Newfoundland and Labrador

LONG TERM CARE AND PERSONAL CARE HOME REVIEW

Expert Advisory Panel Recommendations

Final Report – January 20, 2025

INTRODUCTION FROM THE EXPERT ADVISORY PANEL

January 2025

Long Term Care and Personal Care Home Program Review Expert Advisory Panel

We, the members of the Expert Advisory Panel are pleased to present our final report on the Long-Term Care and Personal Care Home Program Review to the Minister of Health and Community Services.

The goal of the review was to identify opportunities to improve quality of care and quality of life of residents, enhance staff engagement, and improve quality of staff work-life.

We acknowledge with thanks the significant contributions of the residents, their families, long-term care (LTC) and personal care home (PCH) staff and stakeholder organizations who came prepared, and proposed recommendations for our consideration. The many face-to-face focus groups at the 15 care homes we visited in all 5 Provincial Health zones provided invaluable insights to the challenges that are faced in the LTC and PCH sector and the opportunities to build on existing best practices. Information from the nearly 3,000 surveys, the 55 focus group meetings with key stakeholders either virtually or in-person, and the many letters from concerned citizens were considered in our recommendations. We met regularly with the Ministerial appointed Community Stakeholder Committee who were instrumental in keeping the key aspects of the review in focus.

Members of the Expert Advisory Panel are extremely grateful to senior staff in the Department of Health and Community Services who continuously provided the research and documentation we needed. We also acknowledge with thanks the diligence of the contracted consultant group MNP to record and summarize the outcomes of our activities, provide a literature review and jurisdiction scan, and estimate the costs of the proposed recommendations. We appreciate their commitment to ensure the final report is of high-quality.

The 23 recommendations set out herein are designed to prioritize resident quality of life and high-quality resident-centred care, ensure appropriate staffing levels, skill mix and competencies to support a healthy and engaged workforce. We have detailed the key actions areas required to support achieving these recommendations. We believe that the LTC and PCH sector is ready for change; and what is needed now is leadership commitment to invest in and drive transformation throughout the sector.

It has been a privilege to be a part of this important work. Like so many of the residents, their families, and the stakeholders we engaged, we feel a strong investment in these recommendations and are eager to see them implemented. Our hope is that the key recommendations we have identified in this report will serve as priorities to begin transforming the LTC and PCH system in Newfoundland and Labrador.

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Leslie Daye
Family Member Representative

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LIST OF ACRONYMS

AB	Alberta
ABE	Adult Basic Education
ABS	Aggressive Behaviour Scale
ADL	Activities of Daily Living
AH	Alberta Health
AHS	Alberta Health Services
BC	British Columbia
BMS	Behaviour Management Specialist
CASLP	College of Audiologists and Speech-Language-Pathologists
CCAs	Continuing Care Assistants
CCALA	Community Care and Assisted Living Act
CCT	Continuing Care Transformation
CEO	Chief Executive Officer
CHESS	Changes in Health, End-Stage Disease and Signs and Symptoms
CIHI	Canadian Institute for Health Information
CLPNNL	College of Licensed Practical Nurses of Newfoundland and Labrador
CMI	Case Mix Index
CPS	Cognitive Performance Scale
CPSNL	College of Physicians and Surgeons of Newfoundland and Labrador
CRNNL	College of Registered Nurses of Newfoundland and Labrador
CSA	Canadian Standards Association
CUPE	Canadian Union for Public Employees
DCH	Direct Care Hours
DGSNL	Digital Government and Service NL
DHCS	Department of Health and Community Services (Newfoundland and Labrador)
DRS	Depression Rating Scale
DSLTC	Department of Seniors and Long Term Care (Nova Scotia)
EAP	Expert Advisory Panel
ECPs	Essential Care Partners
EDI	Equity, Diversity, and Inclusion

FCI	Facility Condition Index
FTE	Full-Time Equivalent
GNL	Government of Newfoundland and Labrador
HANL	Health Accord for Newfoundland and Labrador
HCA	Health Care Aide
HCAP	Health Career Access Program
HHR	Health Human Resource Plan
HPSW	Home and Personal Support Worker
HQO	Health Quality Ontario
HSO	Health Standards Organization
HSO National LTC Standard	Health Standards Organization National Long-Term Care Services Standard
IENs	Internationally Educated Nurses
LTC	Long Term Care
LTCAs	Long Term Care Assistants
LEAP	Learning Essential Approaches to Palliative Care
LOC	Levels of Care
LPN	Licensed Practical Nurse
MAPLe	Method for Assigning Priority Levels
MNP	MNP LLP
MS	Microsoft
NAPE	Newfoundland and Labrador Association of Public and Private Employees
NL	Newfoundland and Labrador
NLCSW	Newfoundland and Labrador College of Social Workers
NLHS	Newfoundland and Labrador Health Services
NLMA	Newfoundland and Labrador Medical Association
NP	Nurse Practitioner
NS	Nova Scotia
ON	Ontario
OSA	Office of the Seniors Advocate
OT	Occupational Therapist
PCA	Personal Care Attendant
PCBF	Patient-Care Based Funding

PCH	Personal Care Home
PSW	Personal Support Worker
PT	Physiotherapist
QIs	Quality Indicators
QoL	Quality of Life
QoL TF	Quality of Life Task Force
RAI-HC	Resident Assessment Instrument – Home Care
RAI-LTCF	Resident Assessment Instrument – Long Term Care Facilities
RAI-MDS 2.0	Resident Assessment Instrument Minimum Data Set 2.0
RCM	Resident Care Manager
RN	Registered Nurse
RNUNL	Registered Nurses Union of Newfoundland and Labrador
RS	Recreation Specialist
RTW	Recreation Therapy Worker
SCCIP	Story-Centred Care Intervention Program
SLP	Speech Language Pathologist
SW	Social Worker
SWA	Social Work Assistant
VP	Vice President

EXECUTIVE SUMMARY

Continuing care programs in Newfoundland and Labrador (NL) provide services that aid with activities of daily living (ADL), meal preparation, nursing care, medication administration, respite care, palliative care, and various other health care and support services. These services and supports may be provided in different settings including an individual's home, community-based service locations such as adult day programs, personal care homes (PCHs), and long term care (LTC) homes. Individuals undergo a clinical assessment to determine the level of supports and services to best meet their needs.

LTC homes provide care and accommodation to seniors and adults with complex care needs requiring daily access to nursing care (Level III and IV care needs). Provincially, there are 3,296 LTC beds in 43 LTC homes including stand-alone facilities or sites located within or attached to acute care health centres. All LTC homes in NL are publicly operated by Newfoundland and Labrador Health Services (NLHS), except for one privately owned home where some beds are publicly subsidized.

PCHs are licensed, privately-owned, and operated by not-for profit and for-profit entities. PCHs provide care and accommodations to seniors and other adults requiring assistance with the activities of daily living (Level I, II and Enhanced Care needs). PCH residents do not require on site health or nursing services but may require the service of a visiting professional. Provincially, there are 5,477 PCH beds in 87 PCHs.

The COVID-19 pandemic amplified the persisting challenges that existed in the continuing care sector across Canada for many years, including in NL. Since the COVID-19 pandemic, there has been a strong focus on improving continuing care services across Canada. There is recognition that all seniors deserve to age with dignity, safety, and comfort regardless of where they live. This recognition has resulted in the recent development of the Health Standards Organization (HSO) National Long-Term Care Services Standard and recent investments by the Federal Government through Aging with Dignity to improve the quality of life of Canadians as they age.

NL is experiencing a change in demographics including declining birth rates, increased migration of young people and families out of province, an aging population, and an increase in the number of people choosing to move to urban communities[1]. The demand for health and social programs, in NL has been consistently rising with the increase in population of people aged 65 years and over, which is projected to be 29% of the population by 2036. This rapidly changing demographic has raised concerns about the sustainability of LTC and PCH programs.

Similar to other provinces, the health system in NL has been slow to adjust to the evolving needs of a changing demographic. It is recognized that acute care is not equipped to meet the needs of individuals who require supportive care, and there is need for increased access to quality continuing care services.

The LTC and PCH programs in NL are experiencing an increasing demand for services, challenges recruiting and retaining staff, a changing workforce, and public calls to address negative care

experiences, all of which were amplified during the response to COVID-19. It is with this context that the Government of Newfoundland and Labrador (GNL) identified the need for a provincial review of LTC and PCH programs to identify opportunities for improvement in four areas including quality of life, quality of care, quality of staff work life, and governance. Additionally, the Minister of Health and Community Services appointed an Expert Advisory Panel (EAP) to facilitate and oversee the Review. The EAP consisted of members who have expertise in older adult care and a member with lived/living experience including:

- Dr. Janice Keefe; Chair/Full Professor, Department of Family Studies and Gerontology, Mount Saint Vincent University; and Director, Nova Scotia Centre on Aging.
- Dr. Susan Mercer; Clinical Chief, Older Adult Care, Eastern Urban Zone, NLHS; and Assistant Professor, Family Medicine, Memorial University.
- Leslie Daye; Family Member with Lived/Living Experience; and Instructor at College of the North Atlantic.
- Kelli O'Brien; Vice President, Quality & Learning Systems, NLHS; and formerly President and CEO, St. Joseph's Care Group.

The role of the EAP was to:

- Identify opportunities to improve quality of care and quality of life of residents, improve staff engagement and quality of staff work-life, based on best evidence, and informed by relevant stakeholders.
- Oversee the review and provide expert advice to the external consultant and the Minister.
- Ensure the review supports cultural safety and humility and includes the principles of resident-centered care that value dignity, transparency, respect, diversity, and inclusion.
- Ensure recommendations are actionable, future focused and resident centred[2].

MNP LLP ("MNP"), a Canadian accounting and consulting firm, was selected and engaged by the GNL through a competitive process to support the work of the EAP.

The Review was informed by four main sources of information:

- Stakeholder engagement with over 400 people including in-person focus groups at 15 LTC/PCH sites across the province, engagement with a Ministerial appointed Community Stakeholder Committee, virtual focus groups, and over 3,000 survey responses.
- An internal environmental scan of existing data and information sources within the province.
- A literature review of national and international leading practices.
- A jurisdictional review of leading practices in other Canadian provinces including Nova Scotia, Ontario, Alberta, and British Columbia.

The Review conclusions highlight several opportunity areas for improving LTC and PCH service delivery in NL.

Review Conclusions

The following conclusions were drawn related to LTC and PCH quality of life, quality of care, workforce and governance based on an analysis of the findings from the Review.

Quality of Life Conclusions

LTC Conclusions

1. NL is currently performing better than the national average for six LTC quality indicators (QIs) including Falls in the Last 30 Days, Worsened Pressure Ulcer, Experiencing Worsened Pain, Worsened Depressed Mood, Improved Physical Functioning, and Worsened Physical Functioning. NL is performing under the national average for three LTC QIs including Potentially Inappropriate Use of Antipsychotic Medication, Restraint Use, and Experiencing Pain and there is an opportunity to update practices in these areas to improve quality of service delivery.
2. Stakeholders perceive there to be relatively strong relationships between staff and residents in LTC homes. The average rating for relationships between residents and staff was among the highest rated quality of life dimension for LTC survey respondents.
3. Opportunities identified to improve quality of life include, but are not limited to, the quality and choice of meals provided, more meaningful recreational and social activities, prioritized and enhanced emotional well-being supports, enhanced partnerships with community organizations, and more effective use of resident and family councils. Stakeholders also identified a need to increase autonomy and maintain dignity and respect for residents during staff interactions.
4. Stakeholders identified a need to enhance dementia training and supports for staff, residents, families, and essential care partners (ECPs) in LTC homes.
5. Volunteers were perceived to be underutilized in LTC homes and there is a need to standardize practices among health zones for volunteer recruitment, roles, and training.
6. Eighteen of the 22 LTC homes that are 30 years or older in NL had facility condition index (FCI) scores greater than 30% indicating these homes have a higher percentage of components that have reached the end of their projected useful life and might need renovation or replacement. Further, focus group and survey results identified inconsistent "home-like environments" due to shared rooms and small common areas resulting in residents feeling like they live in an institutional setting.
7. Stakeholders indicated that residents have experienced challenges with being separated from their spouses upon admission into LTC homes.

PCH Conclusions

1. Stakeholders perceive there to be relatively strong relationships between staff and residents in PCHs. The average ratings for relationships between residents and staff was among the highest rated quality of life dimension for PCH survey respondents.

2. Stakeholders perceived there to be autonomy and dignity for PCH residents. The average ratings provided by PCH residents, families and ECPs were high for both the autonomy for residents and the dignity for resident quality of life dimensions.
3. Opportunities identified to improve quality of life include, but are not limited to, expanded meal choices to incorporate traditional dishes, more meaningful recreational and social activities (satisfaction varied across sites), better access to emotional well-being supports, enhanced partnerships with community organizations, and better utilization of volunteers to support PCH residents.
4. Stakeholders identified a need to enhance dementia training and supports for staff, residents, and families in PCHs.

Quality of Care Conclusions

LTC Conclusions

1. As a result of concerns raised during the COVID-19 pandemic the Department of Health and Community Services (DHCS) requested homes operated by NLHS conduct LTC resident quality of care audits. Audits continue to be completed on a quarterly basis.
2. NL launched a three-year *Dementia Care Action Plan* for the period from 2023 to 2026 to improve awareness of dementia, improve coordination and quality of supports and services, and support professional development of staff.
3. Focus group and survey respondents identified a need to improve clinical leadership in LTC homes.
4. Stakeholders indicated that accessing allied health services and clinicians such as physiotherapy, occupational therapy, social work, behaviour management, dietetic services, audiology, dental hygiene services, and speech language pathology in LTC is challenging and requires improvement.
5. In 2022/23 over 55% of LTC residents were assessed with a depression rating scale of one or higher, which indicates a potential or actual problem with depression. Focus group and survey respondents also reported a need to improve access to mental health and addictions services.
6. Focus group participants and survey respondents perceived that increasing hours of care could improve the overall quality of care provided to LTC residents. Other provinces in Canada have also recently made investments to increase direct hours of care in LTC including Alberta, Ontario, and Nova Scotia.
7. NL currently has a higher proportion of RNs and LPNs (53%) in the direct care hour staff mix compared to other Canadian jurisdictions (ranges from 20% to 30%). Shifting the staff mix towards a higher proportion of PCAs could allow RNs and LPNs to work to their full scope of practice and align the staff mix in NL with other Canadian provinces.

8. Focus group participants and survey respondents identified a need to enhance teamwork and collaboration in LTC to ensure residents, families and ECPs are included as part of the care team.
9. Stakeholders identified a need to improve the use of technology and digital health services in LTC homes.

PCH Conclusions

1. NL has introduced several new programs to increase community based supportive care options. Recent demonstration projects introduced by DHCS include Community Based Rehabilitation and Restorative Care, Enhanced Dementia Care, and Adult Day Programs. In addition, the Short Stay Option in PCHs offers urgent and short-term placements in PCHs for individuals facing challenges in returning to their previous living arrangements after presenting to acute care.
2. DHCS recently increased the subsidy rates for eligible residents based on the level of care required (I, II, Enhanced, or III).
3. Focus group participants identified a need for increased clinical oversight by community health nurses due to a perceived increase in resident care needs and higher demand for delegation of nursing tasks to unlicensed personal support workers, such as medication administration and wound care.
4. Data accessed from CIHI for Method for Assigning Priority Levels (MAPLe) Activities of Daily Living (ADL), and Depression Rating Scale (DRS) shows increasing acuity of PCH residents, consistent with level of care data trends. There is an opportunity to improve assessment and care/support planning to better address needs of PCH residents, especially those with higher care/support needs.
5. Stakeholders identified a need to improve training and education of PCH staff to better support care needs and increasing resident acuity.
6. Focus group participants and survey respondents indicated challenges with accessing occupational therapy, physiotherapy, and mental health resources.
7. Stakeholders identified a need to increase PCH staffing levels overnight to support resident safety and security.

Workforce Conclusions

LTC Conclusions

1. NL is committed to improving workforce recruitment and retention. The DHCS has completed or is in the process of completing multiple health sector workforce studies, such as the Nursing Think Tank and the Strategic Health Human Resources (HHR) plan. These investments demonstrate the province's commitment to improving the health sector workforce in NL including LTC.

2. NL has been proactive in recruiting internationally educated nurses (IENs) to address LTC staffing challenges. The standardized pathway currently in practice supports nurses to transition into their roles and assists with filling LTC workforce gaps.
3. Stakeholders identified challenges with workplace culture in LTC homes including siloed workplace dynamics which limited input from certain staff roles in care planning.
4. Staff rated workplace morale and workplace satisfaction below 5 out of 10. Elements impacting workplace morale included high-turnover, high levels of burnout among staff, and challenges with maintaining a work-life balance.
5. Focus group participants identified challenges related to racism towards staff, especially internationally recruited employees.
6. Focus group participants noted inconsistencies in leadership and management structures within LTC homes across the province which can influence staff culture and behaviours. There were perceptions of some LTC homes being "top heavy" having several personnel in non-care related roles such as managers, clinical educators, clinical facilitators, and resident care coordinators. Additionally, access to managers was perceived as more limited in larger homes compared to smaller ones. This has created task-based cultures at LTC homes and limited access to leadership, negatively impacting staff morale and satisfaction.
7. Stakeholders identified opportunities to improve awareness of LTC careers to high school students, as well as to provide more incentives and bursaries for staff and/or students to complete training and education.
8. Stakeholders identified opportunities to increase the frequency of hands-on training and education and to ensure that training is paid for and offered during working hours.
9. Stakeholders identified a need to provide additional mental health and wellness supports for LTC staff to improve their overall well-being.

PCH Conclusions

1. Focus group participants expressed a need for personal support workers to receive training to better support residents' care needs, including mental health, addictions, and dementia care, as well as for identifying early signs of resident decline. Stakeholders also reported a need to increase the frequency and amount of training offered to PCH staff to improve workforce retention.
2. Unlicensed staff rated workplace morale and workplace satisfaction below 5.5 out of 10. Elements impacting workplace morale included high-turnover, high levels of burnout among staff, and challenges with maintaining a work-life balance.
3. Stakeholders perceived that increasing wages and benefits for PCH staff would improve recruitment and retention of the workforce. DHCS recently introduced a requirement for PCHs to compensate their staff at a minimum wage rate of $18.00 per hour as of April 1, 2024.

Governance Conclusions

LTC Conclusions

1. Stakeholders reported challenges with the assessment, placement, and admission process for LTC homes. Concerns were raised about inaccurate assessments affecting resident placement and continuity of care, long wait times and delays in LTC placement, and late-night admissions impacting resident quality of care. Stakeholders identified a need for a more holistic assessment model that incorporates trauma informed care and input from multi-disciplinary team members as necessary.
2. The Provincial Long Term Care Operational Standards were developed in 2005 and are in the process of being revised and updated to reflect and prioritize resident quality of life and resident-centred care.
3. Stakeholders reported a need to create an independent body to monitor and enforce standards and publicly report on LTC home inspection outcomes.
4. Currently, there is no legislative framework in place in NL for LTC to underpin and support the Long Term Care Operational Standards. Stakeholder feedback and leading practices suggest a need to develop legislation to better support operational standards and improve accountability for LTC homes in the province.
5. Focus group participants identified a need to improve system navigation, coordination and information sharing between primary care, acute care, and LTC and to improve access to community resources to enhance supports available for residents, families and ECPs.
6. Focus group participants suggested enhancing collaboration between Indigenous Governments and NLHS and access to culturally safe and equitable care in LTC.

PCH Conclusions

1. The Provincial Personal Care Home Operational Standards were developed in 2007 and are in the process of being revised and updated to reflect and prioritize resident quality of life and resident-centred care.
2. The PCH regulations are dated and require updating through development of continuing care legislation to underpin and support the operational standards. Stakeholder feedback and leading practices suggest a need to develop legislation to better support operational standards and improve accountability for PCHs in the province.
3. Stakeholders reported a need to create an independent body to conduct PCH licensing and monitoring of standards, and publicly report on PCH inspection outcomes to ensure a consistent approach to monitoring.
4. Focus group participants highlighted the complexity of accessing PCHs for residents, families, and ECPs suggesting a need for more publicly available information and navigation support.

Summary of Recommendations

The Long Term Care and Personal Care Home Programs Review identified several opportunities for improvement related to quality of life, quality of care, the workforce, and governance based on an analysis of quantitative data sets, stakeholder feedback collected through focus groups and surveys, and leading practices identified through literature reviews and jurisdictional research. A total of 23 recommendations for improvement (Figure 1) have been provided to improve the quality of care in LTC homes and PCHs, and the overall quality of life for LTC and PCH residents in NL.

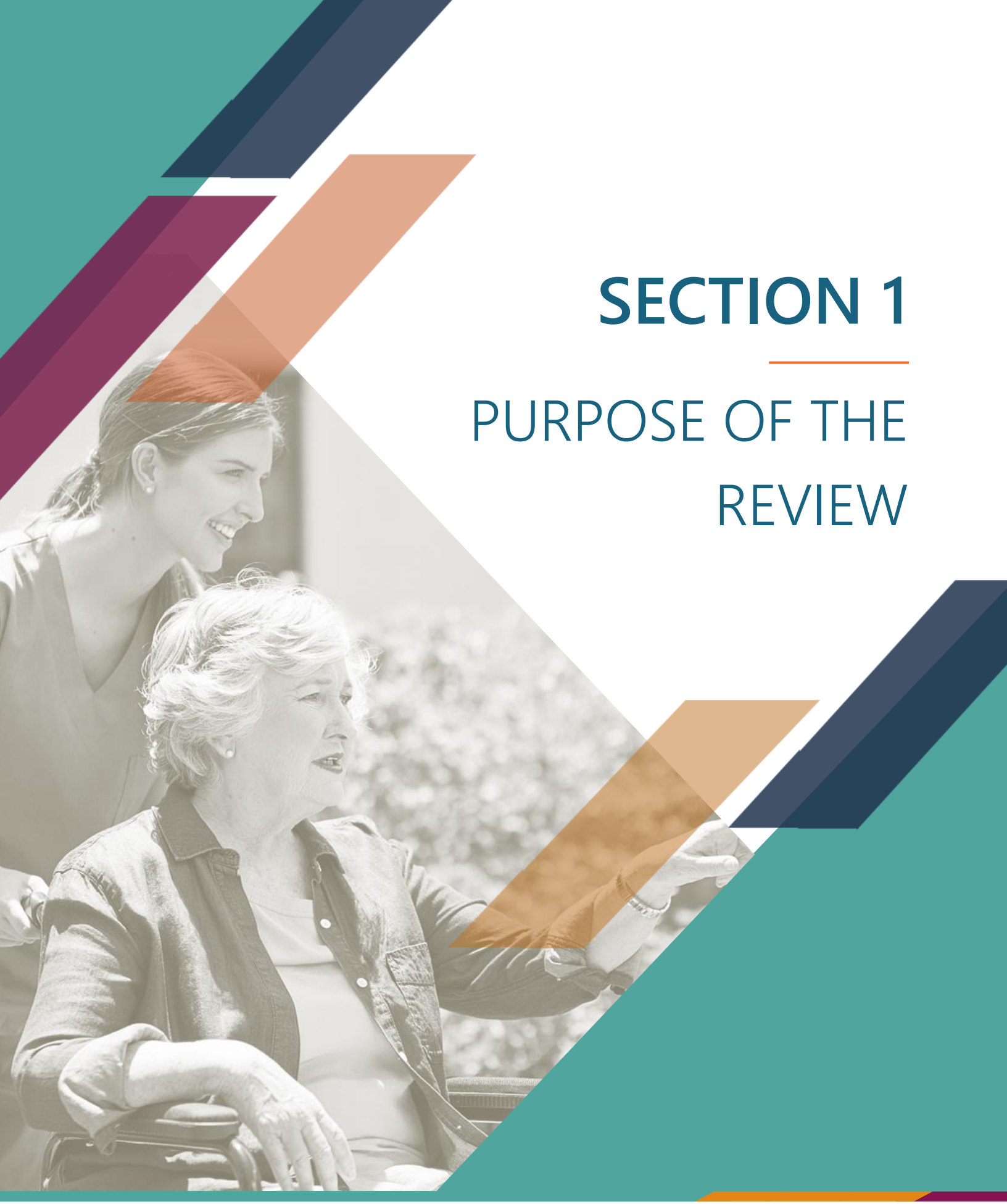
Figure 1: Summary of Recommendations

Quality of Life	**Recommendation #1:** Establish quality of life as the number one priority.
	Recommendation #2: Improve the quality, choice, and flexibility of meals.
	Recommendation #3: Improve access to meaningful activities and recreational programs.
	Recommendation #4: Enhance and support the role of volunteers.
	Recommendation #5: Enhance opportunities and support residents to maintain connections in the community.
	Recommendation #6: Ensure the upkeep and maintenance of existing infrastructure, and renovations (where practical) as well as new construction align with leading practice design standards.
	Recommendation #7: Support couples to remain living together if they choose.
Quality of Care	**Recommendation #8:** Establish quality of care as a main priority of continuing care.
	Recommendation #9: Improve assessment and support/care planning for residents.
	Recommendation #10: Improve access to medical, therapeutic, and other health related services.
	Recommendation #11: Improve access to mental health and addictions supports and resources.
	Recommendation #12: In LTC, increase the direct hours of care for residents and adjust the skill mix and staffing model to ensure staff are working to full scope.
	Recommendation #13: In PCHs, ensure residents are supported to safely age in place.

