiques de dotation en personnel, une procédure de surveillance et de responsabilisation en matière de prévention et de contrôle des infections (PCI) en vigueur jour et nuit, et la confiance du personnel dans la capacité de la direction à gérer les éclosions.

En fonction des leçons tirées du travail réalisé dans les FSLD durant la pandémie de COVID-19, SPO émet présentement quatre (4) recommandations pour améliorer la prévention et la prise en charge des éclosions de maladies infectieuses dans le secteur des soins de longue durée de l'Ontario :

- Qu'on procède à un examen de la structure de gouvernance et des mesures de reddition de compte afin de clarifier les rôles, les responsabilités et les obligations redditionnelles pour chaque organisme et fournisseur de services en SLD;
- Étudier les moyens de normaliser et de favoriser les salaires, les avantages sociaux et les conditions d'emploi des travailleurs de la santé dans les FSLD pour résoudre les problèmes de recrutement et de maintien en poste des employés de première ligne des FSLD, afin de maintenir le personnel nécessaire aux soins et aux pratiques de PIC;
- Exiger un ajustement des seuils minimums des niveaux de dotation de base qui comprend un mélange approprié d'éducation, d'expérience et de compétences des travailleurs dans les FSLD et qui est basé sur les besoins des résidents;
- Que chaque établissement soit tenu d'embaucher, de former et d'avoir dans ses rangs au moins un (1) spécialiste à l'interne de la prévention et du contrôle des infections (PCI), de concevoir des plans exhaustifs de PCI et de se doter des ressources nécessaires pour les mettre en place.

BACKGROUND

Long-Term Care Homes (LTCHs) provide critical care to adults whose needs can no longer be met in the community. The public health unit's role in supporting the health

and safety of residents and staff in LTCHs is to provide Infection Prevention and Control (IPAC) education and outbreak management support. In applying the *Health Protection and Promotion Act (HPPA)* and Ontario Public Health Standards (OPHS), Ottawa Public Health's (OPH) efforts in long-term care are intended to reduce the burden of communicable diseases and other infectious diseases of public health significance[i].

OPH currently supports these efforts through interventions that include surveillance, outreach/prevention and education, and timely and effective detection, identification and management of exposures and local cases. OPH promotes IPAC practices in LTCHs through different strategies such as annual *Outbreak 101 sessions* (outbreak information and IPAC training), assignment of multi-disciplinary teams to each facility, planned and unannounced site visits, and ongoing outbreak support. Successful outbreak management includes cross-agency and LTCH (and associated Corporate, where relevant) engagement and communication, immediate and ongoing site visits, IPAC and outbreak management education, PPE and hand-hygiene audits, coordinated delivery of swabs for testing, tracking of test results, and can include progressive enforcement actions under the *HPPA*.

During the 2018/2019 outbreak season, for LTCHs alone, OPH's IPAC team conducted approximately 90 IPAC educational visits, including facility IPAC meetings, education and training sessions, and 340 IPAC inspections, including outbreak management inspections, IPAC complaint investigations, and inspections related to the investigation of communicable diseases. Comparatively, in 2020, the team completed approximately 900 IPAC inspections.

In preparation for COVID-19, OPH conducted both scheduled and unannounced site visits and coordinated phone calls with leadership from both the LTCHs and associated Corporations (if applicable). Further, OPH continues to participate in LTCH Steering Committee and IPAC Community of Practice meetings, with ongoing engagement and outreach through various communication strategies (e.g., consultations, Notices, etc.)

OPH has engaged in continuous quality improvement, learning from waves one and two of the pandemic in LTCHs. At this point, the key recommendations in this report are aimed at continuing to promote the safety and well-being of LTCH residents and workers going forward, as we face surges and recovery.

COVID-19 Pandemic

The first confirmed infection of COVID-19 in Canada was detected on January 25, 2020[ii]. At that time, there was a limited understanding of the symptoms, transmission

and mechanisms to interrupt the spread. As community spread increased and more was learned about the virus, public health interventions shifted, including testing criteria. Prior to March 12, 2020, Ministry of Health testing criteria was focused on individuals who had travelled internationally, were experiencing symptoms, or were in close contact with someone who had tested positive. As demands rose and testing capacity and resources became limited, the criteria evolved to prioritize people at highest risk - close contacts, people admitted to hospital with symptoms, and people who were part of an ongoing outbreak in either LTCHs or retirement residences. Testing provided a better understanding of asymptomatic transmission and the period of communicability, which led to ongoing surveillance testing in long-term care homes.