Workforce	**Recommendation #14:** Implement a workforce strategy to improve the recruitment and retention of staff.
	Recommendation #15: Develop an engagement strategy to improve workplace morale, workforce culture, workplace safety and flexibility for staff.
	Recommendation #16: Implement an Equity, Diversity, and Inclusion (EDI) strategy to ensure that staff, residents, and family work and live in an environment free from ageism, racism, sexism, and discrimination.
	Recommendation #17: Enhance staff training and education.
	Recommendation #18: In LTC, support leaders to effectively lead and manage.
Governance	**Recommendation #19:** Enhance collaboration and ongoing engagement with Indigenous Partners to better understand the systemic gaps experienced by Indigenous Peoples.
	Recommendation #20: Improve navigation and decision-making support for residents, families, and ECPs.
	Recommendation #21: Improve the placement and admissions process for residents.
	Recommendation #22: Create or update legislation, regulations, and operational standards to improve monitoring and accountability.
	Recommendation #23: Create or identify an independent monitoring and licensing body.

Further details regarding each recommendation including key actions, expected benefits, implementation roadmaps, and financial considerations can be found in Sections 3.5, 4.5, 5.5 and 6.5 of the report. The implementation of these 23 recommendations is expected to be staggered over a 5-year period (except Recommendation #6 which will be implemented over a longer period of time), based on the preliminary implementation roadmaps provided with each recommendation in the report.

The total estimated costs to support and implement these 23 recommendations include total annual investments of $26 million in year 1 and $37 million in year 2 and onward for staffing improvements, training costs, technology and innovation enhancements, setting up an independent monitoring/licensing body, and project management supports; and infrastructure investments ranging from $573 million to $954 million to improve resident quality of life.



SECTION 1

PURPOSE OF THE REVIEW

1 PURPOSE OF THE REVIEW

1.1 Background and Context for The Review

Continuing care programs in Newfoundland and Labrador (NL) provide services that aid with activities of daily living (personal care, dressing and ambulation), meal preparation, nursing care, medication administration, respite care, palliative care, and various other health care and support services. These services and supports may be provided in different settings including an individual's home, community-based service locations such as adult day programs, personal care homes (PCHs), and long term care (LTC) homes.

1.1.1 Long Term Care Homes

LTC homes provide care and accommodation to seniors and other adults with complex care needs requiring daily access to nursing care. Provincially, there are 3,296 LTC beds in 43 LTC sites including stand-alone facilities or sites located adjacent to acute care health services. All LTC homes provide 24-hour nursing care plus varying degrees of medical, rehabilitative, support services, pastoral care, dietetic, pharmaceutical, palliative care, respite, and recreation programs. Some homes maintain specialized programs and units for groups with special needs (e.g., young adults with severe intellectual and/or physical disabilities).

All LTC homes in NL are publicly operated by Newfoundland and Labrador Health Services (NLHS), except for one privately owned home where some beds are publicly subsidized. NLHS is mandated to deliver services in accordance with the Provincial Long Term Care Operational Standards and assumes responsibility for monitoring and oversight of the one privately owned and operated LTC home in the province. All LTC homes are also accredited through Accreditation Canada.

The admission process for LTC homes is through a single-entry system. A comprehensive clinical assessment is completed using the Resident Assessment Instrument-Home Care (RAI-HC) to determine clinical eligibility and the appropriate care setting in accordance with the NL Levels of Care (LOC) Framework which includes four distinct levels ranging from I to IV, with level IV being the most complex and higher care needs. The majority of LTC residents are assessed as requiring level lll or IV care. LTC residents undergo a financial assessment, in accordance with the Financial Assessment Policy for Long Term Care and Community Support Services, to determine eligibility for subsidies towards the cost of services.

1.1.2 Personal Care Homes

PCHs are licensed, privately-owned, and operated by not-for profit and for-profit entities. PCHs provide care and accommodations to seniors and other adults requiring assistance with the activities of daily living. Provincially, there are 5,477 PCH beds at 87 PCHs. PCH residents do not require on site health or nursing services but may require the service of a visiting professional. NLHS and Digital Government and Service NL (DGSNL) share responsibility for licensing and monitoring PCHs for compliance with the Personal Care Home Regulations and the Provincial Personal Care Home Operational Standards.

Like the LTC admission process, PCH admission is through a single-entry system and includes the completion of a comprehensive clinical assessment using the RAI-HC to determine the appropriate care setting in accordance with the NL LOC Framework. Residents eligible for PCHs are assessed to require care within the Level I, II, or Enhanced Care category, are medically stable and do not require continuous supervision or frequent intervention by

professional nursing staff. PCH residents undergo a financial assessment by NLHS to determine eligibility for subsidies towards the cost of services based on an individual's assessed level of care.

1.1.3 Context for Review

The COVID-19 pandemic amplified the persisting challenges that existed in the continuing care sector across Canada for many years, including in NL. Since the COVID-19 pandemic, there has been a strong focus on improving continuing care services across Canada. There is a recognition that all adults deserve to age with dignity, safety, and comfort regardless of where they live. This recognition has resulted in the recent development of the Health Standards Organization (HSO) National Long-Term Care Services Standard and recent investments by the Federal Government through Aging with Dignity to improve the quality of life of Canadians as they age.

NL is experiencing a change in demographics across the province. This change includes declining birth rates, increased migration of young people and families out of province, an aging population, and an increase in the number of people choosing to move to urban communities[1]. Health Accord NL identified the number of people over the age of 65 years has more than doubled in the past 50 years. The demand for health and social programs in NL has been consistently rising with the increase in population of people aged 65 years and over. This rapidly changing demographic has raised concerns about the sustainability of supports and services required for an aging population including LTC and PCH programs.

The health system in NL has not adapted to meet the changing needs of the population. There has been a focus on the societal and health system impacts of caring for older adults over enabling quality of life and quality care. Further, ageism and gaps in understanding the needs of older adults are impacting access to care and diminishing the experiences of older adults, families, and essential care partners (ECPs). The COVID-19 pandemic highlighted gaps in NL regarding quality of care in LTC and the value placed on older adults. This prompted a call to action by the public to improve staffing, hours of care, quality of care and the overall resident experience.

Health Accord NL also identified challenges with several vacancies for health care professional roles across the province, and there are concerns about the ability to "recruit and retain health professionals and other workers" to critical roles in the province[1].

1.2 Purpose and Objectives of the Review

The Minister of Health and Community Services appointed an Expert Advisory Panel (EAP) to complete a provincial review of LTC and PCH programs. The Review aimed to identify opportunities for improvement that support resident-centred care based on best or leading practices and informed by relevant stakeholders and system data. The role of the EAP was to:

- Identify opportunities to improve quality of care and quality of life for residents, improve staff engagement and quality of staff work-life, based on best evidence, and informed by relevant stakeholders.
- Oversee the review and provide expert advice to the external consultant and the Minister.
- Ensure the review supports cultural safety and humility and includes the principles of resident-centered care that value dignity, transparency, respect, diversity, and inclusion.
- Ensure recommendations are actionable, future focused and resident-centred[2].

The EAP consisted of members who have expertise in the clinical, research, public policy, and lived/living experience areas of care of older adults in residential care settings. The four member EAP included:

- Dr. Janice Keefe; Chair/Full Professor, Department of Family Studies and Gerontology, Mount Saint Vincent University; and Director, Nova Scotia Centre on Aging.
- Dr. Susan Mercer; Clinical Chief, Older Adult Care, Eastern Urban Zone, NLHS; and Assistant Professor, Family Medicine, Memorial University.
- Leslie Daye; Family Member with Lived/Living Experience; and Instructor at College of the North Atlantic.
- Kelli O'Brien; Vice President, Quality & Learning Systems, NLHS; and formerly President and CEO, St. Joseph's Care Group.

MNP LLP ("MNP"), a Canadian accounting and consulting firm, was selected and engaged by the GNL through a competitive process to support the work of the EAP. The objectives of the Review were to:

Quality of Life

- Identify opportunities to improve quality of life and make recommendations.
- Identify opportunities to support families, substitute decision makers and ECPs in improving resident's quality of life.
- Identify opportunities to support the roles of volunteers in improving resident's quality of life.
- Identify opportunities to improve the physical environment in LTC homes and PCHs.
- Explore opportunities to integrate LTC homes and PCHs into the broader community.
- Review practices with respect to spousal admissions to LTC homes and outline the implications of a change in policy.

Quality of Care

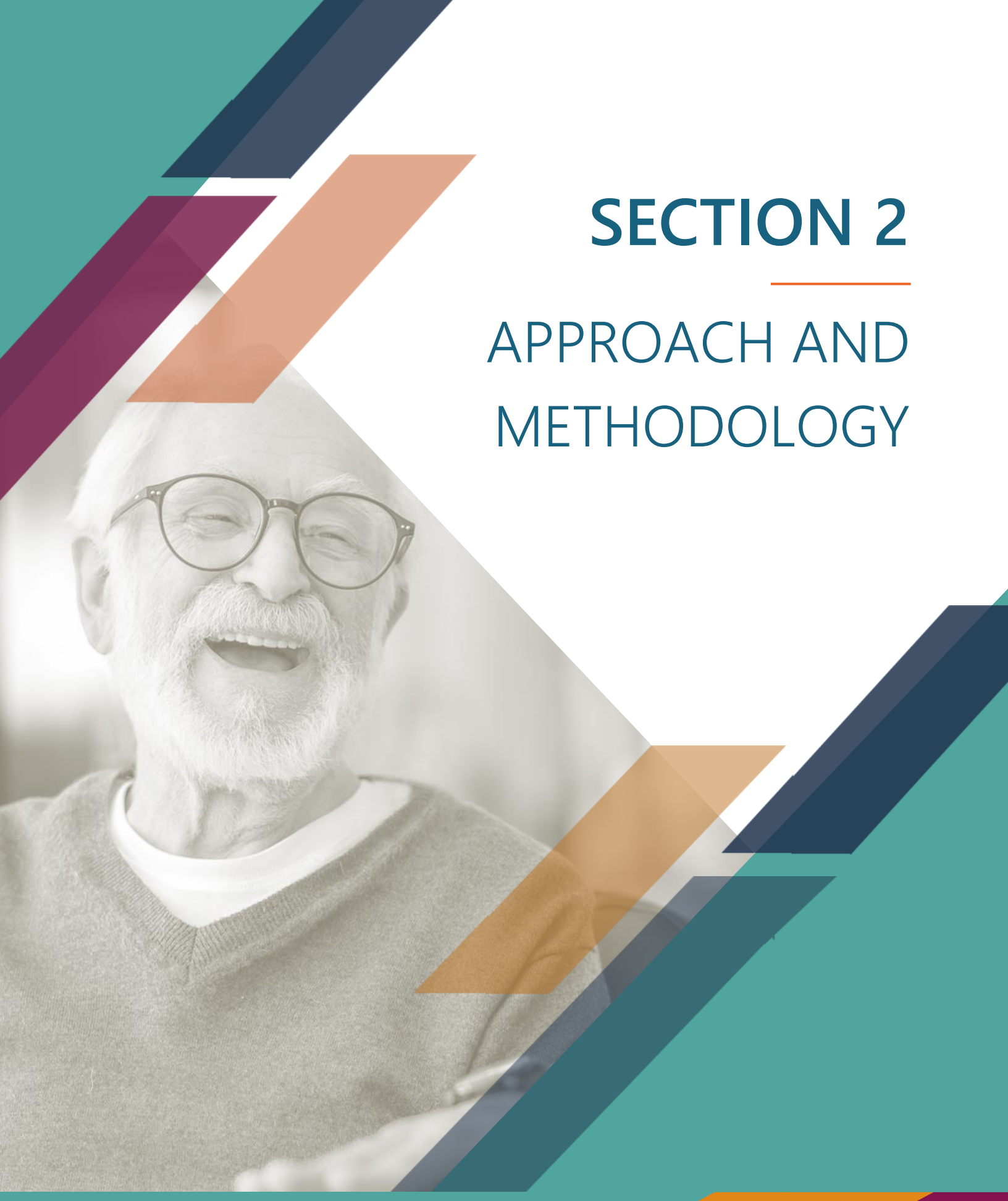
- Identify opportunities to improve quality of care and make recommendations.
- Identify opportunities to engage families, substitute decision makers, ECPs and volunteers as members of the care team.
- Evaluate the existing model of care in LTC and PCHs to identify opportunities for improvements that are consistent with leading or best practices, in other jurisdictions.
- Review staff ratios and skill mix for all staff including nursing (registered nurses, licensed practical nurses, and personal care attendants), pharmacy, allied health (social workers, physiotherapists, occupational therapists, recreational therapists, music therapists, and behaviour management specialists), and management/leadership teams, to identify opportunities to shift from a task-based model to a more resident-centred approach.
- Review the delivery model of primary care in LTC and PCHs to identify opportunities to improve access.

Workforce

- Explore factors affecting attitudes and culture in LTC homes and PCHs and identifying opportunities to increase empathy and meaningful relationships.
- Identify opportunities to improve recruitment and retention, to improve staff engagement and make LTC and PCHs desirable places to work.

Governance

- Identify opportunities to improve compliance monitoring in PCHs.
- Identify mechanisms to increase accountability and improve public trust in the quality of care provided in LTC homes and PCHs.
- Identify opportunities to ensure appropriate utilization of LTC homes and PCHs, including an assessment of inappropriate admissions, and make recommendations to increase value and sustainability.
- Review LTC home governance structures, with specific consideration to the roles of senior management and leadership.
- Identify opportunities to deliver LTC and PCH services in a more cost effective and sustainable manner.



SECTION 2

APPROACH AND METHODOLOGY

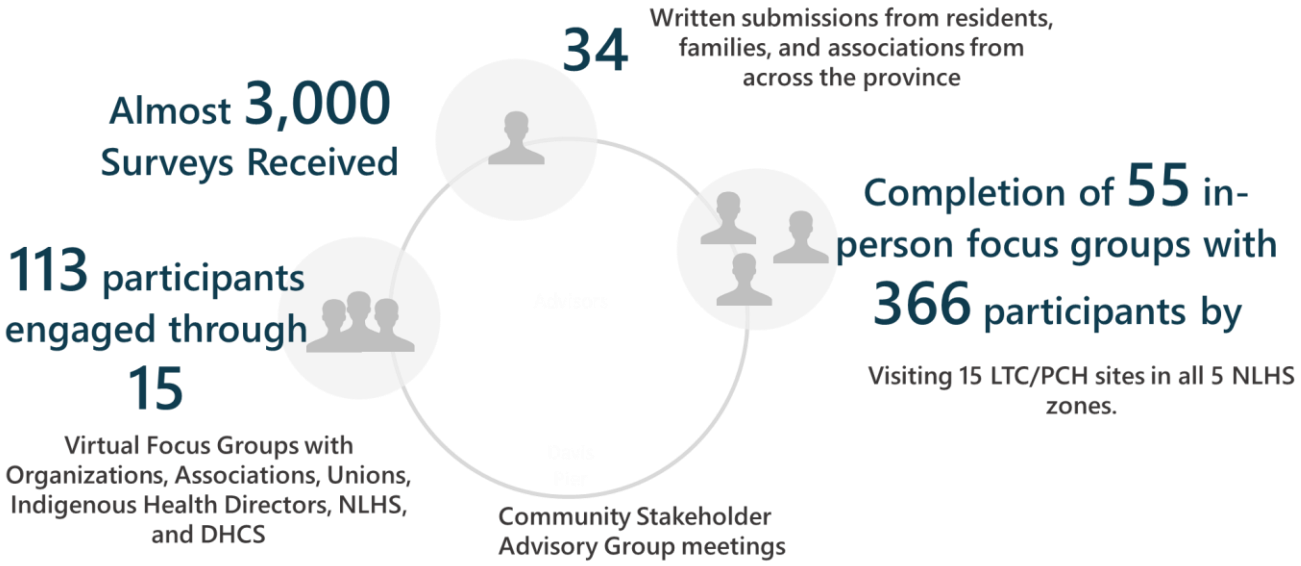
2 Approach and Methodology

Information and data informing the analyses and ultimately the development of the report was collected through four unique sources: stakeholder engagement, an internal environmental scan of existing data and information sources within the province, and a literature review and jurisdictional review of national and international leading practices. Further details regarding each method are provided in the sections that follow.

2.1 Stakeholder Engagement

Stakeholders were engaged through multiple methods including focus groups, surveys, interviews, and written submissions (Figure 2).

Figure 2: Stakeholder Engagement Summary



2.1.1 Community Stakeholder Committee for Review

The Minister of Health and Community Services established a Community Stakeholder Committee to help inform the Review and provide direct input and feedback to the EAP. Committee members consisted of representation from:

- Alzheimer Society, Newfoundland and Labrador
- Citizens for Change in Long Term Care
- Coalition of Persons with Disabilities Newfoundland and Labrador
- Connections for Seniors
- Federal Retirees
- Huntington Society of Canada, Newfoundland Chapter
- Newfoundland and Labrador Association for the Deaf
- Newfoundland and Labrador Coalition for Seniors, Pensioners, and Retirees
- Office of the Seniors Advocate
- Parkinson Society NL
- Seniors NL
- Twin Cities 50+ Club

2.1.2 Focus Groups

In-Person Focus Groups

A total of eight (8) LTC homes and seven (7) PCHs were visited across the province with representation from each health zone. Multiple in-person focus groups were held at each care home with representatives from residents, family, and ECPs; volunteers; unlicensed staff; licensed staff; and leadership; and included at least one member of the EAP. An additional PCH was identified for a site visit; however, due to infection control protocols the site visit could not be completed. A total of 55 in-person focus group sessions were completed with a total of 366 participants to gather diverse perspectives and insights directly from stakeholders.

Virtual Focus Groups

Stakeholder groups were invited to participate in virtual focus group sessions with the EAP and MNP representatives. Fifteen focus groups with a total of 113 participants from different stakeholder groups were completed with representatives from:

- Canadian Union of Public Employees (CUPE)
- Department of Health and Community Services (DHCS) Representatives
- Physicians who provide services to LTC homes and PCHs
- Newfoundland and Labrador Association of Public and Private Employees (NAPE)
- Registered Nurses Union of Newfoundland and Labrador (RNUNL)
- Newfoundland and Labrador Medical Association (NLMA)
- NLHS Community Health Staff Representatives
- NLHS PCH and Placement Services Managers
- NLHS Senior Leadership
- NL Indigenous Peoples Alliance
- Nunatsiavut Government
- NunatuKavut Community Council
- Miawpukek First Nation
- Qalipu First Nation
- PCH Associations including:
    - Quality Living Alliance for Seniors
    - Personal Care Home Owners Association of Newfoundland and Labrador
- Professional Associations Including:
    - College of Registered Nurses of Newfoundland and Labrador (CRNNL)
    - College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL)
    - College of Audiologists and Speech-Language-Pathologists (CASLP)
    - Newfoundland and Labrador College of Social Workers (NLCSW)
    - College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL)

Two other Indigenous communities were invited to participate in a focus group and were unable to do so.

2.1.3 Surveys

Stakeholders were invited to share their input and experiences on LTC and PCHs in the province through a survey, which was available online or in paper format. Ten different surveys were offered, reflecting an individual's current level of involvement with LTC or PCHs. Nearly 3,000 surveys were received from a variety of stakeholder groups.

Table 1 provides an overview of the survey participation from each stakeholder group.

Table 1: Total Surveys Received

Stakeholder Group	Surveys Received
Public	1,674
External Organizations	167
LTC Resident, Family, ECP	349
LTC Unlicensed Staff	238
LTC Licensed Staff	286
LTC Leadership	76
PCH Resident, Family, ECP	126
PCH Unlicensed Staff	31
PCH Licensed Staff	24
PCH Leadership	24
Total Surveys Received	**2,995**

2.1.4 Written Submissions

The EAP, DHCS, and MNP also received 34 written submissions from residents, families, associations, and external organizations from across the province. Written submission input was included as part of the survey "what we heard" findings as the themes aligned with survey submissions and to maintain the confidentiality of written submissions.

2.2 Internal Environmental Scan

MNP conducted a detailed analysis of data, reports, and documents provided by the DHCS and NLHS, or data sets sourced through the Canadian Institute for Health Information (CIHI). Key data sources included:

- **Data Sets:**
  - Number of LTC Homes and PCHs
  - Admission Data
  - Waitlist Data
  - Resident Quality of Care Audits
  - Workforce Data Including Staffing Mix Ratios, Full Time Equivalent (FTE) Hours, Overtime FTEs, Sick Leave, and Compensation
  - Direct Care Hours
  - Funding Levels
- **Data Sets Retrieved from CIHI Including:**
  - Activities of Daily Living (ADL) Data
  - Aggressive Behaviour Scale (ABS)
  - Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) Data
  - Depression Rating Scale (DRS) Data
  - Cognitive Performance Scale (CPS) Data
  - Method for Assigning Priority Levels (MAPLe) Data
  - Behavioural Symptoms Worsened
  - Behavioural Symptoms Improved
  - Worsened Depressive Mood in Long Term Care
  - Restraint Use in Long Term Care
  - Experiencing Pain in Long Term Care
  - Worsened Pain in Long Term Care
  - Inappropriate Use of Antipsychotics
  - Fall in the Last 30 Days in Long Term Care
  - New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home
- **Background Documents:**
  - Long Term Care Facilities Operational Standards
  - Personal Care Homes Operational Standards
  - Health Accord NL
  - June 2015 Auditor General Report – Nutrition in LTC Facilities
  - June 2015 Auditor General Report- Personal Care Home Regulation
  - NLHS Organizational Charts
  - Inspection Reports
  - Volunteer Policies
  - Strategic Health Human Resources Plan
  - Program Background Information
  - Dementia Care Action Plan 2023 - 2026
  - Demand Forecasting Reports
  - Review of Occupational Therapy and Physiotherapy Services
  - Community Support Services Funding Model Refresh Study – March 2023
  - Resident Experience Surveys
  - Home and Personal Support Worker Survey – March 2019
  - Quality of Care NL Reports

2.3 Literature Review of National and International Leading Practices

Relevant provincial, national, and international reports and documents were reviewed to help inform the report recommendations. A complete list of documents, reports and articles cited in this review is provided in Appendix 3. The Health Standards Organization (HSO) National Long-Term Care Services Standard ("HSO National LTC Standard")[3] and Canadian Standards Association (CSA) Z8004:22 – Long Term Care Home Operations and Infection Prevention and Control [4] were also reviewed to help inform the report recommendations.

The HSO National LTC Standard 2023 is designed to address the delivery of safe, reliable, and high-quality LTC services in Canada, and provides evidence-informed practices that define how LTC homes and LTC teams can work collaboratively to ensure the safety of residents[3].

The CSA Z8004:22 Standard addresses the design, operation, and infection prevention and control practices in Canadian LTC homes[4].

2.4 Jurisdictional Review

Emerging practices, literature studies, and best practices from other Canadian provinces and territories, specific to LTC homes and PCHs, were also examined. This included conducting interviews with representatives from the provinces of Nova Scotia, Ontario, Alberta, and British Columbia.

2.5 Dynamic Financial Model Development

A dynamic financial model in MS Excel was developed to model the financial impacts of key recommendations included in the report related to staffing model enhancements, staff and leadership training, technology and innovation improvements, infrastructure investments, investments to improve LTC and PCH governance, and overall project management supports. Detailed assumptions regarding financial impacts are provided in Appendix 2.

2.6 Report Limitations

The EAP and MNP have relied on the completeness, accuracy, and fair presentation of all information and data obtained by stakeholders and engagement activities. The accuracy and reliability of the findings and opinions expressed in this report are conditional upon the quality of this same information.

Additionally, the Review findings were limited by the following factors:

- **Limitations of the PCH Survey Findings:** There was a relatively small number of surveys completed by stakeholders from PCHs. However, significant data was received through the in-person focus groups that took place in PCHs. The data sample that was received from PCH surveys was consistent in many areas with the data from focus group findings.
- **Limitations of the PCH Data:** There was a limited availability of data for PCHs, particularly data regarding workforce and infrastructure conditions. While aggregate clinical data is available from CIHI for PCH residents, prior to 2020 this data could not be separated from home care data. This resulted in limitations creating historical trends for PCH-specific indicators prior to 2020.

2.7 Report Structure

The findings of the Review are organized by the four objectives quality of life (Section 3), quality of care (Section 4), workforce (Section 5), and governance (Section 6). Within each section, the findings and recommendations are presented in subsections as follows:

- LTC findings
    - Current context for LTC homes (including statistics, standards, and practices)
    - What we heard from stakeholder engagements
- PCH findings
    - Current context for PCHs (including statistics, standards, and practices)
    - What we heard from stakeholder engagements
- Leading practices and other jurisdiction research
- Conclusions
- Recommendations including implementation roadmaps and financial considerations

Definitions for key terms used throughout the report are provided in Appendix 1.

SECTION 3

QUALITY OF LIFE

3 Quality of Life

The HSO National LTC Standard defines quality of life (QoL) as a person's sense of well-being and their experiences in life in the context of their culture and value systems and in relation to their goals, expectations, and concerns[3].

The GNL is committed to offering residents and families a high quality of holistic, resident-centred care in a homelike environment as outlined in the Long Term Care Operational Standards and Personal Care Home Program Operational Standards. Resident-centered care prioritizes the well-being and autonomy of residents by creating a safe and homelike environment that addresses the residents' spiritual, psychosocial, cultural, and physical needs. It emphasizes fostering independence, freedom of choice, and supporting residents' involvement in maximizing their personal well-being to the best of their abilities.

3.1 Long Term Care Findings

The following section describes the current context and stakeholder engagement findings for LTC home resident quality of life.

3.1.1 Current Context

LTC homes provide 24-hour access to nursing care for residents who need moderate to total assistance with activities of daily living. LTC residents typically require on-site health and nursing services.

As of March 2024, there were 43 LTC homes in the province, distributed across five health zones: Eastern Urban, Eastern Rural, Central, Western, and Labrador-Grenfell. Homes are grouped into three categories:

- Health Authority LTC homes are owned and operated by NLHS. As of March 2024, there were 37 NLHS sites, including stand alone homes and sites within or attached to a health centre.
- Faith Based homes are located on land owned by faith-based organizations, with operational funding provided by NLHS. A memorandum of understanding outlines the terms of operations. These agreements for Faith Based homes have not been updated since 2004. As of March 2024, there were four Faith Based homes in the province.
- Privately owned homes are owned and operated by a private operator with funding through formal agreements for operating beds with NLHS. As of March 2024, there was one privately owned facility in the province located in the Eastern-Urban Health Zone.

Additionally, the Caribou Memorial Veterans Pavilion (LTC) located in St. John's is funded by Veterans Affairs Canada and provides preferential access for qualifying Veterans.

As of March 2024, 8 LTC homes (19%) were in Eastern Urban zone, 9 (21%) in Eastern Rural zone, 14 (32%) in Central zone, 8 (19%) in Western zone, and 4 (9%) in Labrador-Grenfell zone (Figure 3). However, the distribution of the 3,296 LTC beds in NL is different than the distribution of LTC homes, with 1,326 beds (40%) in Eastern Urban zone, 558 (17%) in Eastern Rural zone, 668 (20%) in Central zone, 593 (18%) in Western zone, and 151 (5%) in Labrador-Grenfell zone (Figure 4).

Figure 3: Number of LTC Homes by Health Zone, March 2024

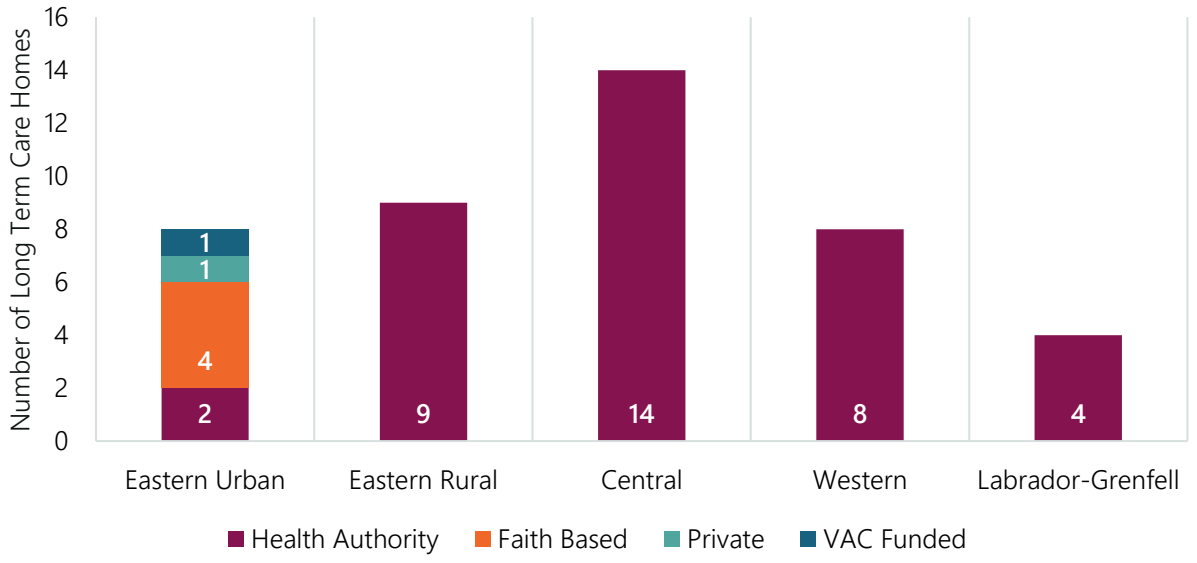
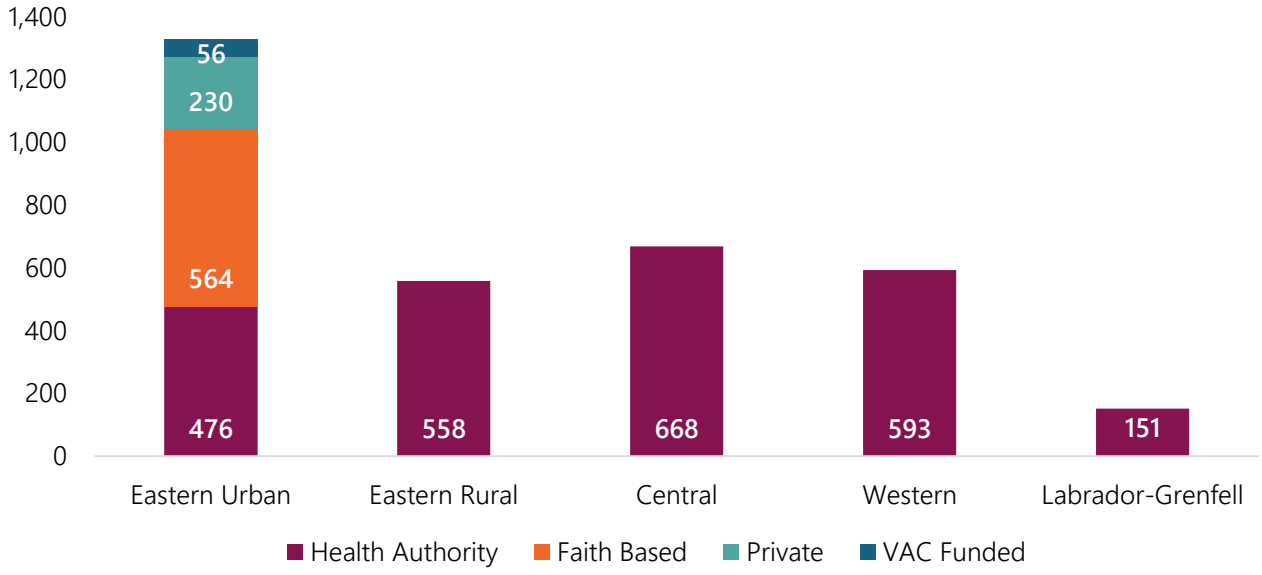


Figure 4: Number of LTC Beds by Health Zone, March 2024



Based on available Facility Condition Index (FCI) information for 37 LTC homes provided by DHCS, the average age of health authority operated LTC homes is approximately 39 years, with 22 homes being 30 years or older. Many of these homes (18 of the 22) have Facility Condition Index (FCI) scores of 30% or higher, indicating that a higher percentage of components in these homes have reached the end of their projected useful life. Failure to replace or renovate these homes increases the risk to operations to the extent that some or all the home may be subject to unscheduled closure until the component is replaced or an alternate solution is found. Table 2 summarizes the result of the most recent FCI assessment of Health Authority LTC homes.

Table 2: Facility Condition Index (FCI) Score for Health Authority LTC Homes

FCI Score[5] [6]	Count	Percent
Up to 5%	5	13%
Greater than 5% up to 10%	1	3%
Greater than 10% up 30%	13	35%
Greater than 30%	18	49%
Total	**37**	**100%**

Long Term Care Operational Standards

The Long Term Care Operational Standards outline the GNL's expectations for service delivery in LTC homes across NL. The GNL sets out the requirements in the standards to acknowledge the unique and complex needs of individuals to ensure the delivery of safe, quality care. NLHS is mandated to adhere to the Standards to ensure LTC homes operate within the established criteria and are committed to continuous quality improvement. A more detailed discussion on the Standards is included in Section 6.1 of the report.

Quality of Life Monitoring

Quality of life monitoring for LTC homes in NL has been limited. The Western Health Zone conducted LTC Resident and Family Experience Surveys in 2021 to guide quality improvement initiatives. However, similar surveys were not completed in the other health zones.

Quality Indicators Reported to CIHI

LTC homes in NL use RAI-MDS 2.0 to support clinical assessments and care planning. The instrument is designed to conduct standardized clinical assessments for residential continuing care and submit data to the Continuing Care Reporting System (CCRS) managed by CIHI[7]. The data collected through the CCRS reports are used to inform LTC quality indicators (QIs), which are publicly reported by CIHI for NL, New Brunswick, Nova Scotia, Ontario, Manitoba, Saskatchewan Alberta, British Columbia, and Yukon. Some of the QIs reported by CIHI related to LTC include:

- Falls in the Last 30 Days
- Worsened Pressure Ulcer
- Potentially Inappropriate Use of Antipsychotic Medication

- Restraint Use
- Experiencing Pain
- Experiencing Worsened Pain
- Worsened Depressed Mood
- Worsened Behavioural Symptoms
- Improved Physical Functioning
- Worsened Physical Functioning

NL is performing better than the national average for seven of the LTC QIs over the 5-year period including Falls in the Last 30 Days, Worsened Pressure Ulcer, Experiencing Worsened Pain, Worsened Depressive Mood, Worsened Behavioural Symptoms, Improved Physical Functioning, and Worsened Physical Functioning (Table 3). NL is performing under the national average for three of the LTC QIs over the 5-year period including Potentially Inappropriate Use of Antipsychotic Medication, Restraint Use, and Experiencing Pain.

Table 3: Comparison of LTC QIs for NL from 2018/19 to 2022/23

	Percentage of LTC Residents									
	2018/19		2019/20		2020/21		2021/22		2022/23	
Quality Indicator	NL	Canada	NL	Canada	NL	Canada	NL	Canada	NL	Canada
Falls in the past 30 days*	10.4	16.7	10.4	16.7	10.2	16.7	10.3	16.4	9.9	16.7
Worsened Pressure Ulcer*	1.9	2.7	1.6	2.6	1.7	2.7	1.7	2.7	1.7	2.7
Potentially Inappropriate Use of Antipsychotic Medication*	28.2	20.2	23.1	20.2	22.3	22.1	26.4	23.9	29.4	24.5
Restraint Use*	12.4	5.2	11.1	4.6	10.5	5.6	11.0	5.3	11.6	4.9
Experiencing Pain*	16.3	6.7	15.3	6.2	14.7	6.3	14.3	6.1	14.1	5.8
Experiencing Worsening Pain*	10.5	10.1	9.0	10	8.7	10.2	7.8	9.7	7.7	9.4
Worsened Depressive Mood*	15.0	21.3	14.9	21.1	14.1	21.4	13.3	20.5	13.2	20
Worsened Behavioural Symptoms*	8.3	12.3	8.0	12.4	8.1	12.4	8.1	12.1	7.3	11.8
Improved Physical Functioning**	39.5	31.4	40.2	31.3	39.3	31.4	40	31.8	40.3	31.5
Worsened Physical Functioning*	30.2	33.2	29.2	33.5	29.8	33.6	29.8	33.2	29.3	33.2
Performing better than national average										
Performing worse than national average										
* lower scores are preferable										
** higher scores are preferable										

DHCS has established working groups with NLHS representation to identify and implement quality improvement opportunities for pain management, the appropriate use of antipsychotics, and restraint use.

3.1.2 What We Heard

Focus group participants were asked to share their experience on a variety of quality of life topics including:

- Resident choice
- Access to meaningful activities
- Volunteers in LTC homes
- Resident and family councils
- Emotional wellbeing supports
- Isolation for residents
- Infrastructure

Survey questions using the quality of life dimensions assessment tool developed by Dr. Rosalie Kane[8] were provided to LTC residents, families, ECPs, and staff. These dimensions were assessed based on metrics related to comfort, security, meaningful activity, relationships, functional competence, enjoyment, privacy, dignity, autonomy, individuality, and spiritual well-being.

Focus Group Findings

Resident Choice

The ability for residents to make choices related to aspects such as daily schedules/routines, meal choices, access to outdoors, and ability to access community events when desired was limited. Some homes provided more flexibility than others, but in general resident choice was very limited and the home environment was very routine-based and heavily focused on task-based care rather than resident-centred care. Focus group participants also shared that resident choice was often limited to maintain resident security and safety.

Focus group participants had different interpretations of what the definition of resident-centered care is and suggested that a task-based culture exists in many LTC homes.

Improved Access to Meaningful Activities

Recreation was a prominent theme amongst several focus groups. Challenges with recreation included:

- Limited number of one-on-one programs and activities for residents who choose not to or cannot participate in group activities.
- Limited or no access to recreation activities on evenings, weekends, and holidays. Recreation hours often are scheduled between 8am – 4pm Monday to Friday.
- Limited physical recreation activities to meet varied resident abilities.
- Limited range of activities to suit the needs of residents, specifically for residents with dementia.

Focus group participants expressed several challenges that influenced recreation such as:

- Limited staff availability to accompany residents to recreation activities.
- Limited recreation staff to facilitate activities.
- Perception by some staff that recreation and socialization is not part of their role, limiting teamwork.
- Perceived change in resident acuity has affected the demand for the types of activities.
- Limited to no volunteers available to help support recreation activities.

Focus group participants indicated that the limited recreation and access to meaningful activities have led to challenging resident outcomes including increased isolation, limited social and physical stimulation, negative effects for residents living with dementia (specifically in the evenings), and increased boredom. Focus group participants also indicated that the types of activities need to be expanded to meet the varied needs of residents, and that there is a greater role for the community in providing activities and programs in the home.

Transportation was identified as a significant barrier for residents and was often limited for medical appointments with no transportation available for other activities. This results in activities and services offered onsite which was perceived as isolating residents from the community.

Volunteers

Focus group participants identified that volunteers were underutilized in LTC homes. Some participants indicated that their home had minimal volunteer participation. During the COVID-19 pandemic volunteer participation was restricted due to concerns of infection spread between visitors and residents. Focus group participants felt that many volunteers did not return after restrictions were lifted. It was also perceived that the volunteer application changed to a centralized and digitized process. This resulted in a complicated online application process that some focus groups participants compared to an employment application process. Consequently, many potential volunteers, typically seniors, did not complete the required application.

Resident and Family Councils

Focus group participants indicated that there were inconsistencies with resident and family councils throughout the province. The inconsistencies were related to areas such as:

- Resident, family, and ECP knowledge that the councils existed at their home.
- Communication and understanding of the role of the resident and family council and how to raise concerns.
- Some councils were led and overseen by staff and management at the home while others were led and overseen by residents and family with facility support.
- Agenda development and ownership of meeting actions.

Focus group participants also shared that resident and family councils did not have anonymity which caused concerns about repercussions towards residents if concerns about quality of care were raised.

Emotional Well-Being Supports

Focus group participants reported limited access to emotional wellness supports. Staffing shortages have led to rushed interactions between staff and residents which has left many residents to experience boredom, isolation, and vulnerability. Some staff participants shared that they have limited time available to have meaningful conversations and relationships with residents which was disappointing and, in some cases, morally distressing.

Isolation for Residents

Focus group participants perceived a growing sense of isolation among residents attributed to communication difficulties between residents and staff due to:

- English not being the primary language spoken by either staff or, in a few cases, the resident.
- Limited American Sign Language Interpreter support in homes for members of the deaf community.
- Resident disability or dementia affecting the resident's ability to speak, understand or process information.

Infrastructure

Focus group participants shared that infrastructure varied across homes in the province. Some older homes have infrastructure challenges impacting quality of life including:

- Small or poor physical layout of rooms which do not promote function and can limit wheelchair usage and the use of other assistive equipment.
- Shared rooms and bathrooms which minimizes privacy.
- Limited number of equipment or appropriate spaces to facilitate resident care.

Survey Findings

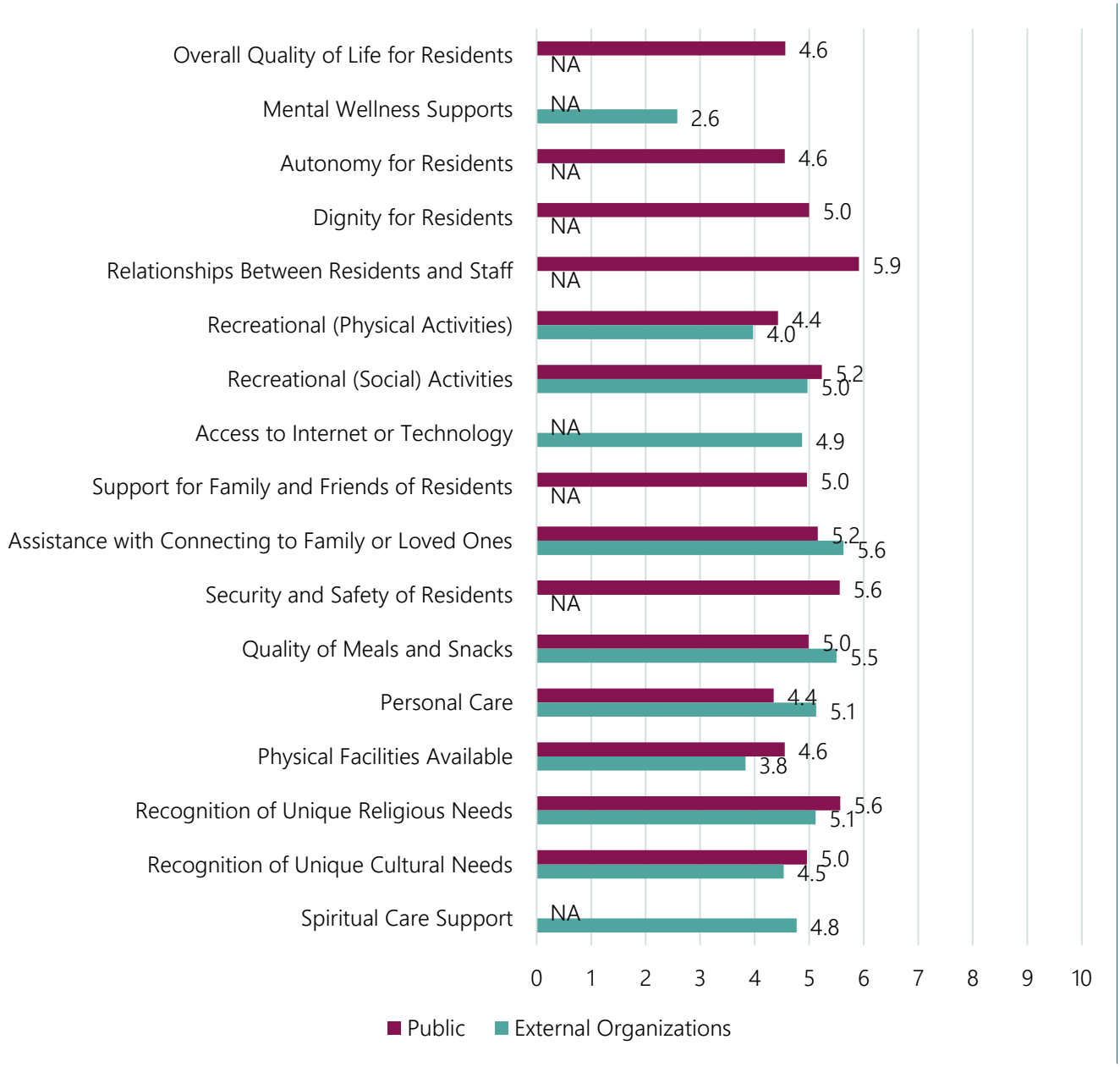
Public and External Stakeholders

A total of 1,674 individuals responded to the public survey and 167 individuals responded to the external organization survey. Survey respondents were asked to provide their input on both LTC and PCHs. Figure 5 provides a summary of the responses from the public and external organizations related to perceptions for LTC homes and PCHs combined. Quality dimensions were assessed on a scale of 0 (lowest quality) to 10 (highest quality).

The average ratings provided by public survey respondents and external organization survey respondents suggest that they perceive that quality of life in LTC homes and PCHs across the province requires improvement. The average ratings for all quality dimensions assessed by public survey respondents ranged from 4.4 out of 10 for recreational physical activities and personal care to 5.9 out of 10 for relationships between residents and staff. Similarly, the average ratings for all quality dimensions assessed by external organization respondents were also low and ranged from 2.6 out of 10 for mental wellness support to 5.6 out of 10 for assistance with connecting to family or loved ones.

Figure 5: Summary of Average Ratings for Different Quality of Life Dimensions - Public and External Organizations (Scale of 0 to 10)

NA - indicates question was not asked



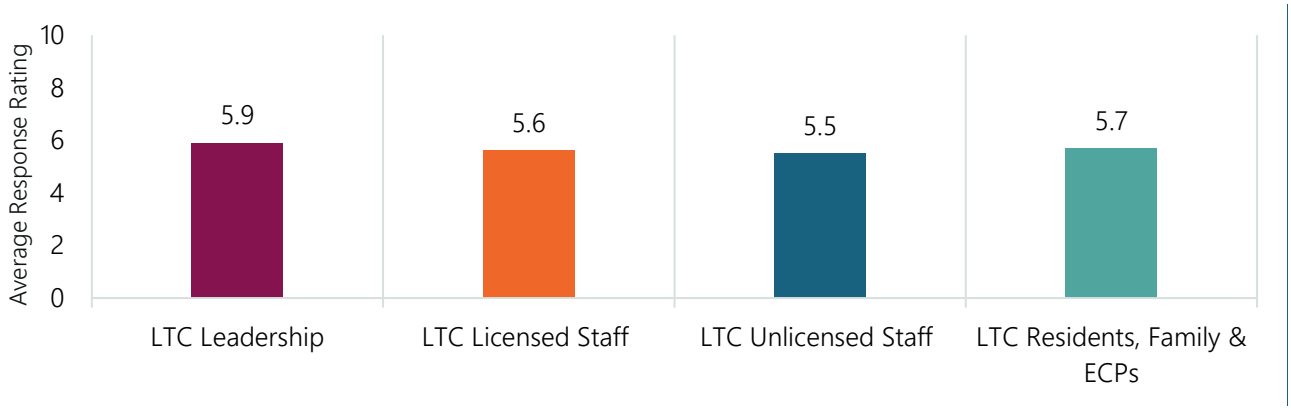
LTC Leadership, Staff, and Residents, Families and ECPs

The following section summarizes the survey results related to quality of life in LTC homes for four stakeholder groups including:

- LTC Leadership – 76 survey respondents
- LTC Licensed Staff – 286 survey respondents
- LTC Unlicensed Staff – 238 survey respondents
- LTC Residents, Family, and ECPs – 349 survey respondents

Survey respondents were asked to rate the overall quality of life for residents in LTC homes on a scale of 0 (lowest quality) to 10 (highest quality). The average response rating was similar for all stakeholder groups and ranged from 5.5 to 5.9 out of 10 (Figure 6).