The first impacts of the pandemic on LTCHs in Ottawa were felt in April 2020, with 670 LTCH residents and staff testing positive in that month alone, representing 54% of all infections reported in Ottawa that month[iii]. Declaration of outbreaks followed the Ontario Ministry of Health definition of an outbreak - LTCHs "must consider a single, laboratory confirmed case of COVID-19 in a resident or staff member as a confirmed COVID-19 outbreak in the home" (*Ministry of Health COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH) Version 2 - April 15, 2020, p.7*). Outbreaks are declared in collaboration between the home and the local public health unit. Enhanced IPAC measures implemented to address the risks to LTCHs included: enhanced screening practices; addressing staff presenting to work while mildly symptomatic; facility-wide isolation; staff and resident cohorting; restricting visitors and short-stay absences for residents; introducing regular surveillance testing of staff; and increased IPAC education for all homes. By October 2020, 10% of all individuals testing positive in Ottawa that month were LTCH residents or staff; in December 2020, the figure was 3.6%.

According to OPH's COVID-19 Epidemiology update, between March and December 2020, OPH investigated 78 outbreaks spanning 26 of 28 LTCHs in Ottawa, with a total of 1,540 individuals testing positive (634 staff and 906 residents). There were 282 deaths associated with the outbreaks in LTCHs, including two staff deaths. In reviewing COVID-19 outbreak information reported from Ottawa's LTCHs since the start of the pandemic, a combination of factors contributed to mitigating the impact of COVID-19 in this vulnerable population, including enhanced detection, robust contact tracing efforts, and improved IPAC measures.

Table 1. Comparison of LTCH COVID-19 outbreak indicators between spring and fall 2020, Ottawa

Indicator	Spring	Fall
Average duration (days)	43	28
Average number of residents testing positive	34	6
Average number of staff testing positive	20	5
Fatality rate among residents	38.5%	17.0%

Notes:

1. Data on confirmed COVID-19 infections are from the COVID-19 Ottawa Database (COD) as of 2:00 p.m. on December 31, 2020.
2. Spring includes outbreaks declared in March, April, and May and all associated infections and deaths. Fall includes outbreaks declared in September, October, and November.

DISCUSSION

Lessons Learned

A number of reviews of factors associated with the devastating outcomes in LTCHs during the COVID-19 pandemic have identified common elements that resonate with the experience of the OPH team. For example, the Ontario Government's LTC COVID-19 Commission and the Ontario COVID-19 Science Advisory Table have noted gaps in the early response and have made recommendations. The Commission's interim recommendations are summarized in Document 1, attached. OPH presented to the Commission, supports many of their recommendations, and has worked to address their recommendations where relevant to OPH's role. As OPH continues to respond to subsequent waves and recover, staff will further consult with the LTC sector to expand on lessons learned and future recommendations.

As others have noted, during the first wave of the pandemic, OPH observed that LTCHs experienced barriers to procurement and access to adequate PPE when OPH recommended universal masking in homes early on in the response, delays in testing turnaround times to identify people who tested positive and in order to implement adequate cohorting, and unprecedented staffing shortages, which presented challenges

in providing consistent care and support for residents and in implementing IPAC measures.

As a result of COVID-19 outbreak measures that limited visitors and cancelled therapeutic group activities, residents living in homes with a declared outbreak were isolated to their rooms for purposes of preventing further transmission. As proactive prevention measures early in the pandemic, some homes applied similar restrictions in the absence of an outbreak from fear of COVID-19 entering their facilities. This has led to a broad range of negative consequences, including a rapid decline in the mental or physical health of residents and significant distress among family members unable to visit. To respond to social isolation and essential care needs of residents in LTCH, OPH has collaborated with various partners (The Ottawa Hospital, Elisabeth Bruyère Hospital, LTC networks, etc.) and promoted stakeholder engagement with resident and family councils to identify solutions and recommendations to alleviate these issues. OPH also participated in work to convey the vital nature of essential caregivers and promote practices to include these caregivers in homes even during an outbreak.

The physical layout of most LTCHs includes multi-resident rooms with limited space, making cohorting of staff and COVID-19 positive residents difficult. Cohorting of staff results in more demands on employees to complete their work effectively, including the added time and effort needed to perform heightened environmental cleaning and IPAC practices. Cohorting also changed staff's typical workflow, limiting their movement within the facility. As a result, when cohorting was introduced, LTCHs had to adjust how they staffed each shift. During the pandemic, several enhanced measures were implemented to enforce physical distancing rules within LTC facilities, increase bed availability in order to create isolation rooms within the homes, and ensure sufficient clinical and non-clinical workers were available in the event of staff shortages. These measures all contributed to staffing issues in LTCHs experiencing outbreaks.