Figure 6: Average Stakeholder Ratings for Overall Quality of Life in LTC (Scale of 0 to 10)

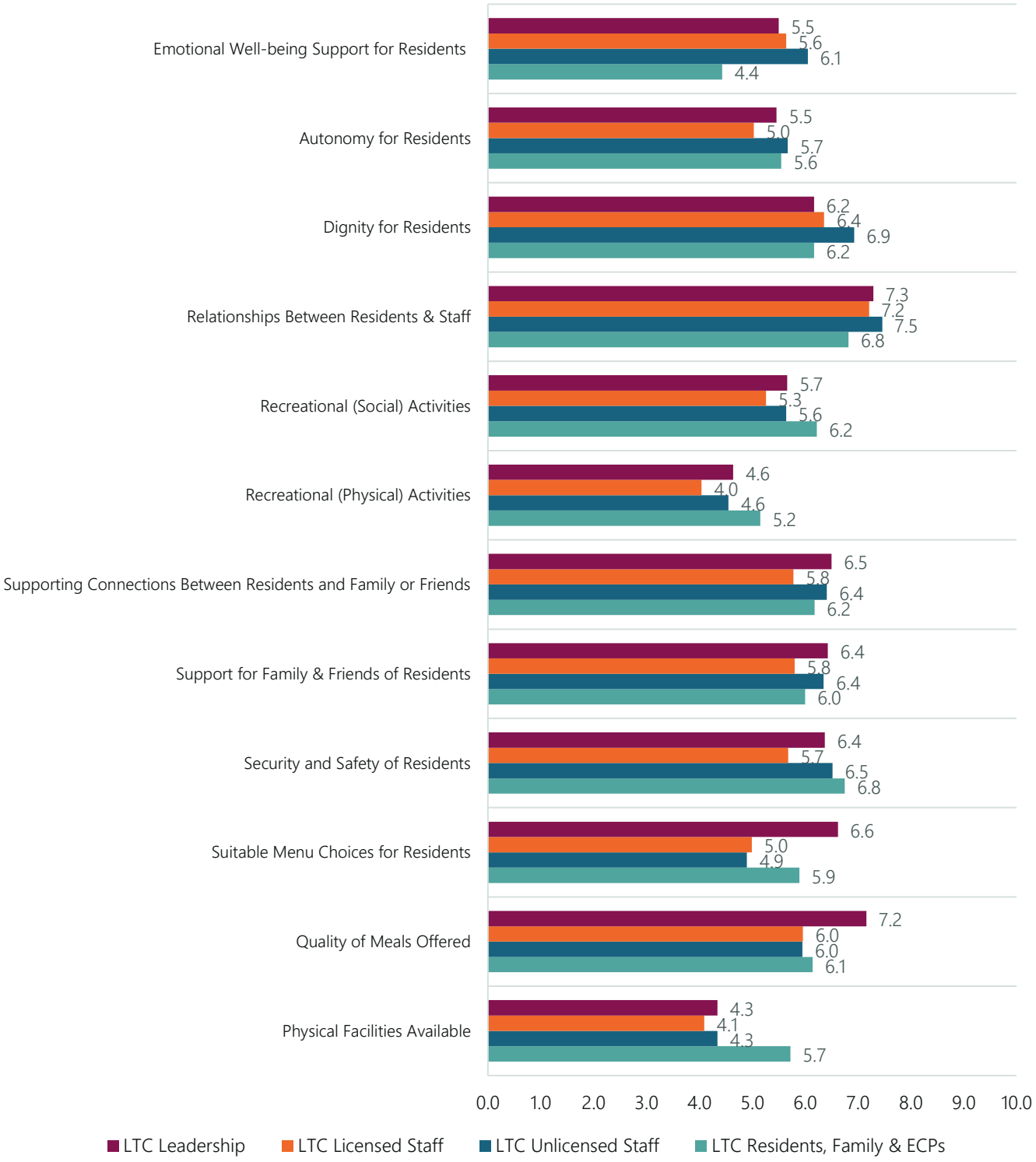


Survey respondents rated LTC quality of life for a variety of dimensions using a scale of 0 (needs improvement) to 10 (strength). Overall, the average ratings provided by LTC Residents, Family, and ECPs was either similar or higher for most dimensions compared to the average rating provided by LTC Leadership, LTC Licensed Staff and LTC Unlicensed Staff (Figure 7).

The highest rated dimensions by LTC Residents, Family, and ECPs included relationships between residents and staff, security and safety of residents, dignity for residents and recreational (social) activities (Figure 7). The dimension rated the lowest by LTC Residents, Family, and ECPs was emotional well-being support for residents, which was rated significantly lower compared to the average rating provided by LTC Leadership, Licensed Staff and Unlicensed Staff. Other dimensions rated as requiring improvement by LTC Residents, Family, and ECPs included recreational (physical) activities, and autonomy for residents.

Forty-two percent of LTC Residents, Family, and ECPs responded that they reside in (or that their family member or friend resided in) a LTC facility that had volunteers while 24% responded no. The remaining 34% were unsure.

Figure 7: Average Ratings for Quality of Life Dimensions in LTC (Scale of 0 to 10)



Survey participants also rated quality of life dimensions specific to dementia care supports for LTC residents and staff using a scale of 0 (needs improvement) to 10 (strength). The average ratings for many dementia care supports were rated below 5 out of 10 by all stakeholder groups (Figure 8). LTC Residents, Families and ECPs rated supports such as training and education programs for staff, volunteers, family, or ECPs; and access to recreation, engaging activities, and programs on evenings, weekends, and holidays as requiring the most improvement.

Opportunities for improvement in LTC reported by survey respondents:

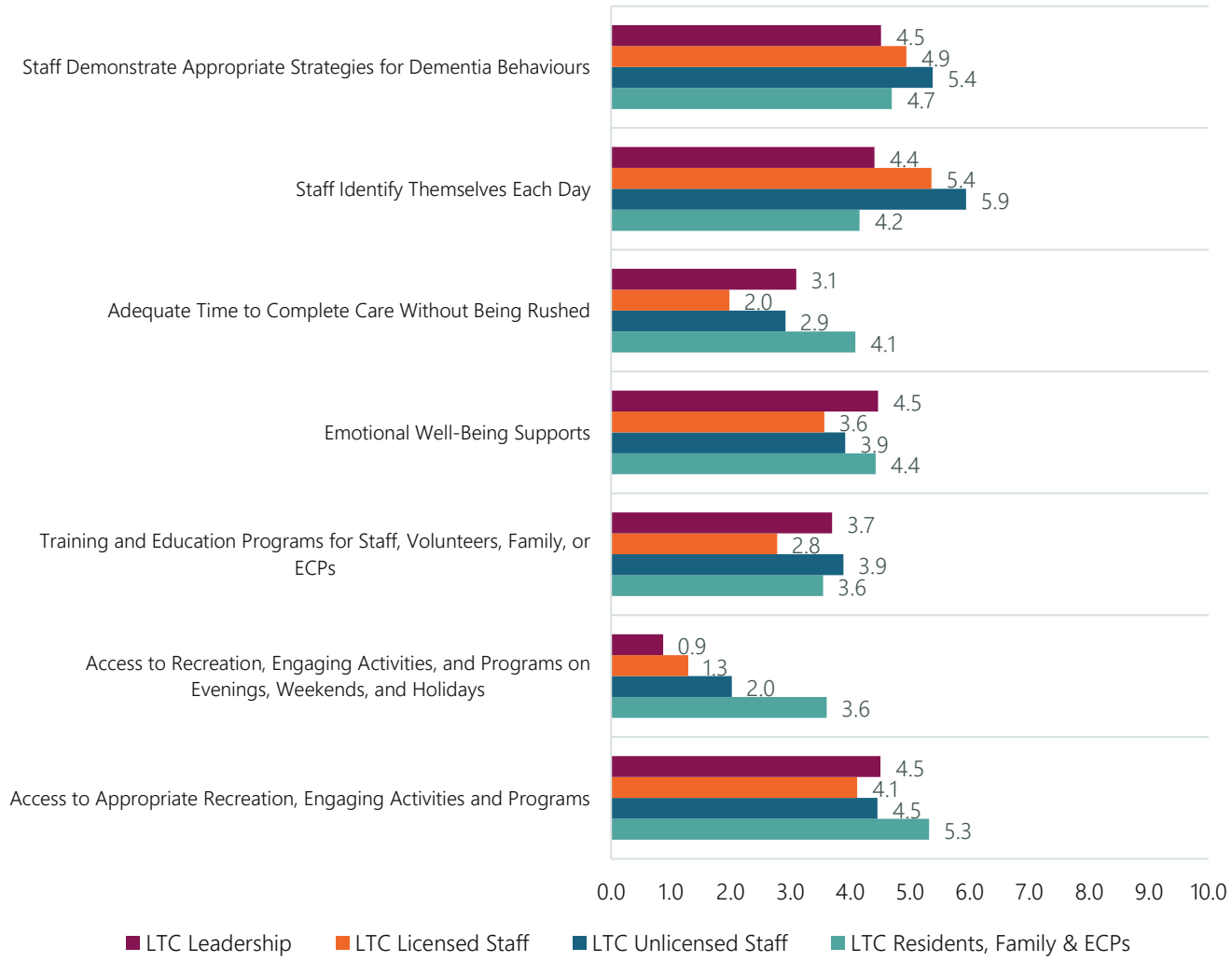
"Weekend activities are needed."

"Help connect residents with various relatives who are unable to visit (e.g., FaceTime calls)."

"More outdoor time."

"Live stream from the facility to check in remotely."

Figure 8: Average Ratings for Dementia Supports in LTC (Scale of 0 to 10)



Opportunities for Improvement

Survey respondents and focus group participants were also asked to provide further insight into what opportunities might help improve LTC resident quality of life. The following themes were identified:

- Move towards a resident-centred care model and improve aspects related to resident choice (meal types, mealtimes, wakeup, and bedtimes, etc.).
- Improve access to recreation and meaningful activities.
- Create policies and guidelines for resident and family councils to ensure they are effectively utilized at all LTC homes.
- Create a more home-like environment and move away from institutional settings (shared rooms and small common areas.).
- Review assessment and admission processes to accommodate resident preference for location and spousal admissions.

> ***"Rooms are extremely small. Two people should not be allowed to occupy such a small space."***

- Reduce barriers for volunteer applications and create a provincial pool of volunteers to coordinate the volunteer process.
- Improve access to emotional wellness supports for residents to reduce isolation and boredom. This may include more volunteer supports to provide companionship, improve supports for residents who have communication barriers, and improve the staffing model to be more holistic and focus on building resident relationships.
- Partner with communities, associations, and community councils to help provide local programs, activities, and support for residents and families.
- Strengthen programs, training, and awareness for dementia care supports for residents in LTC.

3.2 Personal Care Home Findings

The following section describes the current context and stakeholder engagement findings for PCH quality of life.

3.2.1 Current Context

PCHs are privately owned residences that provide care and accommodations to seniors and other adults who require assistance with activities of daily living.

As of December 2023, there were 87 PCHs in NL including 22 (25%) in Eastern Urban zone, 21 (24%) in Eastern Rural zone, 26 (30%) in Central zone, 14 (16%) in Western zone, and 4 (5%) in Labrador-Grenfell zone (Figure 9). Overall, there was a total of 5,477 PCH beds in the province with the highest proportion of beds in the Central Zone, and fewest in Labrador-Grenfell Zone (Figure 10).

Figure 9: Number of PCHs in NL, December 2023

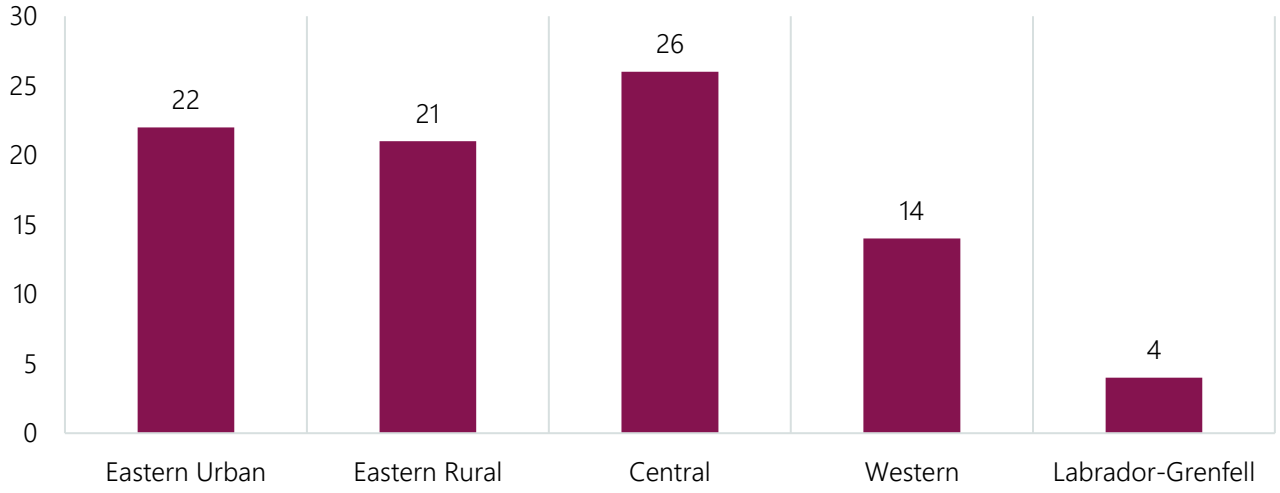
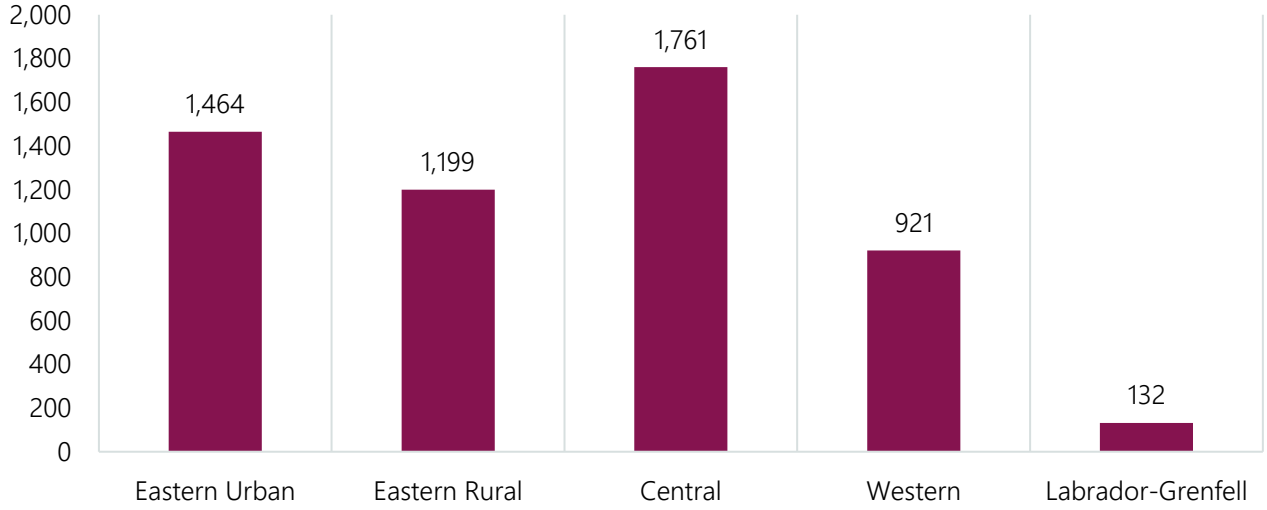


Figure 10: Number of PCH Beds in NL, December 2023



Personal Care Home Operational Standards

The Personal Care Home Operational Standards outline the GNL's expectations for PCHs to ensure consistency, establish guidelines for performance, and ensure tasks are carried out to a certain level of quality. Further details about these Standards are provided in Section 6.1.2.

CIHI does not report on quality indicators for PCHs in a manner similar to LTC homes (see section 3.1.1). However, the quarterly PCH Standards Monitoring Reports provide a quality assurance mechanism, which includes monitoring of certain dimensions of quality of life such as recreation activities, documentation of resident complaints and incidents,

resident rights, and food and nutrition. At present, the results of monitoring related to specific PCH standards are not publicly reported, with the exception of fire and safety and environmental health inspections completed by DGSNL.

3.2.2 What We Heard

Focus group participants were asked to share their experience on a variety of quality of life topics including:

- Resident choice
- Recreational and meaningful activities
- Volunteer opportunities and community connections
- Financial barriers

Survey questions using the quality of life dimensions assessment tool developed by Dr. Rosalie Kane[8] were provided to PCH residents, families, ECPs, and staff. These dimensions were assessed based on metrics related to comfort, security, meaningful activity, relationships, functional competence, enjoyment, privacy, dignity, autonomy, individuality, and spiritual well-being.

Focus Group Findings

Resident Choice

Focus group participants shared that in some PCHs there were limited meal choices and meal offerings were restricted to meeting the requirements of Canada's Food Guide which did not allow for influence of local cuisine and traditional dishes. It was perceived that these restrictions placed a higher value on nutrition than accommodating resident choice and food variety.

Recreation and Meaningful Activities

Perceptions regarding access to recreation and meaningful activities in PCHs varied amongst focus group participants. Some participants reported that the type, frequency, and extended hours of recreational activities was positive in PCHs, and some participants reported gaps in these activities. Participants indicated that as the number of residents with higher care needs increase, providing appropriate activities that meet the needs of a diverse group of residents is more challenging, and attendance at group activities has decreased.

Volunteer Opportunities and Community Connections

Focus Group participants indicated that volunteer opportunities and connections with the community were more accessible in some PCHs than others. PCHs were perceived to have fewer barriers than LTC for volunteer opportunities, making it easier to attract volunteers. Some PCHs also shared that they had community involvement through music performances, arts and craft programs, and transportation for outings in the community. However, access to transportation was also identified as an area for improvement in PCHs.

Financial Barriers

Focus group participants indicated that the comfort allowance for PCH residents was not providing enough financial support. Participants also felt that there were limited policies in place to regulate the increase in rent that operators can impose on privately paying residents.

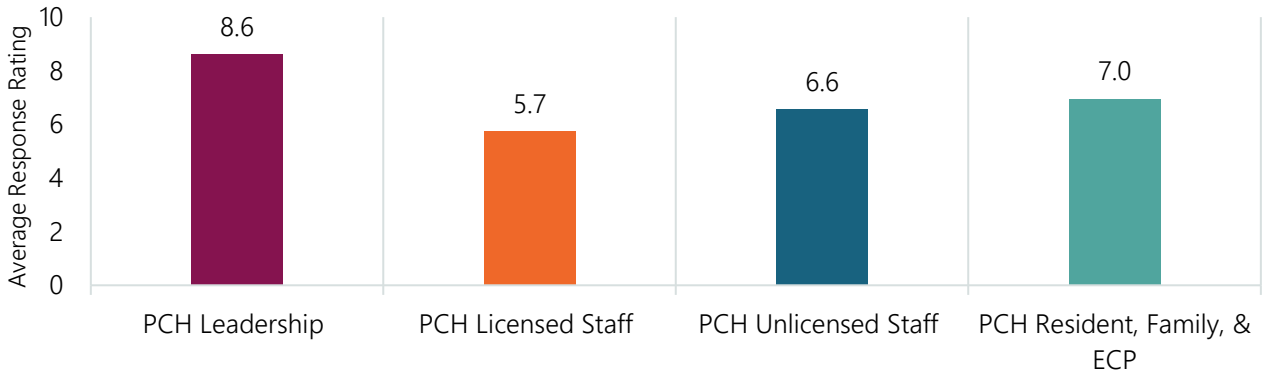
Survey Findings

The following section summarizes the survey results related to quality of life in PCHs for four stakeholder groups including:

- PCH Leadership – 24 survey respondents
- PCH Licensed Staff – 24 survey respondents
- PCH Unlicensed Staff – 31 survey respondents
- PCH Residents, Family, and ECPs – 126 survey respondents

Survey respondents were asked to rate the overall quality of life for residents in PCH homes on a scale of 0 (lowest quality) to 10 (highest quality). PCH leadership rated resident quality of life the highest at 8.6 out of 10, while PCH licensed staff rated it the lowest at 5.7 out of 10 (Figure 11).

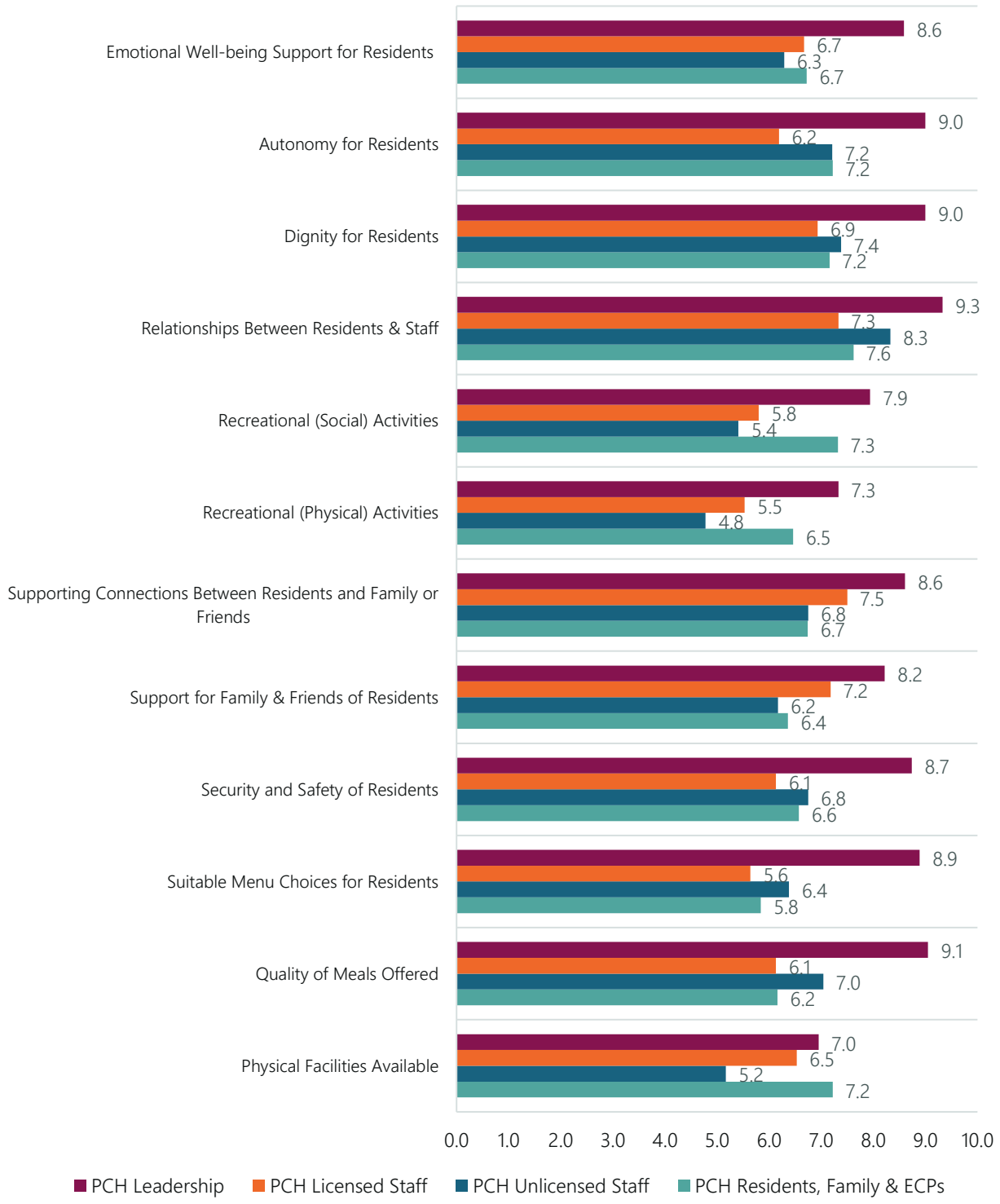
Figure 11: Average Ratings for Quality of Life in PCHs (Scale of 10 to 10)



Survey respondents rated PCH quality of life for a variety of dimensions using a scale of 0 (needs improvement) to 10 (strength). Overall, the average ratings provided by PCH Leadership were higher for most dimensions (except physical homes available) than the average ratings provided by PCH Residents, Family, and ECPs, PCH Unlicensed Staff, and PCH Licensed Staff (Figure 12).

The highest rated dimensions provided by PCH Residents, Family, and ECPs included relationships between residents and staff, recreational (social) activities, autonomy for residents, dignity for residents, and physical facilities available. Dimensions rated as needing improvement were suitable menu choices for residents, quality of meals offered, and support for family and friends of residents.

Figure 12: Average Ratings for Quality of Life Dimensions in PCHs (Scale of 0 to 10)



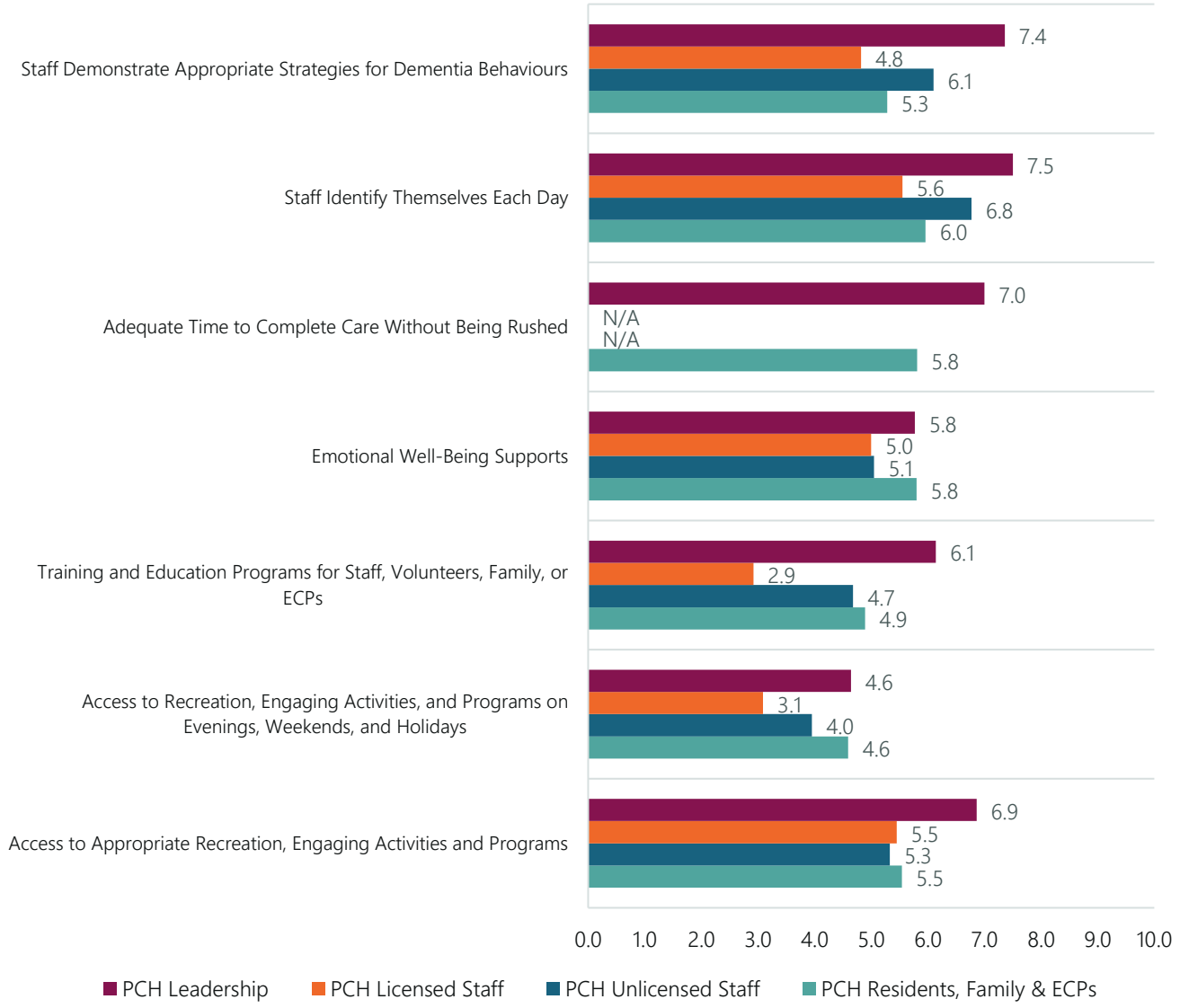
Thirty-nine percent of PCH Residents, Family, and ECPs responded that they reside in (or that their family member or friend resided in) a PCH that had volunteers while 24% responded no. The remaining 37% were unsure.

Survey participants also rated quality of life dimensions specific to dementia care supports for PCH residents and staff using a scale of 0 (needs improvement) to 10 (strength). The average ratings provided by PCH Leadership were higher than the ratings provided by other stakeholder groups for most supports (Figure 13).

PCH Residents, Families, and ECPs rated supports such as access to recreation, engaging activities, and programs on evenings, weekends, and holidays; and training and education programs for staff, volunteers, family, and ECPs as requiring the most improvement. The 'Adequate Time to Complete Care Without Being Rushed' was not provided as a category on the PCH Licensed Staff and PCH Unlicensed Staff surveys.

> ***"Exercise programs (that can be done sitting in chair if necessary) aimed at functional fitness are needed."***

Figure 13: Average Ratings for Dementia Supports in PCHs (Scale of 0 to 10)



Opportunities for Improvement

Survey respondents and focus group participants provided feedback on opportunities to improve PCH resident quality of life. The following themes were identified from surveys and focus group participants:

- Improve resident-centred care model and enhance ability for resident choice and decision making in care.
- Enhance dementia training and supports for staff, residents, and families.
- Improve access to recreation and meaningful activities.
- Further support the role of volunteers to support quality of life for residents.
- Enhance community partnerships for residents in areas such as transportation, access to programs and activities.
- Create a provincial policy to standardize the rate increases that operators can implement.

> ***"Residents need to have more social contact, be stimulated, and be engaged."***

3.3 Leading Practices and Other Jurisdiction Research

The following section identifies emerging, leading, and best practices identified through literature review and interviews with representatives from other provinces to improve of resident quality of life, based on the opportunities for improvement identified from the findings in Sections 3.1 and 3.2 above.

3.3.1 Leading Practices

The HSO National LTC Standard defines quality of life (QoL) as a person's sense of well-being and their experiences in life in the context of their culture and value systems and in relation to their goals, expectations, and concerns. Quality of life is a broad-ranging concept that is affected in a complex way by a person's physical health, psychological state, personal and spiritual beliefs, existential concerns, social relationships, and their relationship to salient features of their environment (page XV) [3].

Quality of Life Dimensions

The QoL Measures for Nursing Home Residents developed by Dr. Rosalie A. Kane and colleagues identifies 11 QoL domains to assess nursing home resident QoL[8]. These 11 QoL domains were used to guide stakeholder survey question development to assess resident QoL in NL (see Sections 3.1.2 and 3.2.2). Table 4 summarizes the 11 QoL domains including factors that influence each domain.

Table 4: Quality of Life Measures for Nursing Home Residents: 11 Domains and Related Factors

Domain	Factors	
Comfort	Too cold	Bothered by noise in own room
	So long in same position it hurts	Bothered by noise elsewhere in nursing home
	In physical pain	Get a good night's sleep
Security	Possessions are safe	Confident can get help when needed
	Clothes lost or damaged in laundry	Can get doctor or nurse quickly
	Afraid because of how you or others are treated	
Meaningful Activity	Get outdoors as much as you want	Enjoyable things to do at nursing home on weekends
	How often you get outdoors	Enjoys organized activities at nursing home
	Gives help to others	
Relationships	Easy to make friends at nursing home	Staff stop just to have friendly conversation
	Considers any resident to be close friend	Consider one or more staff to be a friend
	Nursing home makes it easy for family & friends to visit	
Functional Competence	Easy to get around room by self	Can get to bathroom quickly anywhere in nursing home
	Easily can reach things you need	Can easily reach toilet articles
	Take care of things & room as much as wanted	
Enjoyment	Likes the food here	Get favorite foods here
	Enjoy mealtimes at nursing home	
Privacy	Can be alone when want to	Can visit with someone in private
	Can make private phone call	Can be together with other residents in private
	Staff knock & wait before entering	
Individuality	Sense of being known as a person	Embrace your sense of self
	Express your identity	
Dignity	Staff treats you politely	Staff handles you gently
	Staff treats you with respect	Staff respects your modesty
	Staff takes time to listen to you	
Autonomy	Go to bed at the time you want	Can you decide what clothes to wear
	Get up in the morning when you want	Successful in making changes at nursing home
Spiritual Well-Being	Participate in religious activities	Feel your life has meaning
	Religious observances have meaning	Feel at peace

The study by Dr. Kane and colleagues focused on the psychological and social aspects of QoL, going beyond health-related quality of life (HRQOL)[8]. While there is more recent literature on QoL in LTC, Kane's QoL domains provide a comprehensive approach on how QoL can be represented in policy[9].

Changing Culture to Improve Quality of Life

The HSO National LTC Standard developed four guiding principles for people-centred care (page V) that should be incorporated into the culture for delivering LTC and PCH services in NL. The principles are:

- Integrity and relevance: uphold the expertise of people in their lived experiences of care; plan and deliver care through processes that allow mutual understanding of people's goals, needs and preferences and facilitate outcomes that have been influenced by the expertise of all.
- Communication and trust: communicate and share complete and unbiased information in ways that are affirming and useful; provide timely, complete, and accurate information to enable people to effectively participate in care and decision-making.
- Inclusion and preparation: ensure that all people have equitable access to care and the opportunity to plan and evaluate services; empower people to participate in care and decision-making to the extent that they wish.
- Humility and learning: encourage people to share problems and concerns to promote continuous learning and quality improvement; promote a just culture and system improvement over blame and judgement[3].

The HSO National LTC Standard defines resident-centred care (page XV) as an approach based on the philosophy of people-centred care that ensures that the resident is a partner and active participant in their care[3].

A culture shift is needed to transition from a transactional task-based approach to a more holistic, resident-centred, team-based approach focused on quality of life. Many demonstration projects have been implemented throughout the world as part of this culture change. Some of the practices from these projects could be trialed in NL to improve the culture in LTC and PCHs. Notable demonstration projects include:

- The Eden Alternative[10] maintains that care is not to be provided unilaterally, but rather a collaborative partnership whereby care providers and residents are "care partners". It uses environmental and social enrichment to overcome boredom, helplessness, and loneliness among residents.
- Green House Projects use small group home settings where residents receive care from a consistent group of direct care staff with expanded work responsibilities including[11]:
    - Organizing and conducting recreational activities.
    - Light housekeeping and meal preparation.
    - Personal care for residents.
- The Butterfly Household Model of Care has been proven to have positive impacts on the quality of life for people experiencing different stages of dementia in areas such as overall increased well-being, improved safety alerts, and weight gain[12]. The Butterfly Project also focuses on resident-centred care through nurturing leadership, staff, families, and ECPs to be included in the care planning.

Research studies worldwide have highlighted the following key steps for achieving a culture shift towards a resident-centred approach[13] [14] [15]. These steps could be considered to shift towards a more resident-centred model of care for LTC and PCHs in NL.

Leadership and Engagement for Culture Change

- The vision for change must be endorsed as the values and principles of the organization, and the declaration for change must come from the highest leadership level such as the CEO of the organization.
- All levels of management, including LTC administrators, program managers, and clinical leaders of the facility organizations, must champion the change.
- Staff must be provided with support and education on the benefits and approach for the change. There are staff at sites across the province who are already committed to delivering services to achieve resident quality of life. These staff could be "change agents" and leaders in their organizations to champion the change.

Redesign the structure, process, and outcomes of the organization to achieve culture change.

The Donabedian model[16] [17] references structure, process, and outcome as fundamental dimensions to achieving quality care across various health care settings including LTC/PCH homes. Examples of how this model could be incorporated to change current practices and improve quality of life for residents in NL include:

- Structure:
    - Reviewing facility designs to ensure that they achieve resident quality of life.
    - Training staff to implement a resident-centred care approach to care.
    - Encouraging staff to increase social interaction and enhance relationships with residents.
    - Enhancing recreational programs to add features that will improve resident quality of life: e.g., inclusion of music, pets, and gardening as recreational activities.
    - Reviewing facility schedules to see how they can be made more flexible to accommodate resident choices.
    - Reviewing food and meals to enable wider selections and cater to resident cultural diversity.
- Process:
    - Focussing legislation and standards on improving resident quality of life.
    - Introducing demonstration projects and evaluation to assess the outcomes of specific care practices designed to enhance quality of life.
    - Profiling practices to improve quality of life in LTC homes and PCHs across NL.
- Outcome:
    - Developing outcome indicators to measure resident quality of life.
    - Ensuring/Requiring LTC homes and PCHs measure and report on quality of life.

Resident-Centered Delivery of Care.

The current management model at LTC homes and PCHs is top-down. There is a "chain of command" in which all care staff must follow. Cultural change promotes a redesign of the workforce where the goal is to "flatten" the hierarchy. This levelling can be done by creating self-managed work teams (e.g., a group of PCAs responsible for providing care to a specific group of LTC residents). The team members are encouraged to tailor resident care based on their overall needs, honoring their preferences, and adjusting schedules as needed. For instance, if a resident prefers to sleep in during the morning, that choice is respected, and they can enjoy a later breakfast in a designated area designed for flexible snacking. Research studies have demonstrated that self-managed work teams correlate with greater job satisfaction, enhanced self-esteem among workers, improved efficiency, and reduced staff turnover[18].

Quality, Choice, and Flexibility of Meals

Stakeholders identified the quality, choice, and flexibility of meals as one of the biggest areas for improvement in LTC homes and PCHs (see Sections 3.1.2 and 3.2.2). The following section presents standards and leading practices that can be incorporated to improve the quality of meals for LTC and PCH residents in NL.

According to the HSO National LTC Standard[3]:

- Mealtimes in LTC homes are designed to meet residents' nutritional, emotional, and social needs, with leaders ensuring preferences are considered, menus are varied, and diets are modified as necessary (criterion 3.1.4).
- Flexible food and beverage options offered outside of set mealtimes are tailored to residents' preferences and may include snack trolleys or stations stocked with healthy alternatives, with staff providing support for residents who need assistance with accessing and consuming food and beverages beyond regular meal hours (criterion 3.1.5).
- Mealtime is facilitated in a clean, bright, and calm environment, fostering socialization, and allowing residents to enjoy their meals at their own pace while respecting their cultural and spiritual practices (criterion 3.1.4).

There are multiple studies that focus on improving the dining experience in residential continuing care homes.[19] [20] Common practices that can improve the dining experience for residents include:

- Providing flexible meal schedules, including personalized menu options, for meeting residents' nutrition and hydration care needs.
- Providing a relaxed, supportive dining environment, including cultivating a warm and welcoming dining atmosphere.
- Ensuring meal service operations are organized and efficiently managed.
- Ensuring continuity of staff to foster familiarity with residents' individual requirements.
- Providing residents with all planned menu choices including beverages, entrées, vegetables, desserts, and their alternates, in a manner suitable to each resident's ability and/or limitations (e.g., visual, verbal, or written).
- Upholding each resident's rights to respect, dignity, and privacy, ensuring that medications are not given in the dining room during meal service unless indicated on the resident's care plan.

Meaningful Activities and Recreational Programs

As indicated in sections 3.1.2 and 3.2.2, the focus groups and surveys identified access to meaningful and recreational activities for residents in LTC and PCHs as an area for improvement.

The HSO National LTC Standard emphasizes[3]:

- LTC facility leaders play a crucial role in providing meaningful activities that enhance residents' quality of life by fostering a sense of purpose, facilitating social interactions, and improving physical and mental health while reducing loneliness, helplessness, and boredom (criterion 3.1.3).
- The importance of offering activities that meet residents' diverse needs, including physical, spiritual, intellectual, social, intergenerational, cultural, and creative aspects. Activities should be co-designed and programmed with input from residents, substitute decision makers, and family. When desired activities are

not available, efforts should be made to support residents in accessing broader community programs (criterion 3.1.3).

- Engagement in outdoor activities to foster a sense of belonging and social connection within neighborhoods and communities, particularly for individuals living with dementia as it reduces agitation (criterion 3.1.6).
- Teams facilitate residents' utilization of outdoor spaces by helping and considering seasonal and environmental factors for their comfort and safety. Indoor environments should be designed to promote connectivity to nature through features such as natural light, balanced spatial layouts, and good air quality, further enhancing residents' holistic experience and satisfaction (criterion 3.1.6).

Emotional Well-Being

The findings from the stakeholder focus groups and surveys identified emotional support as another area for improvement. The following practices could be considered for improving resident emotional wellbeing in LTC homes and PCHs.

Several research findings and emerging practices highlight the significant impact of emotional well-being on quality of life, with residents who experience positive emotional states reporting higher levels of satisfaction with their living arrangements, better physical health outcomes, and greater overall life satisfaction[21] [22]. Two emerging practices include:

- A Story-Centred Care Intervention Program (SCCIP) designed to enhance a resident's well-being by integrating their life stories into care practices[21].
- Implementing a dementia-inclusive garden into a facility or community and incorporating the garden into therapy goals and daily programs such as physiotherapy, occupational therapy, and horticultural therapy[22].

Role of Volunteers

The focus group and survey findings identified an opportunity to expand the role of volunteers in LTC and PCHs and improve the consistency in the processes for screening, onboarding, and training of volunteers among the health zones.

According to the HSO National LTC Standard, volunteers significantly contribute to enhancing residents' quality of life in LTC homes by offering relational care through various social and cultural activities, thereby reducing social isolation and loneliness (criterion 3.1.7)[3]. Their roles may include friendly visiting, mealtime assistance, organizing special events like pet therapy and music, as well as supporting administrative tasks and fundraising efforts. It is suggested that LTC leaders collaborate with teams to promote volunteer programs and ensure clear role definitions to establish procedures for recruiting and screening, training, coordinating, and retaining volunteers.

Research has shown that volunteers feel more effective and supported when they are included as part of the care team[23]. It is suggested that volunteers are trained through formalized mentorship programs which encourages them to assume more responsibilities while respecting staff boundaries. Further, success is attributed to regularity and consistency of volunteers, ongoing education, support from both clinical and non-clinical staff, and gaining acceptance from management and frontline staff[24].

Importance of Social Interactions

The findings in Sections 3.1.2 and 3.2.2 identified an opportunity to improve access to transportation to enable LTC and PCH residents to attend meaningful activities in the community.

The HSO National LTC Standard[3] outlines the importance of supporting social interactions of residents as part of enabling meaningful quality of life. It provides guidelines on how community resources, events, and programs facilitate social interactions, belonging, and intergenerational connections encompassing libraries, parks, art shows, and volunteer programs (criterion 3.1.8).

Information and communication technology can enhance residents' social engagement and quality of life through access to phones, computers, and Wi-Fi networks tailored to accommodate sensory or cognitive impairments (criterion 3.1.9).

LTC leaders and care teams can assist residents in accessing transportation to participate in community activities and access services, appointments, care, and events beyond the home (criteria 3.1.10 and 4.3.11). The LTC home can support residents by coordinating with transportation providers, providing schedules, and ensuring the safety and reliability of recommended transportation services.

Role of Family

Families play an essential role to enhance the quality of life of residents in LTC[25]. Family members and ECPs assist care staff by filling in the gaps in resident care by providing invaluable, though often invisible, assistance, such as intimate or direct assistance with clothing maintenance, support with eating[26], and psycho-social aspects of the resident's well-being[27] [28]. Much has been written about the restrictions that families and ECPs faced during the COVID-19 pandemic and the negative effect these restrictions had on themselves, the residents, and the staff of LTC facilities. Research has demonstrated that the initial refusal to all families and ECPs to enter LTC and later restricting their visitations, essentially eliminating opportunities for family engagement, had devastating consequences on residents' quality of life[29]. Researchers and advocates acknowledge that it is imperative that families can continue access to residents[25] [29] [30].

There is a need to include family members and designated ECPs in resident care planning and delivery in LTC and PCHs in NL (Sections 3.1.2 and 3.2.2). The HSO National LTC Standard (criterion 2.3.1) explicitly states that LTC home leaders and teams promote the role and presence of ECPs[3]. Similarly, a 2021 study by Joseph Gaugler and Lauren Mitchell found that family involvement is crucial for resident quality of life and well-being in LTC settings, and efforts to enhance family involvement in care decisions and care planning are needed to improve resident and family outcomes[31].

Autonomy

There is an opportunity to improve autonomy for LTC and PCH residents in NL based on stakeholder feedback in Sections 3.1.2 and 3.2.2.

The HSO National LTC Standard defines autonomy as having control over one's life and the freedom to make decisions on personal choice or preference. According to criterion 2.2.6 teams enable residents' autonomy in their daily life and care activities by enabling residents to make their own decisions based on goals, needs, and preferences, participate independently in daily life and care activities, keep and restore their mobility, keep and restore their functional capacity, and socially interact with people they choose (criterion 2.2.6)[3].

Further, residents who participate in planning, delivering, and improving the quality of their care tend to feel more empowered and have better care experiences and health outcomes (criterion 2.2.7). Teams can support residents to be actively engaged in their daily life and care activities in various ways including understanding and respecting their diversity and lived experiences, practicing cultural safety and humility, including residents in developing their care and choosing their ECPs if residents wish to have them, having ongoing conversations with residents about their

experiences living in the LTC home, and communicating in a positive way to maintain a residents' engagement. (criterion 2.2.7)[3].

Infrastructure

There are currently 22 LTC homes in NL that are 30 years or older, many of which that have FCI scores of 30% or higher, indicating that a higher percentage of components in these homes have reached the end of their projected useful life and might need renovation or replacement. Further, the focus group and survey findings show that there is a desire to improve the physical environment in LTC homes and PCHs to promote a homelike environment to improve resident quality of life.

The newly released CSA Z8004:22 Standard Long Term Care Home Operations and Infection Prevention and Control[4] addresses the design, operation, and infection prevention and control practices in Canadian LTC homes. While NL has not built any new homes since the release of the CSA Z8004:22 Standard, recent LTC home construction has aligned with the latest CSA standards that were developed at that time.

The HSO National LTC Standard incudes criteria related to LTC facility infrastructure including addressing dated infrastructure; incorporating communication methods such as call responder systems, wayfinding, and signage to support verbal and written communication (criterion 2.4.1); and creating a safe and welcoming environment while promoting physical safety (criteria 3.1.1 and 3.1.2)[3].

Restructuring the physical design of facilities to promote privacy and dignity plays a crucial role in resident-centred care[32] [33] [34]. Whenever feasible elimination of semi-private, three- and four-bed rooms are essential. Instead, private one-person rooms (except for couples' rooms) are the preferred accommodation to ensure resident privacy. Additionally, creating smaller dining spaces, providing recreational areas for social events, and ensuring access to green spaces all contribute to fostering a homelike environment and enhancing resident quality of life.

3.3.2 Other Jurisdiction Research

The following notable practices from British Columbia (BC), Alberta, Ontario, and Nova Scotia were gathered through interviews and secondary research. These practices have been taken into consideration to inform the recommendations in Section 3.5.

British Columbia

Relationships and Social Connections: Role of Volunteers

Volunteers can establish meaningful relationships with LTC residents which can improve their quality of life. Volunteers at LTC homes in BC are organized by Volunteer Coordinators and the utilization of this position varies across the province based on the availability of funding, as it is often funded through external fundraising. The Volunteer Coordinator position manages the recruitment, training, and retention of volunteers and at sites without a dedicated coordinator that often falls on existing staff as an additional duty rather than a primary focus.

Volunteers are subjected to a screening process like that of an employee, which may include criminal record checks to ensure the safety and integrity of the organization and its residents. The BC *Model Standards for Continuing Care and Extended Care* suggests sites develop a clear scope of responsibilities for volunteers, including assisting as language interpreters for residents[35].

Relationships and Social Connections: Role of Family

LTC homes in BC are encouraged by Health Authorities to develop Resident and/or Family Councils whose main responsibility is to identify and resolve issues and support quality of life improvements for LTC residents[36]. Resident and/or Family Councils serve to enhance communication and collaboration among residents, family members, staff, and management in LTC facilities by engaging in projects, offering recommendations, and addressing shared concerns for improvements[37]. Further, in each health authority, Independent Regional Associations of Family Council exist to:

- "Advocate on regional, systemic issues.
- Promote awareness of the benefits of Resident and/or Family Councils.
- Provide support and advice to existing or emerging councils.
- Promote understanding and awareness of the Residential Care Regulations, Community Care and Assisted Living Act and other relevant statutes, regulations, policies, and practices"[38].

Alberta

Quality of Life

Alberta Health (AH) is currently implementing Continuing Care Transformation (CCT) that includes initiatives designed to improve the quality of life and quality of care for Alberta continuing care home residents. CCT includes implementing recommendations arising from the *Facility Based Continuing Care Review* (FBCC), as well as recommendations that are a priority for the Government of Alberta as reflected in the Premier's mandate letter to the Minister of Health, including the recommendation that quality of life be made a number one priority.

Alberta Health is working collaboratively with Alberta Health Services (AHS) to implement over 50 improvement initiatives. They have established a Quality of Life Taskforce (QoL TF), co-chaired by AH and AHS, which includes three working groups: measurement, framework and toolkit. These working groups are working on identified CCT priorities, planning actions, and resources that will support the implementation of the CCT and QoL TF work. Some of the outputs expected from the work of the QoL TF and its working groups, include:

- A QoL framework.
- A QoL toolkit (expected to serve as practical resource for organizations).
- Recommendations regarding QoL measurement in continuing care homes.

Anticipated shortly, and useful to inform the work of AH, AHS, the QoL TF and its working groups, the Health Quality Council of Alberta is expected to publicly release the results of the most recent continuing care homes experience surveys, which will include the first use of one standardized quality of life tool within continuing care homes.

Alberta Health also launched the Continuing Care Home Quality of Life Initiatives Grant. The purpose of this grant program is to provide publicly funded continuing care home operators with one-time grant funding to lead and develop innovative resident informed initiatives with the goal of improving the quality of life for continuing care home residents, including, but not limited to, persons living with dementia. The grant will support innovative projects that are designed to enhance resident quality of life by addressing at least one of three priorities:

- Opportunities to participate in meaningful activities.
- Access to culturally appropriate care and services.
- Improving the mealtime experience.