LTCHs have a high number of residents with dementia, acquired brain injury (ABI), and memory loss and these residents often engage in behavior that creates greater risk of COVID-19 transmission, such as wandering. OPH noted residents unintentionally entering each other's rooms or initiating physical contact, posing a risk for spreading COVID-19. The additional challenges that some clients with dementia and ABI pose are a result of their decreased cognition and increased confusion, making it difficult for them to consistently adhere to expectations of self-isolation and physical distancing without constant intervention. Accordingly, homes with residents with more complex needs require more support to control outbreaks of COVID-19.

OPH supported an evolution in the testing strategy in LTCHs, including working with city and hospital partners to rapidly implement the first round of surveillance testing. Early and ongoing surveillance testing identified infections quickly and allowed OPH to implement outbreak strategies within facilities to halt transmission. The introduction of active surveillance became key to identifying asymptomatic infections, which would have otherwise gone undetected and would have led to more severe and prolonged outbreaks.

At times, lab capacity issues caused delays in receiving test results, which in turn delayed facility cohorting strategies and contributed to difficulties in facilities' ability to manage outbreaks. OPH actively engaged with local labs to streamline processes to increase both testing and lab capacity to ensure a timely turnaround of test results. OPH efforts supported the development of the *lab prioritization matrix* (the provincial testing criteria and ongoing messaging about testing criteria/priorities), which led to a testing strategy that ensured that those who most needed testing were tested and prioritized by the laboratories.

As noted by the Science Table, communities at higher risk for COVID-19 infection, lower income and racialized communities, often newcomers with more crowded housing conditions, include members of the LTCH front-line work force. As an example of the link between inadequate housing and work in LTC that amplifies risk of COVID-19 transmission, OPH identified COVID-19 transmission from a long-term care home to a shelter, where a LTCH worker was residing. OPH has sought to address this risk by supporting LTCH workers who may require shelters to make use of the voluntary self-isolation centre opened by OPH. Further, during the pandemic, OPH observed staff continue to work with mild symptoms for fear of lost wages required to meet basic needs, and case managers have connected workers who test positive to emergency social service supports.

OPH's experience and observations are that LTCHs that successfully managed outbreaks all have key factors critical to their success – the ability to cohort or isolate on-site those who have tested positive, access to single rooms for residents, sound staffing practices, and 24/7 IPAC oversight and accountability for implementing and monitoring IPAC practices. LTCH staff's confidence in their leadership to effectively respond to the pandemic and keep residents and staff safe was also found to be an important factor in successfully managing outbreaks. Examples of sound staffing practices include: adequate number/representation of full-time and regular part-timers; decreased reliance on agency staff to fill shift needs reactively; ability to staff-up to respond quickly to outbreaks and staff shortages; visible presence of and supervision

under regulated health care professions; good staff retention/low staff turnover rates; facility policies that support staff and reduce potential for burnout.

Facilities without these factors experienced more severe and challenging outbreak scenarios.

As previously stated, public health units' mandate in relation to COVID-19 in LTCHs is to reduce the burden and transmission of infectious diseases by promoting IPAC practices and outbreak management strategies. OPH is not mandated nor resourced to address specific gaps in leadership accountability, staffing shortages, nor to provide 24/7 on-site IPAC oversight. To address these gaps in the early stages of the pandemic, OPH took on roles not traditionally assigned to public health, effectively supporting facilities with IPAC oversight. OPH also worked with the Ministry of Health, Ministry of Long-Term Care, and Ontario Health, highlighting the existence of these gaps and the importance of addressing them in order to limit the spread and reduce risks of COVID-19.

The complexity in the governance, accountability and oversight approaches for LTCHs and the agencies that support them includes provincial, regional and municipal organizations, which created challenges when mobilizing emergency response efforts. Early in the pandemic, this resulted in challenges with moving staff resources to support LTCHs in critical need. Pandemic operations require a coordinated response across various levels of government, agencies and sectors, based on their respective mandates and reporting structures. Addressing gaps and challenges across the current system required that local partners work together to clarify their respective roles in addressing the various needs of LTCHs experiencing outbreaks and other adverse events during the pandemic. Through these efforts, oversight and enforcement of illness prevention and health promotion interventions were consistently applied across agencies. OPH learned from wave 1 that issuing *HPPA* Section 29 Orders to operators in situations of complex, prolonged and challenging outbreaks was a mechanism to more rapidly add supports to a home. These orders were issued in three instances to enable an acute care partner (The Ottawa Hospital), to assume leadership of these homes in order to control infection rates, reduce ongoing transmission, and address non-compliance issues with IPAC and outbreak management strategies.

In line with the recommendation of the LTC COVID-19 Commission, OPH has strengthened cross-agency and LTCH collaboration and communication through weekly/ongoing meetings, and OPH participation in Regional IPAC Team and LTC Community of Practice. OPH also continues to collaborate directly with agency partners,

including *Ontario Health*, *Ministry of Long-Term Care*, *Retirement Homes Regulatory Authority* and many of Ottawa's acute care partners. The cross-agency collaboration has contributed significantly to the coordination and enhancement of oversight and more rapid support for LTCHs with staffing and IPAC and the resulting improvement in outcomes for residents and staff from wave 1 to present. OPH has, and continues to play, a leadership role in implementing IPAC and outbreak management guidance from regional and provincial partners. OPH participates in various Regional Taskforces, including IPAC, surveillance, testing, etc.

Once the COVID-19 vaccines were available in Ontario, OPH recommended that LTCH populations be the top priority for vaccination. At the time of this report, all LTCHs have had mobile COVID-19 vaccination teams on-site to provide first and second doses of a COVID-19 vaccine. OPH will continue to monitor COVID-19 in homes to help evaluate the impact of the immunization of residents, staff and essential caregivers. OPH continues to promote a culture of immunization in LTCHs and will ensure staff are offered ongoing opportunities for immunization.

Reflections on lessons learned and recommendations from other reviews will continue to inform OPH's strategies for the current surge and post-COVID recovery. OPH will continue to report observations and identify solutions to partners who can implement policy and procedural changes to improve the pandemic response in LTCHs. OPH strategies are focused on ongoing outbreak prevention efforts, ongoing collaboration with agencies, involvement at various regional tables (e.g., Regional IPAC Team, Testing Taskforce), ongoing stakeholder engagement (e.g., with LTCH and family/resident councils) and work on applying an ethical framework to outbreak management (e.g., to better consider the impacts of resident isolation).

Priority Recommendations

Based on the lessons learned to date, OPH is prioritizing four (4) recommendations at this time, as described below, with the goal of strengthening the prevention and management of infectious disease outbreaks in Ontario's LTC sector. Specifically, OPH is recommending that the Government of Ontario:

1. **Review governance structures and accountability measures related to LTCHs, as well as those of the provincial, regional and municipal/local agencies that work with and support them, to ensure clarity with respect to roles, responsibilities and accountability** regarding the mobilization of resources such as staffing and emergency support, the procurement and management of personal protective equipment (PPE), designated leadership,

and IPAC accountability and oversight. The Province should consider having representation from the LTC sector in regional systems planning and implementation tables. Based on the successes of partnerships with hospitals to date, the Province may want to also consider mandating that each LTCH be required to establish a formal partnership with at least one (1) acute care hospital in order to coordinate a rapid response when there are specific concerns related to outbreak management, a request for IPAC consultation, and/or temporary need for increased resources and support.

2. **Investigate ways to standardize and incentivize wages, benefits and employment conditions for health care workers in LTCHs** to address issues with recruitment and retention of front-line LTCH employees, in order to maintain the staffing required for care and IPAC practices. Approaches that limit people working multiple jobs /across different homes, and which enable workers to stay home when sick without jeopardizing their basic needs, are recommended to limit transmission of infections. When employees can stay home when ill without financial repercussions, such as when they have access to paid sick leave, the risk of transmission of infectious illnesses within homes, and resulting costly outbreaks, will be reduced. Some potential options for standardizing wages include: a new category of minimum wage for LTC workers, application-based wage subsidies for LTCHs, or having a percentage of staff positions designated as ministry-funded, similar to ministry-funded beds that are available in other sectors. Improving compensation and job security in this sector would have the added benefit of reducing the need for workers to have two or more concurrent positions at different facilities or across different sectors, including home care and social services, a factor that has led to infection transmission and outbreaks during the COVID-19 pandemic in Ottawa.