Applicants must ensure residents are engaged to have a voice in designing, implementing, and evaluating the projects, and use a standardized quality of life evaluation tool as one of the ways that involved residents' quality of life is assessed over the course of the grant project.

Relationships and Social Connections: Role of Volunteers

Continuing care home volunteers in Alberta should be provided with a clean and comfortable environment and training in security, community, and emergency call systems according to the 2024 Accommodation Standards[39].

Infrastructure

Alberta recently published the *Continuing Care Design Standards and Best Practices, 2023* to integrate design concepts facilitating the delivery of quality accommodation and healthcare services in comfortable, safe, aesthetically pleasing, and home-like environments. The standard outlines that individual households shall have up to a maximum of 14 residents.[40]

Alberta is promoting a single room model, where each resident room will accommodate only one resident and a minimum of 8% of the resident rooms will be connected for sharing spaces (e.g., couples, companions, etc.). The design of the resident rooms prioritizes comfort, safety, independence, and dignity for each resident, with good sightlines to promote orientation and comprehension of surroundings. Rooms are sized and configured to facilitate quality care delivery, allowing ECPs unobstructed access to the bed. Additionally, the resident room will act as a personal sanctuary where residents can engage in various activities, including visiting with family and friends, completing tasks independently or with others, and enjoying leisure activities. Personalization of the room with familiar furniture is possible to further enhance the resident's sense of familiarity and comfort.

Each resident room will have access to a private bathroom with wheelchair accessible shower, toilet, and sink. Further, the design standards are implementing well-design corridors to promote resident engagement, mobility, orientation, comfort, safety, and satisfaction. Efficient corridor design supports operational efficiency, facilitating the discreet delivery and removal of supplies/linens and enabling efficient staff coverage.

Living rooms and activities spaces will be included in each household to accommodate a variety of planned social activities aimed at enhancing residents' quality of life, including hobbies, crafts, exercise sessions, recreational activities, and special events.

The dining room will be designed to be accessible and sized to accommodate residents, visitors, and mobility aids, considering operational efficiency and food service delivery models. Key features include hand-washing sinks, adjacent resident washrooms, and private dining rooms for residents and their families.

Additional spaces, such as beauty shop/barber shop, fitness/wellness area, large multi-purpose room, place for worship and cultural/spiritual expression, and outdoor areas, will be available at every facility. Optional spaces, such as gift shop and snack bar and indoor resident smoking room, may be provided at some homes.

Ontario

Quality of Life

Ontario recognizes several resident-centred care models, such as the Butterfly Model, the Eden Principle, and the Green House Model, in delivering LTC services. Recently, Toronto introduced CareTO to improve the experiences of all residents, staff, and visitors[41]. The key aspects of CareTO include:

1. Equity Driven Care:

- Ensures fair access to opportunities and individualized treatment.
- Considers equity, diversity, and inclusion in addressing social and emotional needs.
- Recognizes the diverse backgrounds of LTC residents.

2. Resident-Centered Care
    - Puts the resident at the center of their care.
    - Empowers residents to have an active voice in decisions (e.g., food preferences, activities).
    - Guides the culture and approach to care delivery.
3. Emotion Focused Care:
    - Focuses on understanding and managing emotions.
    - Prioritizes emotional needs and care preferences aligned with individual lifestyles.
4. Relationship Based Care:
    - Builds and nurtures relationships among residents, staff, and families.
    - Enables participatory implementation through collaborative decision-making and co-creation.

A preliminary review of CareTO was completed in 2022 and found that[42]:

- CareTO is seen as a flexible, person-centered, and emotion-based approach to care.
- CareTO goes beyond attending to the physical and medical needs of residents and emphasizes the importance of their social and emotional care needs.
- CareTO enhances resident experience as evidenced in dining preferences and creating a home-like environment where residents have more autonomy to participate in self-care and therapies.

The following considerations were identified regarding the ongoing implementation of CareTO[42]:

- CareTO is a culture shift.
- Engage with Family and Resident Council to communicate and create opportunities for shared decision making.
- Ensure communications and information about CareTO are easy to find.
- Provide time to allow staff to re-think their scope of practice in the team and how they work together.
- Keep lines of communication open to keep staff engaged.

Meaningful Activities and Recreational Programs

The *Fixing Long Term Care Act, 2021* was legislation introduced to replace the *Long Term Care Homes Act, 2007*[43] and improve the well-being of LTC and retirement home residents[44]. The new Act specifies that licensees are required to offer recreational and social activities to residents weekdays, evenings, and weekends[45]. Recreational and social activities in Ontario are expected to be offered outside of the times of 8 a.m. to 4 p.m. and be available during holidays as well.

Quality, Choice, and Flexibility of Meals

LTC homes are mandated to provide three meals and two snacks daily, with options tailored to accommodate various dietary needs. However, operators are experiencing challenges with inflationary pressures on food costs that have resulted in budget constraints limiting their ability to meet these standards while remaining financially viable. Ontario has proposed a shift in meal offerings to address this issue and is encouraging operators to serve one

complete meal for all residents, supplemented by a side option conveniently stored in the freezer for easy microwaving. However, many operators have still chosen to continue to offer two meal options for residents to cater to individual preferences and dietary requirements.

Relationships and Social Connections: Role of Family and Volunteers

LTC homes are required to establish a Resident's Council and are encouraged to establish a Family Council, according to the *Fixing Long Term Care Act, 2021*[46]. A Resident's Council is responsible for organizing resident activities including collaborating with community groups and volunteers. LTC homes are required to appoint a Residents' Council Assistant to assist the Residents' Council in carrying out their duties.

Nova Scotia

Infrastructure

The Government of NS is actively expanding and enhancing LTC capacity to meet the growing needs of its aging population by adding approximately 5,700 LTC beds throughout the province by 2032, including 2,000 net new beds[47].

The LTC Facility Requirements in Nova Scotia are in the process of being updated. According to representatives from the Department of Seniors and Long Term Care, new LTC homes will be designed as single-story to four story structures with a minimum of 48 beds and a maximum of 144 beds. Each household unit in a facility will range from 16 to 24 beds. All new living spaces will be single rooms, each equipped with its own private washroom which will enhance privacy, dignity, and comfort for residents.

Additional spaces such as hair salons, occupational/physical therapy areas, and designated smoking rooms with proper ventilation will be incorporated to increase resident choice and eliminate barriers to placement. Some homes will also incorporate community connection rooms as multipurpose spaces to engage with volunteers, host events, and provide entertainment.

Other design features to enhance resident quality of life include:

- Having a memory box outside each resident room for placing personal mementoes to improve wayfinding.
- Equipping rooms with Wi-Fi connectivity and desks for tablets and laptops.
- Positioning bedroom windows at a lower height to allow easy access and views from bed level, with limited ability to open to ensure resident safety.
- Having connecting room doors for couples.
- Having a designated bariatric room per 48 beds.
- Eliminating locked units and examining options for wearable technology to prioritize freedom and accessibility for residents with dementia.

Culturally Appropriate Facilities

The Government of NS has focussed on incorporating culture into LTC facility design and programming. The government worked collaboratively to plan and develop the first LTC home, Kiknu, on a First Nation Community. Kiknu means "our home" in Mi'kmaq. Kiknu was inspired by Turtle Island and the facility was built in the shape of a turtle with a designated central gathering place for Elders, family and loved ones[48]. Kiknu is operated by Shannex which has established a contract with Sysco to provide traditional foods to accommodate the preferences of Elders.

Meaningful Activities and Recreational Activities

The Rosedale Home for Special Care in Lunenburg County, Nova Scotia (NS), implements therapeutic recreational and leisure programming through a resident-centered approach to honor each resident's story and empowers them to make choices about their lifestyle. Programs are offered daily including holidays to meet a resident's physical, emotional, spiritual, and intellectual needs[49]. Qualified staff lead both group and individualized activities to address a resident's unique circumstances. Activities offered include narrative programs, sensory stimulation therapy, music therapy, pet therapy, an iPod program, intergenerational programs, and outings.

3.4 Quality of Life Conclusions

The following conclusions have been drawn for LTC and PCH quality of life based on the findings in the preceding sections.

3.4.1 Long Term Care Home Conclusions

1. NL is currently performing better than the national average for six LTC quality indicators (QIs) including Falls in the Last 30 Days, Worsened Pressure Ulcer, Experiencing Worsened Pain, Worsened Depressed Mood, Improved Physical Functioning, and Worsened Physical Functioning. NL is performing under the national average for three LTC QIs including Potentially Inappropriate Use of Antipsychotic Medication, Restraint Use, and Experiencing Pain and there is an opportunity to update practices in these areas to improve quality of service delivery.
2. Stakeholders perceive there to be relatively strong relationships between staff and residents in LTC homes. The average rating for relationships between residents and staff was among the highest rated quality of life dimension for LTC survey respondents.
3. Opportunities identified to improve quality of life include, but are not limited to, the quality and choice of meals provided, more meaningful recreational and social activities, prioritized and enhanced emotional well-being supports, enhanced partnerships with community organizations, and more effective use of resident and family councils. Stakeholders also identified a need to increase autonomy and maintain dignity and respect for residents during staff interactions.
4. Stakeholders identified a need to enhance dementia training and supports for staff, residents, families, and ECPs in LTC homes.
5. Volunteers were perceived to be underutilized in LTC homes and there is a need to standardize practices among health zones for volunteer recruitment, roles, and training.
6. Eighteen of the 22 LTC homes that are 30 years or older in NL had facility condition index (FCI) scores greater than 30% indicating these homes have a higher percentage of components that have reached the end of their projected useful life and might need renovation or replacement. Further, focus group and survey results identified inconsistent "home-like environments" due to shared rooms and small common areas resulting in residents feeling like they live in an institutional setting.
7. Stakeholders indicated that residents have experienced challenges with being separated from their spouses upon admission into LTC homes.

3.4.2 Personal Care Home Conclusions

1. Stakeholders perceive there to be relatively strong relationships between staff and residents in PCHs. The average ratings for relationships between residents and staff was among the highest rated quality of life dimension for PCH survey respondents.
2. Stakeholders perceived there to be autonomy and dignity for PCH residents. The average ratings provided by PCH residents, families and ECPs were high for both the autonomy for residents and the dignity for resident quality of life dimensions.
3. Opportunities identified to improve quality of life include, but are not limited to, expanded meal choices to incorporate traditional dishes, more meaningful recreational and social activities (satisfaction varied across sites), better access to emotional well-being supports, enhanced partnerships with community organizations, and better utilization of volunteers to support PCH residents.
4. Stakeholders identified a need to enhance dementia training and supports for staff, residents, and families in PCHs.

3.5 Quality of Life Recommendations

The findings from Section 3.1 to Section 3.4 above identified several opportunities to improve resident quality of life in LTC homes and PCHs in NL. A total of seven recommendations for improvement were developed. Each recommendation includes:

- A description of the recommendation.
- The key actions required to implement the recommendation.
- The expected benefits of implementing the recommendation.
- Implementation roadmap for the recommendation.
- The financial considerations of the recommendation.

Recommendation #1: Establish quality of life as the number one priority.

Several opportunities were identified to improve resident quality of life in LTC and PCHs. The findings also show that quality of life is not measured or monitored in LTC and PCHs. Leading practices and literature (Section 3.3) support implementing the improvements identified in the key actions below.

Key Actions Required

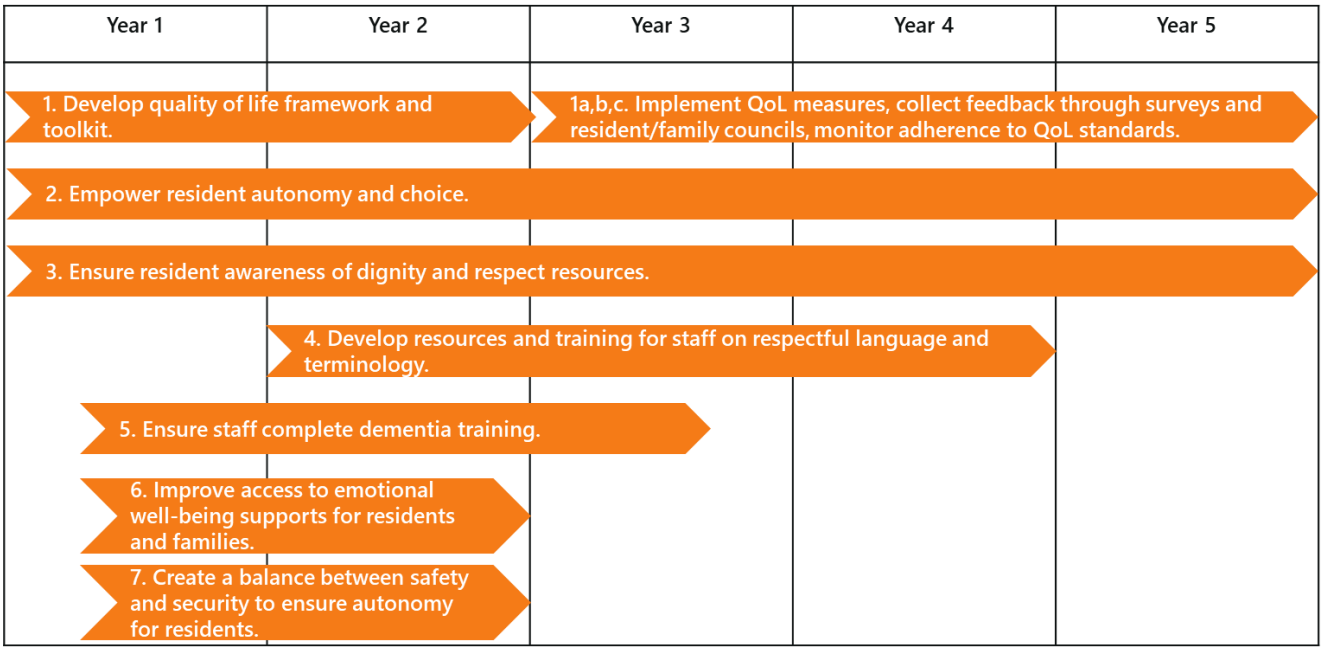
1. Collaborate with residents, families, ECPs, and staff to develop a quality of life framework and toolkit which fosters autonomy, dignity and respect for residents.
    a. Implement standards and outcome measures to monitor quality of life.
    b. Ensure regular input and feedback through surveys and resident and family councils.
    c. Ensure leaders support and monitor adherence to the quality of life standards.
2. Empower resident autonomy by enabling opportunities to exercise choice and control over their daily routines, activities, and interactions.
3. Ensure residents are aware of the resources available regarding their right to be treated with dignity and respect and their responsibility to treat others with dignity and respect.

4. Develop resources and training for staff and leadership on resident quality of life, such as respectful language, terminology, and interactions with residents.
5. Ensure staff complete dementia training to foster respectful interactions and acknowledge the increased time and flexibility required to provide appropriate care for residents living with dementia.
6. Improve access to emotional well-being supports for residents and families.
    a. Enhance emotional well-being supports during transition to LTC or PCHs.
    b. Ensure staff are equipped to address residents' emotional needs effectively.
7. Create a balance between safety and security, to ensure autonomy for residents.

Expected Benefits

The expected benefits of this recommendation include the ability to measure and monitor quality of life outcomes for residents, improved resident quality of life, and improved training and resources for staff and leadership.

Implementation Roadmap



Financial Considerations

Staff time will be needed to support the development and implementation of quality of life standards and outcome measures. The estimated costs of providing dementia training to LTC and PCH staff are estimated to be $708,450 over five years. Detailed costing assumptions are provided in Appendix 2.

Recommendation #2: Improve the quality, choice, and flexibility of meals.

Based on Section 3.2, stakeholders perceived a need to improve the quality and choices of meals available to LTC and PCH residents. Leading practices and literature (Section 3.3) support implementing the improvements identified in the key actions below.

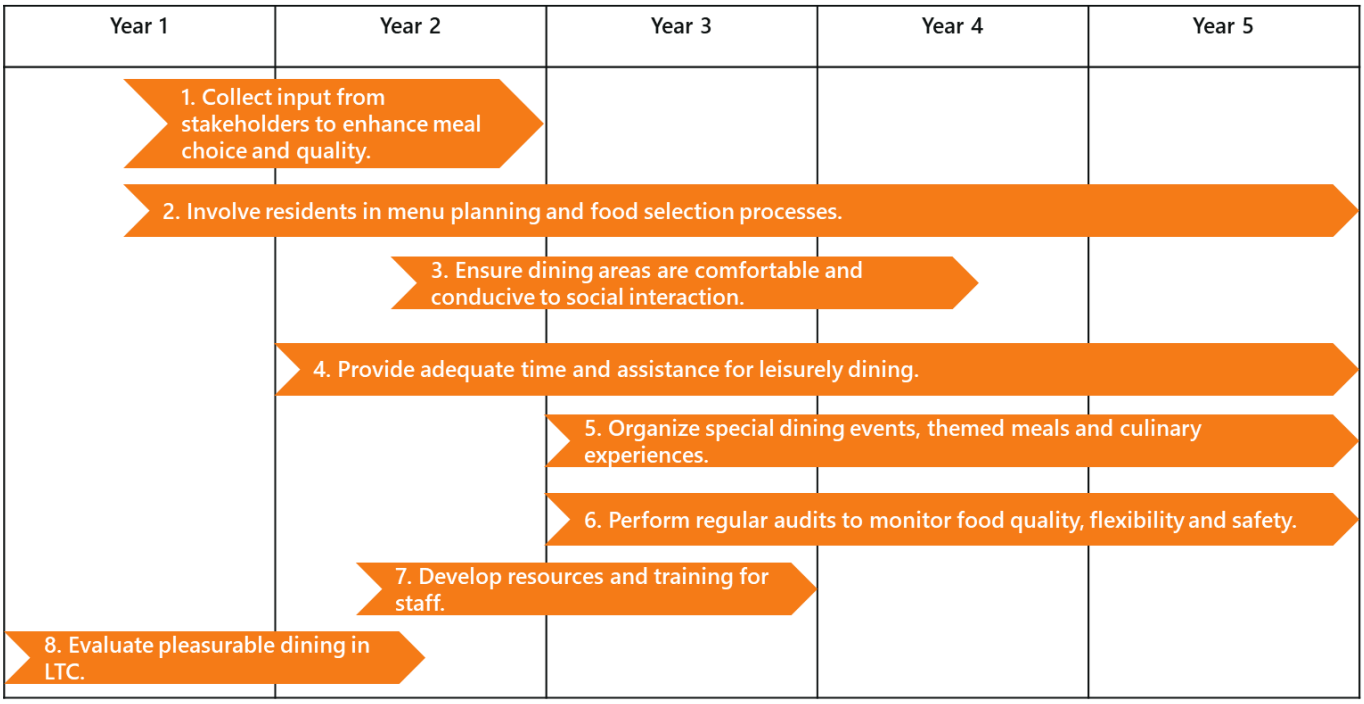
Key Actions Required

1. Enhance the quality, choice, and flexibility of meals through input from residents, families, ECPs, dietitians, home leadership, and food service providers.
2. Involve residents in menu planning and food selection processes that reflect their preferences and needs.
    a. Examine options to provide a balance between offering modified diets or healthy menu choices and a resident's choice to eat at risk.
    b. Ensure modified diets are appealing and high quality for residents.
    c. Incorporate traditional foods into the meal planning process.
    d. Ensure meals are served in a manner to support resident abilities.
3. Ensure that dining areas are comfortable, visually appealing, and conducive to social interaction, cultural practices, and spiritual needs.
4. Provide adequate time and assistance for leisurely dining, especially for people living with dementia.
5. Organize special dining events, themed meals, or culinary experiences to enhance social interaction and resident engagement.
6. Monitor the quality, flexibility, safety, and food options available to residents through surveys, feedback, and regular audits.
7. Develop resources and training for staff on resident-centered dining practices, mealtime support techniques, and cultural sensitivity.
8. In LTC, evaluate the experience and outcomes of pleasurable dining where already implemented. Scale and expand pleasurable dining as appropriate.

Expected Benefits

The expected benefits of this recommendation include improved quality of meals, more meal choices for residents and enhanced dining experiences to reduce resident isolation and decrease boredom.

Implementation Roadmap



Financial Considerations

Additional costs to support upgrades to infrastructure and equipment for homes to ensure that dining areas are comfortable and visually appealing have been included as part of the costing for Recommendation 6. Additional staff resources may also be required to support pleasurable dining at other LTC homes, which have been taken into consideration in the costing for Recommendations 3, 10, 11, and 12.

Recommendation #3 Improve access to meaningful activities and recreational programs.

Based on Sections 3.1 and 3.2, stakeholders found that there was limited access to meaningful activities and recreational programs for LTC and PCH residents. Corresponding literature also indicates a positive correlation between meaningful activities, recreational programs, and improved resident quality of life (Section 3.3).

Key Actions Required

1. Expand access to meaningful activities and recreation.
    a. Expand hours of recreation into the evenings and weekends.
    b. Provide additional human resources, supplies and equipment to enhance recreation programming.
    c. In PCHs, develop, implement, and monitor a recreation standard.
2. Ensure activities are inclusive and meet the needs of a diverse group of residents, such as:
    a. Activities for residents with varying cognitive abilities and residents with dementia.
    b. Activities for younger adults.
    c. Activities for residents with hearing impairment.
    d. Greater variety of physical activities for the unique physical abilities of residents.
    e. One-on-one activities for residents that prefer or cannot participate in group activities.

f. Access to cultural and spiritual activities in accordance with resident preferences.

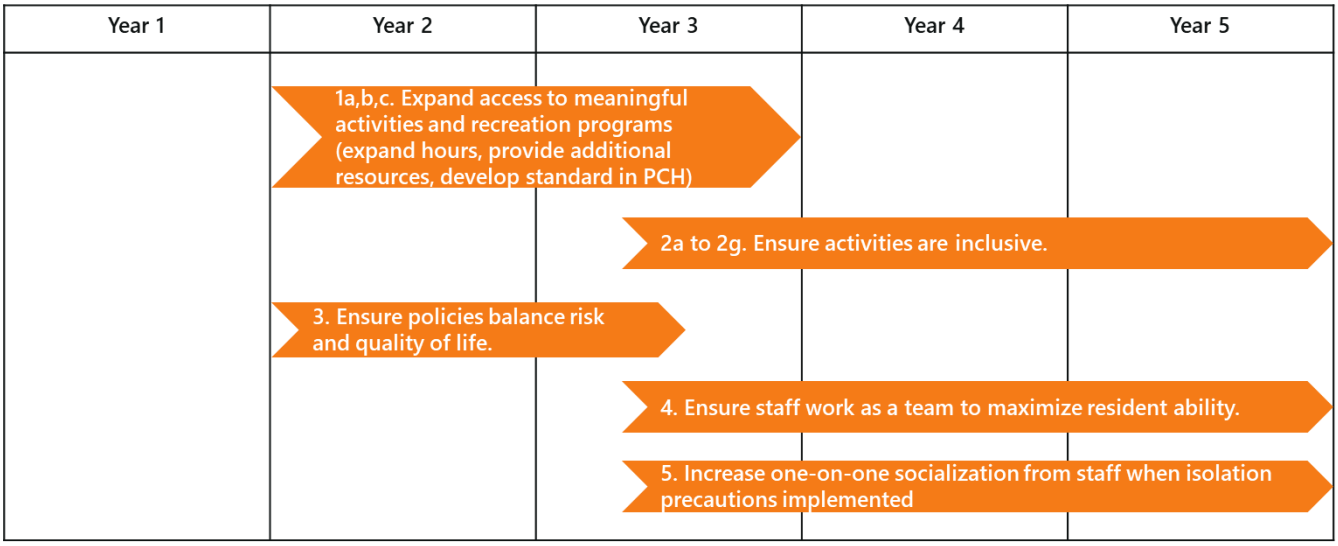
g. Increase opportunities for residents to spend time outdoors.

3. Ensure policies balance risk and quality of life with respect to recreation programming.
4. Ensure staff work as a team to maximize residents' ability to attend recreation events.
5. Increase one-on-one socialization from staff when isolation precautions are implemented.

Expected Benefits

The expected benefits of this recommendation include improved resident quality of life through increased access to meaningful activities and recreational programs.

Implementation Roadmap



Financial Considerations

The projected cost to hire additional staff to expand access to meaningful activities and recreational programs is $2.3 million annually. Detailed assumptions are provided in Appendix 2.

Recommendation #4: Enhance and support the role of volunteers.

The findings in Sections 3.1 and 3.2 indicate that the role of volunteers in LTC and PCHs could be expanded to support resident quality of life. Many of the findings in the literature (Section 3.3) also suggest that volunteers have been shown to reduce resident isolation and boredom and enhance quality of life.