3. **Examine and define appropriate staffing levels for the various types of positions among front-line LTC workers so that the mix of positions and staffing levels reflect the individual facility's needs, during every shift, and are based on residents' acuity and complexity of care**. Financial compensation and benefits are not the only solutions needed with regards to staffing in LTCHs to promote IPAC practices. Another factor to consider is that simply increasing the number of staff will not address effective and timely responses to future outbreaks. Ensuring staff have the knowledge, experience and scope of practice to manage outbreaks and implement the required IPAC strategies is essential going forward. Review of the current minimum standards

for the number and type of health care providers on shift, and introducing accountability mechanisms to ensure adherence to new standards will also be important. Further, given that wandering residents contributed to transmission of COVID-19 within some LTCHs, the sector should collaborate with educational institutions on the curriculum for health care workers specific to LTC, with a focus on dementia/ABI and the management of responsive behaviours. Consideration should also be given to establishing standards and requirements with respect to hiring workers with explicit knowledge of how to support residents with dementia or other acquired brain injuries that cause individuals to engage in risky wandering behaviour.

4. **Require each home to hire, train, and retain at least one (1) in-house IPAC expert and to have a comprehensive IPAC/outbreak plan in place with the means to implement it**. Given the shortage of IPAC experts available for hire, a focus on supporting homes to internally “skill-up” the leads in each home is recommended. Additionally, homes should require an annual demonstration of IPAC competencies for each staff. The Ministry of Long-Term Care should make comprehensive IPAC outbreak plans a requirement of licensing, to be enforced with compliance inspections. This would ensure that accountability for IPAC practices remain primarily the responsibility of each home’s leadership.

RURAL IMPLICATIONS

There were no rural implications associated with this report.

CONSULTATION

No public consultation was undertaken in preparing this report.

LEGAL IMPLICATIONS

There are no legal impediments to receiving the update on lessons learned from the pandemic, as outlined in this report, and in approving recommendations 2 and 3 of this report.

RISK MANAGEMENT IMPLICATIONS

There are no risk implications associated with this report.

FINANCIAL IMPLICATIONS

There are no direct financial implications associated with this report.

ACCESSIBILITY IMPACTS

There are no accessibility impacts associated with this report.

SUPPORTING DOCUMENTATION

Document 1 - Long-Term Care COVID-19 Commission – Summary of Interim Recommendations

DISPOSITION

Following Board approval of this report, the Board Secretary will assist the Chair in preparing a letter to the COVID-19 Long-Term Care Commission and Premier of Ontario, as referenced in recommendation 3.

Document 1

Long-Term Care COVID-19 Commission – Summary of Interim Recommendations

The Commission published two interim reports, released on October 23, 2020 and December 4th 2020, highlighting important considerations for all stakeholders and partners to action moving into the surge and recovery phases of this pandemic. These reports emphasized the need to prioritize work in several key areas based on information collected over the course of the first and second waves experienced by Ontario residents and care providers in LTC homes.

First Interim Recommendations

This initial report identified gaps in IPAC knowledge and effective leadership in LTCHs across the province. Three areas requiring immediate intervention included the staffing and human resource needs in LTC, the need to improve and facilitate intersectoral collaboration and communication, and the importance of standardized IPAC measures. Specific strategies identified included:

- Addressing inadequate workload and staff-to-resident ratios
- Optimizing a mix of qualified staff and supervisory roles in each facility and for each shift
- Creating staff consistency and improving recruitment/retention with the establishment of more full-time/permanent positions over casual and part-time
- Promoting opportunities for ongoing learning and development of staff related to IPAC
- Including visible, on-site, active leadership in each facility (IPAC experts, NPs etc.)
- Maintaining clear protocols to ensure rapid response / contingency plans to manage outbreaks (e.g., when and where to enact decanting of residents)
- Ongoing collaboration between partners in LTC, acute care hospitals, and public health

Second Interim Recommendations

The follow-up report focused on resident quality of care and outlined ways to reduce the impact of the virus's spread using factors within the control of the LTCH. It emphasized

effective leadership by skilled staff with appropriate expertise, ensuring accountability through compliance, and improving the flow of information between governmental agencies representing health and long-term care. Specific strategies emphasized included:

- Establishing skilled IPAC leads and defining the IPAC roles and responsibilities in each LTCH
- Developing more meaningful measures of quality of care that include resident satisfaction and family engagement
- Intentional planning to prioritize the most vulnerable residents (surveillance, testing, vaccines, etc.)
- Reinstating annual Resident Quality Inspections (RQIs)
- Continuing to build communication, knowledge transfer, and collaboration efforts between MLTC and public health agencies to eliminate working in silos

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[i] Ministry of Long-Term Care, Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, pg. 42

[ii] Bronca, T. (2020, April 8). *COVID-19: A Canadian timeline*. Retrieved from Canadian Healthcare Network: https://www.canadianhealthcarenetwork.ca/covid-19-a-canadian-timeline

[iii] Special Focus: Outbreaks of COVID-19 in Long-Term Care Homes, Ottawa Public Health. January 11, 2021.