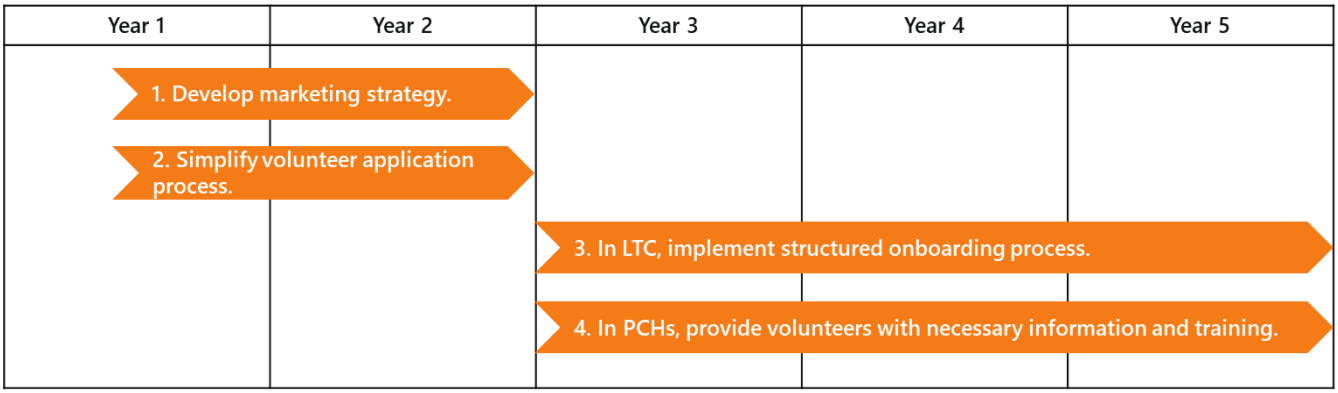
Key Actions Required

1. Develop a marketing strategy including engagement with local schools and community groups to enhance intergenerational programs and attract volunteers to LTC and PCH.
2. Simplify the volunteer application process within LTC using a risk-based approach.
3. In LTC, implement a structured onboarding process for new volunteers to include orientation sessions, training modules on interacting with residents, and volunteer shadowing opportunities.
4. In PCHs, ensure volunteers are provided with the necessary information and training required to understand their role and ensure resident safety.

Expected Benefits

The expected benefits of this recommendation include increased volunteerism in LTC and PCHs which will increase social visits and reduce isolation and boredom for residents. This recommendation is also anticipated to improve intergenerational relationships.

Implementation Roadmap



Financial Consideration

The total estimated annual costs for developing marketing materials and conducting marketing activities are projected to be $40,000, which includes marketing efforts for volunteers as well as for promoting LTC and PCH careers in Recommendation 14.

Recommendation #5: Enhance opportunities and support residents to maintain connections in the community.

The findings in Sections 3.1 and 3.2 indicate that residents' have limited opportunity to maintain connections with the community including attending social events, recreational outings, and/or cultural events. Stakeholders expressed that one of the main challenges was limited transportation, volunteers, and recreation support. Leading practices and literature (Section 3.3) support implementing the improvements identified in the key actions below.

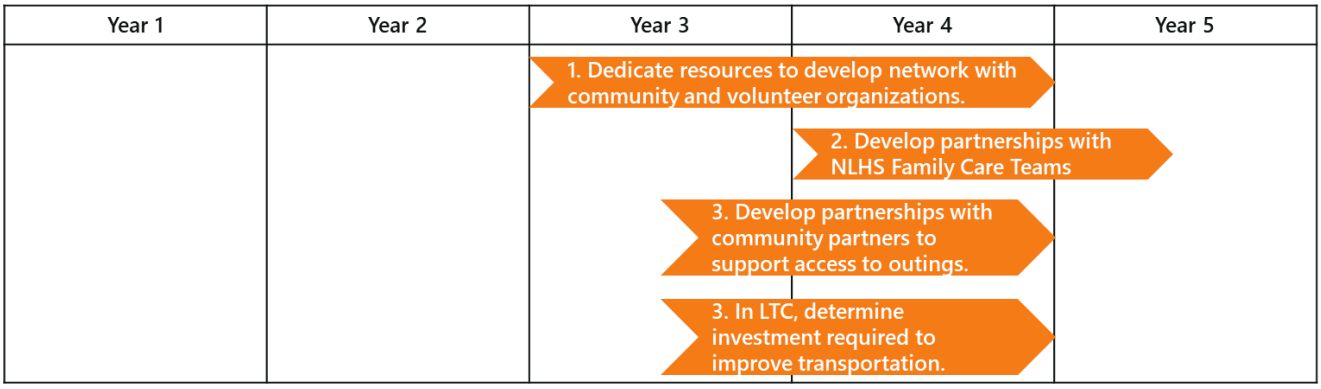
Key Actions Required

1. Dedicate resources to build a network with community agencies, associations, and volunteer organizations which supports residents and foster a sense of belonging.
2. Develop partnerships with Family Care Teams for social navigation.
3. Develop partnerships with community partners to support residents access to social and recreational outings in the community.
4. In LTC, determine the investment required for homes to improve residents access to community events (e.g., transportation, supports).

Expected Benefits

The expected benefits of this recommendation include enhanced resident connection to the community, improved transportation options, and an improved variety of outings, activities, and social events for LTC and PCH residents.

Implementation Roadmap



Financial Considerations

Financial considerations for this recommendation include existing staff time to build connections and partnerships and evaluate transportation enhancements.

Recommendation #6: Ensure the upkeep and maintenance of existing infrastructure, and renovations (where practical) as well as new construction align with leading practice design standards.

As shown in Section 3.1.2, stakeholders expressed that infrastructure conditions and the home atmosphere is varied across the province. Section 3.3 includes a description of leading practices that align resident quality of life with the layout of facility infrastructure.

Key Actions Required

LTC

1. Ensure that new infrastructure and renovations (where practical) are designed to align with HSO National LTC Services Standard and CSA LTC Home Operations and Infection Prevention and Control Standard. This includes considerations such as:
    a. Private rooms with ensuite bathrooms.
    b. Communal areas for socializing and activities.
    c. Natural lighting.
    d. Accessible outdoor spaces like gardens or courtyards.
2. Engage residents, families, ECPs, and staff in the design of new infrastructure and renovations.
3. Utilize the existing FCI index to assess the physical condition of homes. Prioritize modifications and renovations to infrastructure for homes with high FCI index scores.
4. Integrate technology into LTC homes to enhance residents' quality of life and safety. This could include smart home technology for monitoring and assistance, telemedicine for remote healthcare services, and virtual reality for entertainment and cognitive stimulation.

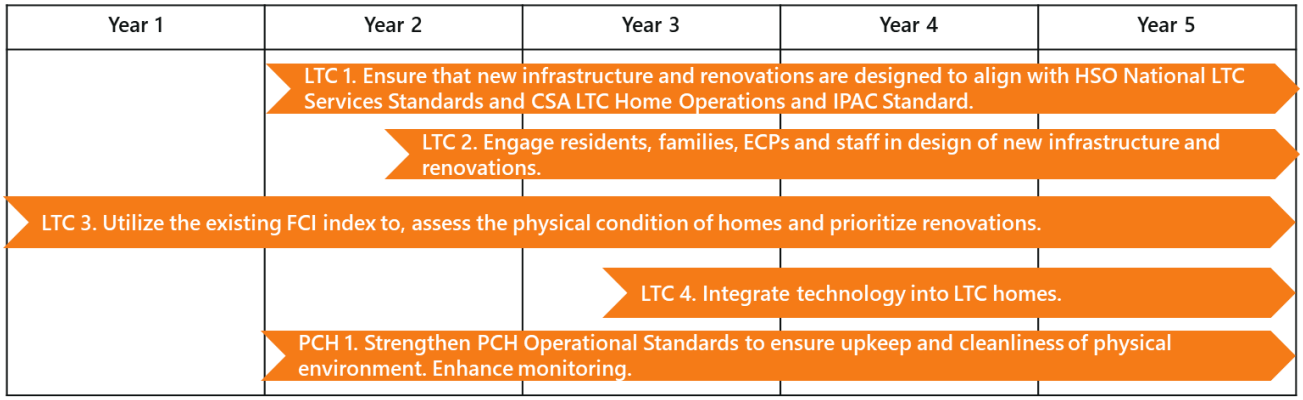
PCHs

1. Strengthen the existing PCH Operational Standards to ensure upkeep and cleanliness of the physical environment. Enhance monitoring to ensure compliance.

Expected Benefits

The expected benefits for this recommendation include enhancements and improvements to infrastructure and improved resident quality of life.

Implementation Roadmap



Financial Considerations

Financial considerations in this recommendation include the existing staff time and engagement of consultants to assess the physical condition of homes and prioritize planning for homes with high FCI scores of 30% or higher. The estimated costs for replacing LTC home beds with FCI scores over 30% through renovation or new development ranges from $573 million to $954 million. An additional $3.6 million will be invested to develop a technology and innovation strategy over 2.5 years. Detailed assumptions are provided in Appendix 2.

Recommendation #7: Support couples to remain living together if they choose.

Section 3.1.2 indicates that some residents have experienced challenges being placed as a couple into LTC homes which can be difficult for the resident, family, and ECPs.

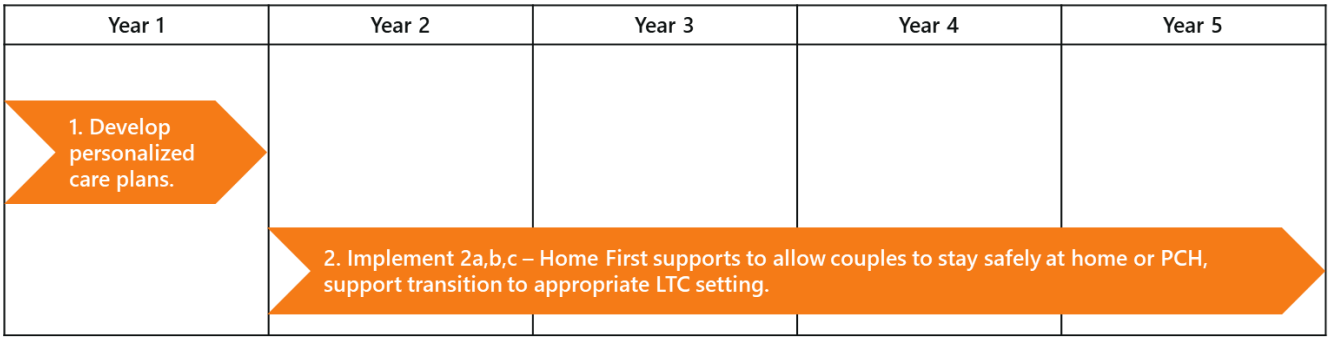
Key Actions Required

1. Develop personalized care plans that accommodate the needs of both partners while promoting their independence and quality of life.
2. When couples have different levels of care needs:
    a. Provide additional allocations and supports through Home First to allow couples to safely stay in their home.
    b. Provide additional supports through Home First to allow couples to safely remain together in PCHs.
    c. Upon consultation with the resident and family, support couples to transition to an appropriate setting in a LTC home should care needs change.

Expected Benefits

The expected benefits of the implementation of this recommendation are improved ability to support couples to stay together in a suitable environment that supports their quality of life.

Implementation Roadmap:



Financial Considerations:

Financial considerations for this recommendation include time commitments by DHCS and NLHS staff to develop related policies for couples' admissions.

SECTION 4

QUALITY OF CARE

4 Quality of Care

The review of quality of care included aspects such as appropriate staffing mix to support resident care needs, coordination between community and health services, and access to care services in LTC and PCH settings.

4.1 Long Term Care Findings

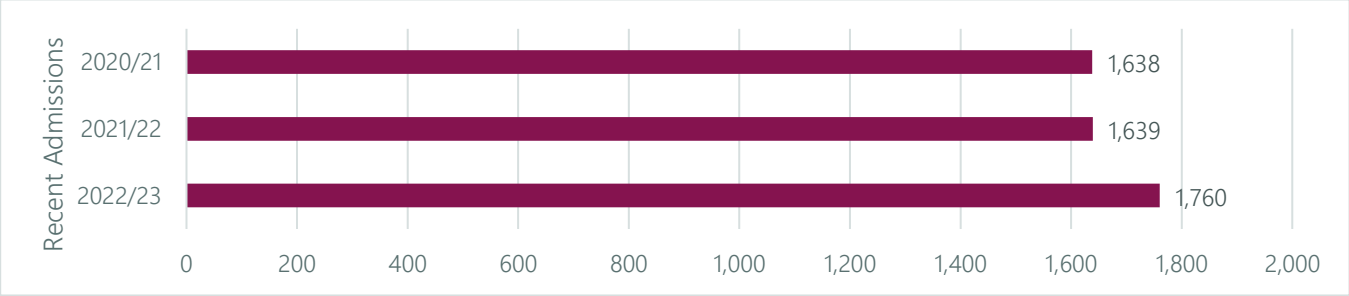
The following section describes the current context and stakeholder engagement findings for LTC home quality of care.

4.1.1 Current Context

Demand for Long Term Care Beds

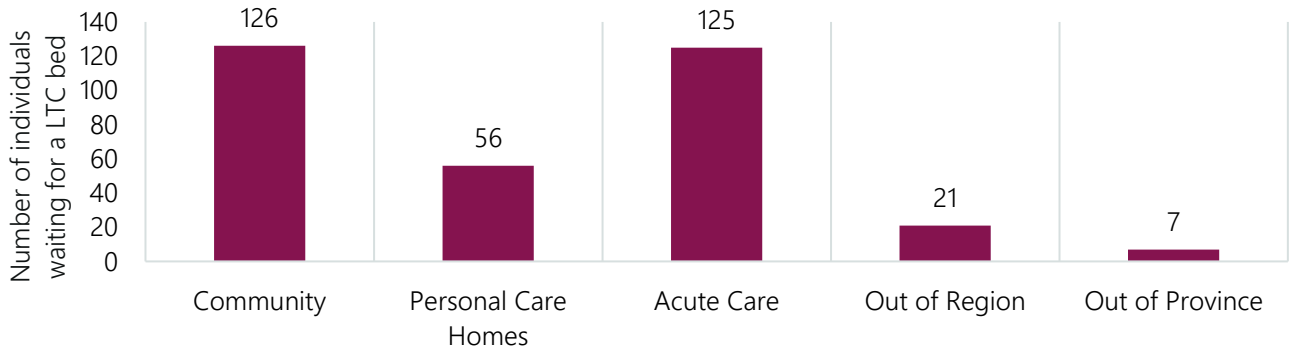
As of April 19, 2024, there were 3,119 LTC residents in NL. LTC resident admissions increased by 7.4% in 2022/23 compared to 2021/22, which was a result of two LTC homes opening in 2022 (Figure 14). Despite the increase in bed capacity, many individuals remain waiting to be admitted to LTC.

Figure 14: LTC Admission Data Analysis, 2020/21 to 2022/23



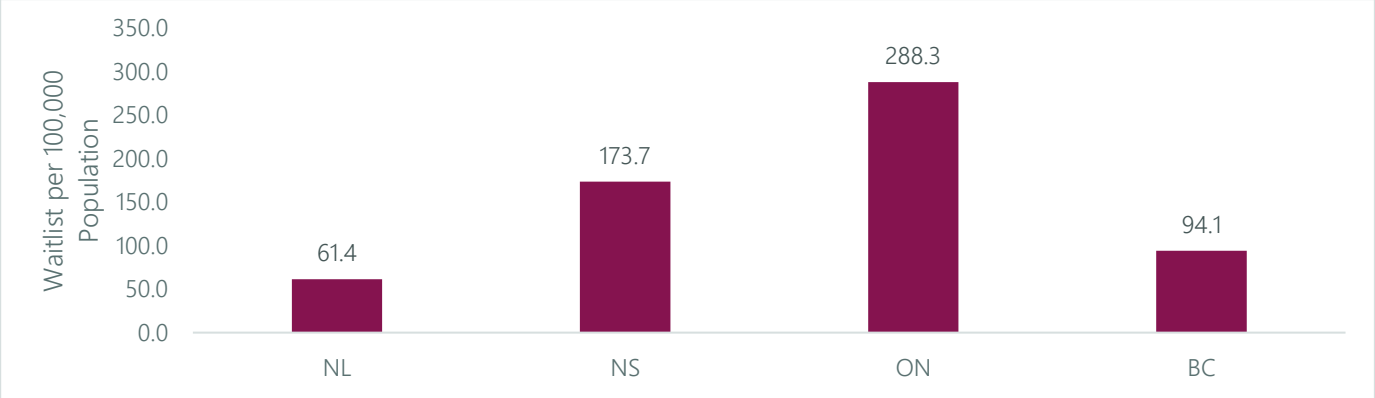
As of January 2024, there were 335 individuals waiting for LTC (Figure 15), the majority waiting to be placed from the community (126 individuals) or acute care settings (125 individuals). There were also 154 individuals living in LTC who were waiting to be transferred into their LTC home of choice.

Figure 15: Waitlist Data for LTC Placement, January 2024



Overall, the LTC waitlist per 100,000 population is lower in NL compared to Nova Scotia, Ontario, and BC (Figure 16).

Figure 16: Comparison of LTC Waitlist Data for NL, NS, ON and BC, 2023/24



The average length of stay of LTC residents in 2022/23 was 737 days (2.0 years) in Central Zone, 875 days (2.4 years) in Labrador-Grenfell Zone, 905 days (2.5 years) in Western Zone, and 1,088 days (3.0 years) in Eastern Zone. For comparison purposes, the average length of stay for LTC residents in other provinces was 2.9 years in NS[50], 2.0 years in ON[51], 1.9 years in AB[52], and 2.3 years in BC[53].

The projected demand for LTC beds in NL is expected to grow by 602 beds in 2028, and by 1,424 beds in 2033 according to data provided by the DHCS. Overall, admission and waitlist data show increasing demand for LTC services in NL and a need to proactively manage LTC bed waitlists. The demand for LTC beds is expected to grow significantly between now and 2033.

Direct Care Hours and Staffing Ratios

Provincially, the average budgeted direct care hours (DCH) for LTC homes are 3.4 hours per resident day, however, this varies between homes and may be above or below the provincial average depending on the care needs of residents at each site, the size of the facility and the proximity of other health services. The DCHs include a mix of nursing professionals including Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), as well as Personal Care Attendants (PCAs).

The province completed a staffing mix review in 2006 and recommended that RNs provide 14 to 20% of DCHs, LPNs provide 40 to 53% of DCHs, and PCAs provide 33 to 40% of DCHs (Table 5). The staff mix for LTC DCHs in 2023 has become more variable compared to 2006, with greater ratio ranges for each position. The staff mix ratios for LTC can vary as some sites are stand-alone homes and others are within or attached to an acute care site that may be able to provide staffing support.

Table 5: Nursing Staff Mix Ratio for DCHs

Professionals	2006 Staffing Mix Review Recommendation	Current Ratio (2023)
Registered Nurses	14 to 20%	4 to 28%
Licensed Practical Nurses	40 to 53%	37 to 65%
Personal Care Attendants	33 to 40%	35 to 50%

RNs take on clinical leadership responsibilities, such as resident assessments, care planning, nursing interventions, and medication monitoring and provide an educator role to the nursing team. LPNs work collaboratively with RNs to perform nursing interventions, medication management and clinical assessments, as well as support PCAs with providing direct personal care. PCAs support residents in all aspects of daily living including but not limited to assistance with personal hygiene, nutrition, and mobility.

The DCHs for NL do not include the estimated 0.37 care hours per resident day provided by allied health professionals, including occupational therapists (OTs), physiotherapists (PTs), recreation therapists, recreation workers, social workers, dieticians, speech language pathologists (SLPs), and physiotherapy support works. Section 5.1.1 of the report provides additional details regarding characteristics of the LTC workforce.

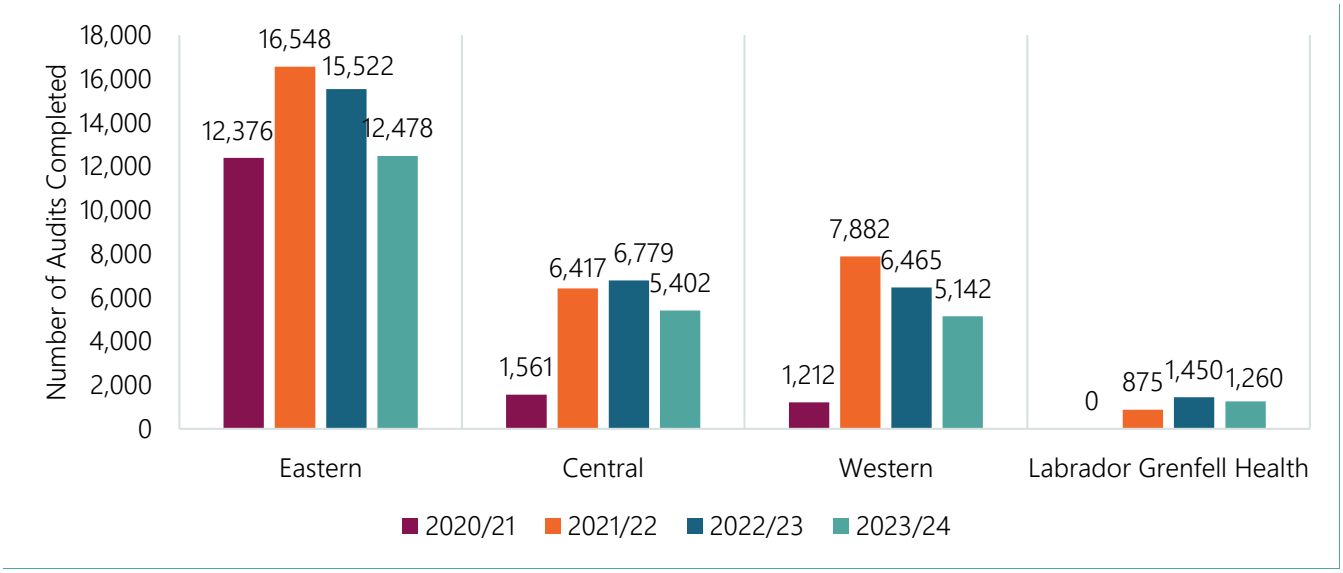
Resident Quality of Care Monitoring

LTC resident quality of care audits were implemented part way through 2020/21 during the height of COVID-19 restrictions and were initially completed every month. Currently, the audits are completed quarterly and include an assessment of the following:

- **Personal Care:** includes an assessment of teeth cleaning, hair washing, face cleaning, cleanliness of clothes, appropriate finger/toenail care (cleaning and clipping) etc.
- **Weight Loss:** includes an assessment of weight loss (e.g., 5% or more in last 30 days, or 10% or more in last 180 days), weight gain (e.g., 5% or more in last 30 days, or 10% or more in last 180 days).
- **Pressure Ulcers:** includes monitoring the worsened condition of residents with stage two to four pressure ulcers.

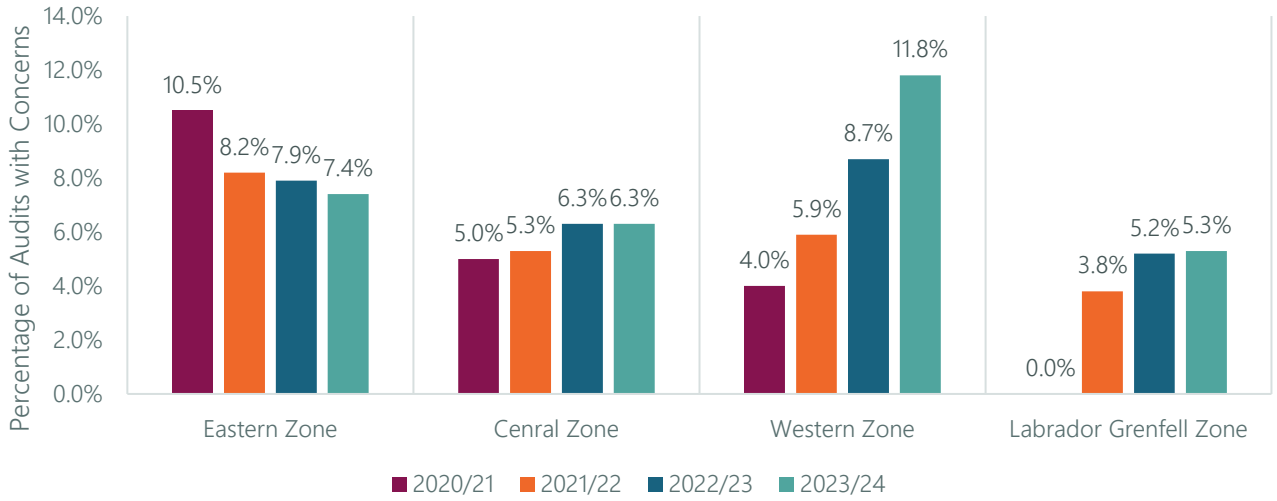
Figure 17 summarizes the total number of quarterly audits completed annually by health zone from 2020/21 to 2023/24.

Figure 17: Total Number of Quarterly Audits Completed Annually by Health Zone, 2020/21 to 2023/24



The percentage of audits with identified concerns for personal care, weight loss, or pressure ulcers has remained below 12% in each zone between 2020/21 to 2023/24 (Figure 18). However, the percentage of audits with identified concerns has been increasing in all zones except for Eastern Zone. For example, the percentage of the audits completed in Western Zone with identified concerns increased from 4.0% in 2020/21 to 11.8% in 2023/24.

Figure 18: Percentage of LTC Audits with Identified Concerns by Zone, 2020/21 to 2023/24



Long Term Care Acuity Level Data

The health conditions of LTC residents can provide an indication on changes to resident acuity levels. CIHI uses the results of health assessments from the Resident Assessment Instrument MDS 2.0 (RAI-MDS 2.0) to report the health condition of LTC residents in Canada. Included in the RAI-MDS 2.0 assessments are:

- Activities of Daily Living (ADLs)
- Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS)
- Depression Rating Scale (DRS)
- Cognitive Performance Scale (CPS)
- Aggressive Behaviour Scale (ABS)

The Activities of Daily Living (ADLs) Performance Hierarchy indicator measures a resident's functional abilities and independence in performing activities of daily living. The assessment includes four scale items, including personal hygiene, toilet use, locomotion, and eating. The levels of assistance on these assessment items are categorized as follows[54]:

- Independent: No help or staff oversight.
- Supervision: Oversight, encouragement, or cueing provided.
- Limited Assistance: Received physical help in guided maneuvering of limbs or other non-weight-bearing assistance.
- Extensive Assistance: Performed part of the activity but received specific types of help (e.g., weight-bearing support).
- Total Dependence: Full staff performance of the activity.

Resident conditions are scored from 0 to 6, with higher scores indicating greater decline in ADL performance[55].

Over 80% of LTC residents in NL were assessed in the extensive (~30%) or dependent/totally dependent (~52%) categories, which remained relatively consistent between 2018/19 to 2022/23 (Table 6). The percentage of residents assessed as independent in performing ADLs was approximately 4%, while the percentage of residents requiring supervision/limited assistance increased slightly from 14.1% in 2018/19 to 15.5% in 2022/23. The ADL Scale data suggests a consistently high number of residents requiring significant support with their ADLs.

Table 6: CIHI Data, LTC: Activities of Daily Living (ADL), 2018/19 to 2022/23

ADL Scale	2018/19	2019/20	2020/21	2021/22	2022/23
Independent	4.0%	3.8%	3.1%	3.5%	3.7%
Supervision / Limited	14.1%	14.3%	15.1%	14.4%	15.5%
Extensive	30.3%	29.1%	29.0%	29.7%	29.1%
Dependent / Total Dependency	51.6%	52.8%	52.8%	52.4%	51.7%

The Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) indicator measures the severity of illness, frailty, and health instability and identifies individuals at risk of serious health decline[49]. The assessment includes nine CHESS scale items including cognition, assistance with daily living, and end-stage disease. Resident conditions are scored from 0 to 5, with higher CHESS scores associated with adverse outcomes such as mortality, hospitalization, pain, caregiver stress, and poor self-rated health[55] [56].

Table 7 shows that over 75% of LTC residents in NL received a score of 0 (slight decrease from 44.8% in 2018/19 to 42.6% in 2022/23) or 1 (remained relatively consistent and ranged from 31.7% to 32.5% between 2018/19 to 2022/23). Further, there was a corresponding minor increase in the percentage of residents that scored a 2, 3, 4 or 5 from 22.7% in 2018/19 to 24.9% in 2022/23. CHESS Scale data suggests the needs of residents remained relatively stable over the past five years.

Table 7: CIHI Data, LTC: Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS), 2018/19 to 2022/23

CHESS Scale	2018/19	2019/20	2020/21	2021/22	2022/23
No instability (0)	44.8%	43.9%	43.7%	42.0%	42.6%
Score 1	32.5%	32.1%	31.7%	32.1%	32.4%
Score 2	14.4%	14.9%	15.1%	15.5%	15.9%
Score 3	5.5%	5.9%	6.4%	7.1%	5.8%
Score 4	2.1%	2.3%	2.4%	2.6%	2.8%
High instability (5)	0.7%	0.8%	0.7%	0.6%	0.4%

The Depression Rating Scale (DRS) indicator measures the level of a resident's depression. The assessment includes seven DRS items, including persistent anger, repetitive anxious complaints, and sad, pained, worried facial

expressions. The DRS ranges from 0 to 14 and a score of 3 or more may indicate a potential or actual problem with depression[55].

Table 8 shows that over 50% of LTC residents in NL were assessed a score of 1 or higher on the DRS scale between 2018/19 to 2022/23, and that the percentage of residents assessed in each category remained relatively consistent over that time. This demonstrates a need for mental health and emotional support services in LTC homes.

Table 8: CIHI Data, LTC: Depression Rating Scale, 2018/19 to 2022/23

DRS Scale	2018/19	2019/20	2020/21	2021/22	2022/23
No depressive symptoms (0)	49.6%	48.4%	47.0%	47.6%	49.2%
Some depressive symptoms (1 or 2)	21.6%	21.3%	21.4%	21.8%	21.5%
Possible depressive disorder (3 or more)	28.8%	30.3%	31.6%	30.6%	29.3%

The Cognitive Performance Scale (CPS) indicator describes a resident's cognitive status. The assessment includes five CPS scale items, including short-term memory, expressive communication, and cognition skills for daily decision-making. Resident conditions are scored from 0 to 6, with higher scores indicating more severe cognitive impairment[49].

Table 9 shows that the percentage of LTC residents with relatively intact cognitive abilities decreased slightly from 28.4% in 2018/19 to 26.4% in 2022/23, while those with mild or moderate cognitive impairments increased from 24.0% to 28.4% between 2018/19 to 2022/23. Almost half of LTC residents have a severe cognitive impairment. This proportion declined slightly from 47.6% in 2018/19 to 45.2% in 2022/23.

Table 9: CIHI Data, LTC: Cognitive Performance Scale (CPS), 2018/19 to 2022/23

CPS Scale	2018/19	2019/20	2020/21	2021/22	2022/23
Relatively intact	28.4%	26.5%	26.0%	25.4%	26.4%
Mild/Moderate Impairment	24.0%	25.4%	26.1%	26.4%	28.4%
Severe Impairment	47.6%	48.1%	47.8%	48.2%	45.2%

The Aggressive Behaviour Scale (ABS) provides a measure of aggressive behaviour. The scores for ABS range from 0 to 12, with higher scores indicating greater frequency and diversity of aggressive behaviour. Table 10 shows that the percentage of LTC residents with more severe aggressive behaviours increased slightly from 7.1% in 2018/19 to 9.9% in 2022/23. ABS data suggests the aggressive behaviour of residents remain relatively stable over the past five years.

Table 10: CIHI Data, LTC: Aggressive Behaviour Scale, 2018/19 to 2022/23

ABS	2018/19	2019/20	2020/21	2021/22	2022/23
No aggressive behaviour (0)	67.6%	66.0%	64.6%	64.6%	67.4%
Mild to moderate aggressive behaviour (1-4)	25.4%	27.0%	27.5%	25.5%	22.7%
More severe aggressive behaviour (5 or more)	7.1%	7.1%	7.9%	9.9%	9.9%

RAI-MDS 2.0 also collects information on disease diagnoses of assessed residents in LTC homes. The number of residents with diabetes increased by 12.4% from 1,103 in 2018/2019 to 1,240 in 2022/2023. Further, the number of residents diagnosed with psychiatric/mood diseases increased by 7.4% and the number of residents diagnosed with dementia increased by 3.5% between 2018/19 to 2022/23.

Dementia Care Action Plan 2023 – 2026

NL launched a *Three-Year Dementia Care Action Plan* for the period from 2023 to 2026. The vision of this plan is to increase awareness and inclusion, reduce stigma, and improve supports and services with a goal to enhance the quality of life for individuals and families affected by dementia, ensuring they feel included in their communities. Currently, the province is in year two of the action plan focusing on medium-term actions.

The plan outlines 36 actions within the following focus areas:

- Increase awareness, reduce risk of dementia, and address stigma.
- Diagnosis and coordination of care.
- Supports and services for individuals living with dementia, their care partners, and families.
- Professional learning and development.

The plan aims to create safe and accepting communities where individuals living with dementia can be active and engaged. The plan aligns with the DHCS' strategic plan to improve population health, quality care, and access.

4.1.2 What We Heard

Focus group participants were asked to share their experience on a variety of quality of care topics including:

- Clinical oversight and continuity of care
- Access to allied health services
- Mental health and addictions
- Training
- Access to LTC services

Focus Group Findings

Clinical Oversight and Continuity of Care

Focus group participants indicated that LTC homes with regular clinical oversight provided by a physician or a nurse practitioner had improved continuity of care. It was also noted that frequent workforce turnover had a negative effect on residents because:

- Staff are unable to recognize changes in health status of residents due to unfamiliarity with their baseline.
- It is challenging for staff to participate meaningfully at physician/NP rounds due to unfamiliarity with residents.

Access to Allied Health Services

Focus group participants shared that access to allied health services and clinicians was a challenge in many homes. Access to services such as physiotherapy, occupational therapy, social work, behaviour management, dietetic services, audiology, dental hygiene services, and speech language pathology were challenging for LTC residents. Participants also indicated that allied health services are often spread amongst several LTC homes and in rural settings this may also include a large geographic area.

Mental Health and Addictions

Focus group participants shared that there was a significant gap in services and supports for residents with mental health and addictions needs. This included inadequate training and supports available for staff to provide safe and quality care for residents with more complex mental health and addictions.

Training

Focus group participants shared that there were inconsistencies with the types of training that staff received in LTC. For example, dementia care training as well as CPR and first aid training were primarily offered to direct care staff and not to staff in other areas such as housekeeping and food services who still interact with residents on a regular basis. Further, dementia care related training was inconsistently offered to direct care staff. Staff participants indicated that there is a desire to have more training to help meet LTC resident needs.

Access to Long Term Care Services

Focus group participants shared that there is a challenge in accessing LTC services in many remote areas of NL. Residents residing in smaller remote communities can be placed in a LTC home located a far distance away from their home community. Several challenges were expressed in areas such as Labrador where the availability of LTC beds was more limited resulting in less visits from family and friends, language barriers, and isolation from culture. Focus group participants also shared that there is an overall shortage of LTC beds in the province which has resulted in long wait times, residents staying in PCHs or at home longer without appropriate supports or staying in an acute care setting for long periods of time.

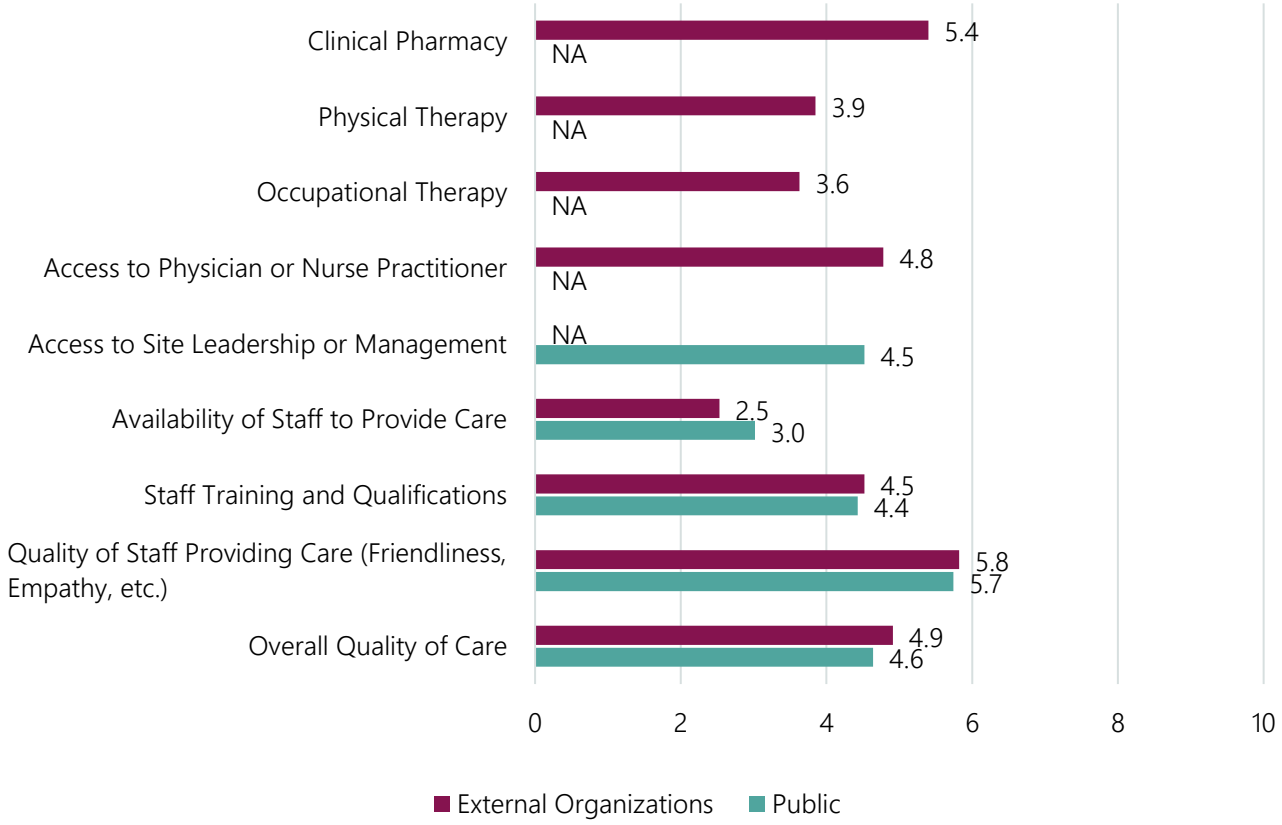
Survey Findings

Public and External Stakeholders

A total of 1,674 individuals responded to the public survey and 167 individuals responded to the external organization survey. Figure 19 provides a summary of the responses from public and external organizations survey participants regarding LTC and PCH quality of care. Survey respondents rated quality of staff providing care (5.8 out of 10 by external organizations and 5.7 out of 10 by the public) the highest; but the average ratings for this dimension were below 6 out of 10 and it is still an area for improvement. The aspects of care requiring the most improvement included the availability of staff to provide care (2.5 out of 10 by external organizations and 3.0 out of 10 by the public) and access to occupational therapy services (3.6 out of 10 by external organizations). Overall quality of care was also rated below 5 out of 10 (4.9 out of 10 by external organizations and 4.6 out of 10 by the public) and is also an area for improvement.

Figure 19: Average Ratings for Quality of Care Dimensions – Public and External Organization Survey Participants (Scale 0 to 10)

NA - indicates question was not asked



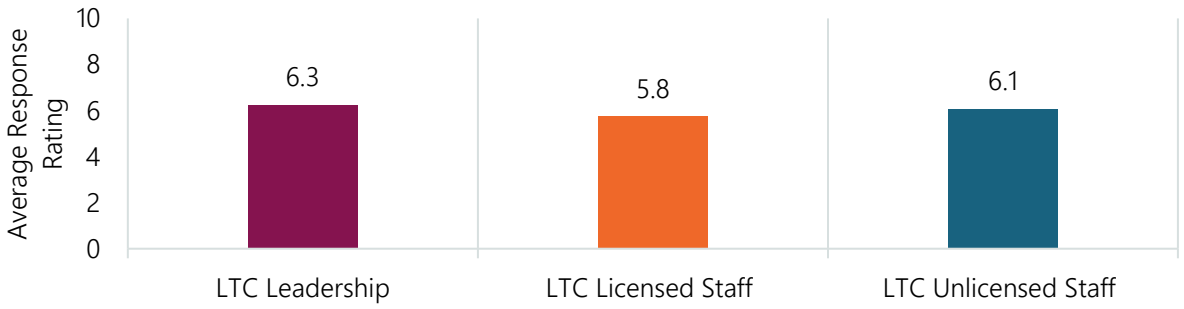
LTC Leadership, Staff, and Residents, Families and ECPs

The following section summarizes the survey results related to quality of care in LTC homes for four stakeholder groups including:

- LTC Leadership – 76 survey respondents
- LTC Licensed Staff – 286 survey respondents
- LTC Unlicensed Staff – 238 survey respondents
- LTC Residents, Family, and ECPs – 349 survey respondents

Survey respondents were asked to rate the overall quality of care for residents in LTC homes on a scale of 0 (lowest quality) to 10 (highest quality). LTC leadership had the highest average rating for overall quality of care at 6.3 out of 10, compared to 6.1 out of 10 by unlicensed staff and 5.8 out of 10 by licensed staff (Figure 20).

Figure 20: Stakeholder Perception of Overall Quality of Care in LTC (Scale 0 to 10)



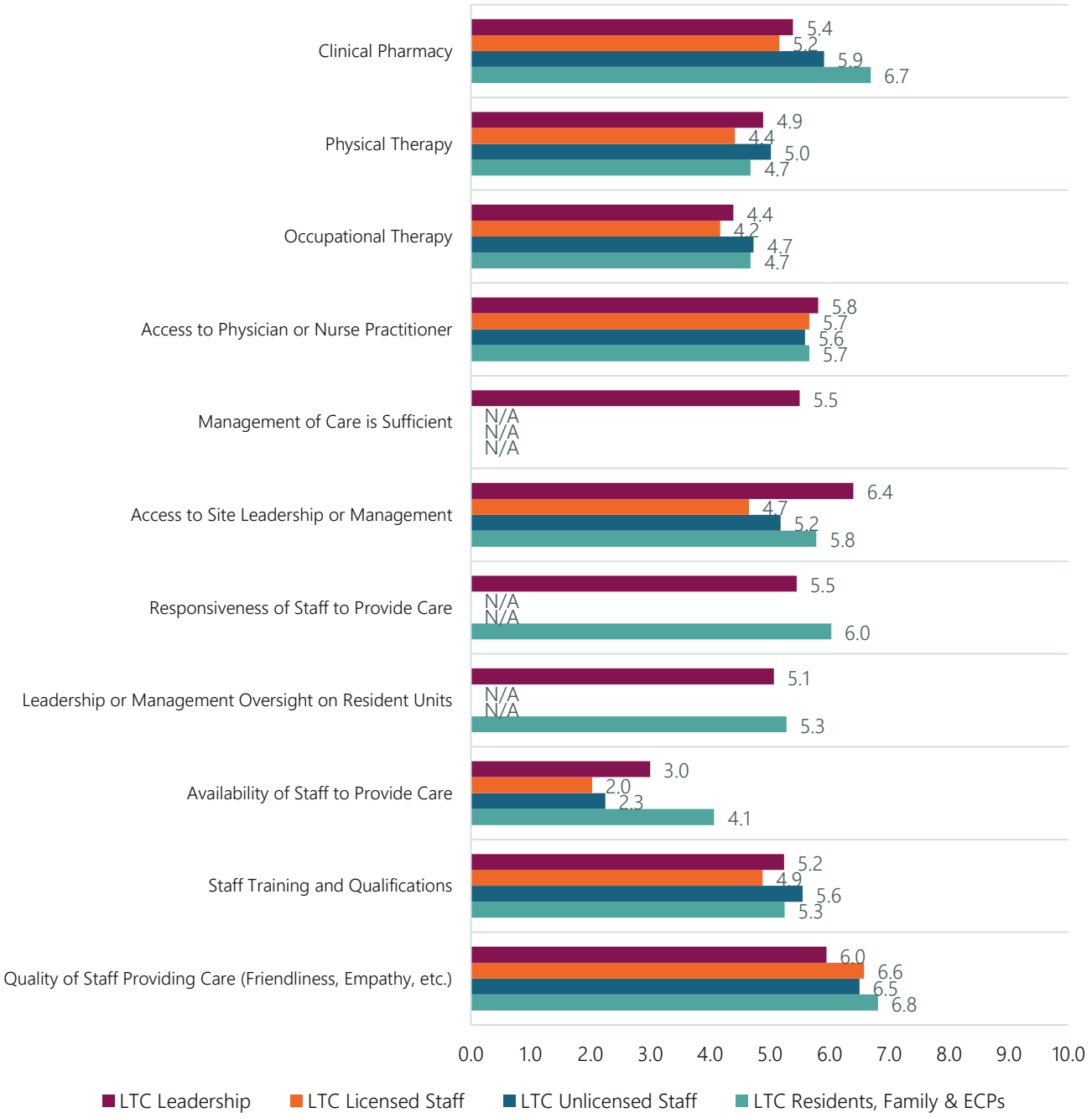
Survey respondents were then asked to rate quality of care for a variety of categories using a scale of 0 (needs improvement) to 10 (strength). Overall, the average ratings provided by LTC Residents, Family, and ECPs was either similar or higher for most categories compared to the average rating provided by LTC Leadership, LTC Licensed Staff and LTC Unlicensed Staff.

The highest rated categories by LTC Residents, Family, and ECPs included quality of staff providing care and clinical pharmacy (Figure 21). The category rated the lowest by LTC Residents, Family, and ECPs was availability of staff to provide care, which was also rated significantly lower by LTC Leadership, Licensed Staff and Unlicensed Staff. Other dimensions rated as requiring improvement by LTC Residents, Family, and ECPs included occupational therapy, and physical therapy.

> ***"LTC homes need more access to things like physio, chiropractors, dentists, massage therapists, acupuncture."***

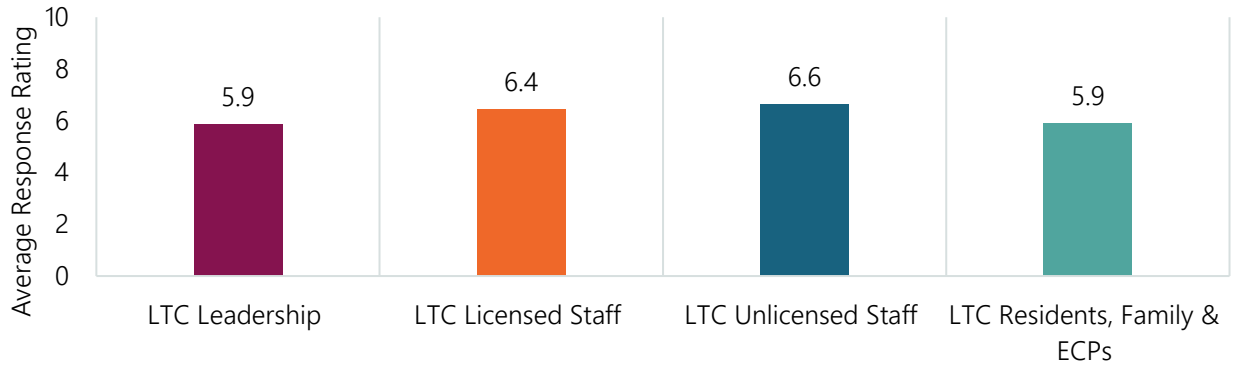
Figure 21: Average Ratings for Quality of Care Categories in LTC (Scale of 0 to 10)

NA - indicates question was not asked



LTC survey participants were asked to rank the level of influence that residents, family, and ECPs had on making informed choices and decisions on LTC services from 0 (no level of influence) to 10 (high level of influence). LTC Leadership and Residents, Family and Caregivers ranked this area the lowest at 5.9 out of 10 (Figure 22).

Figure 22: LTC Resident, Family, and ECP Inclusion in Decision Making (Scale 0 to 10)



Overall, 81% of LTC Residents, Families, and ECPs responded that they were comfortable with bringing forward their concerns at LTC homes, while only 14% were not.

Opportunities for Improvement

Focus group and survey respondents were asked to provide suggestions for improving LTC resident quality of care. The following themes were identified from surveys and focus group participants:

- Improve access and oversite from clinical leadership (physician and nurse practitioners).
- Improve access to allied health services such as physiotherapy, occupational therapy, behaviour management specialists, dieticians, etc.
- Improve access to mental health resources and supports for residents.
- Improve access to LTC closer to home to maintain cultural connections and language supports.
- Improve collaboration and communication between staff, leadership, residents, ECPs, and other health and community service providers.
- Provide consistent and more frequent dementia training for all levels of staff working in LTC.
- Shift culture in LTC to a holistic resident-centred model of care versus a medical or task-based model.
- Improve the nursing staff model and mix to better support resident care needs and allow staff to work to their full scope of practice.
- Improve quality of personal care including personal hygiene, safety, and security.
- Increase direct hours of care to reflect higher resident acuity.
- Increase bed availability in LTC to reduce wait times for residents.
- Increase supports for family and ECPs for emotional wellness, peer support groups, etc.
- Improve the use of technology and digital health services to improve access to programs and resident monitoring.

4.2 Personal Care Home Findings

The following section describes the current context and stakeholder engagement findings for PCH quality of care.

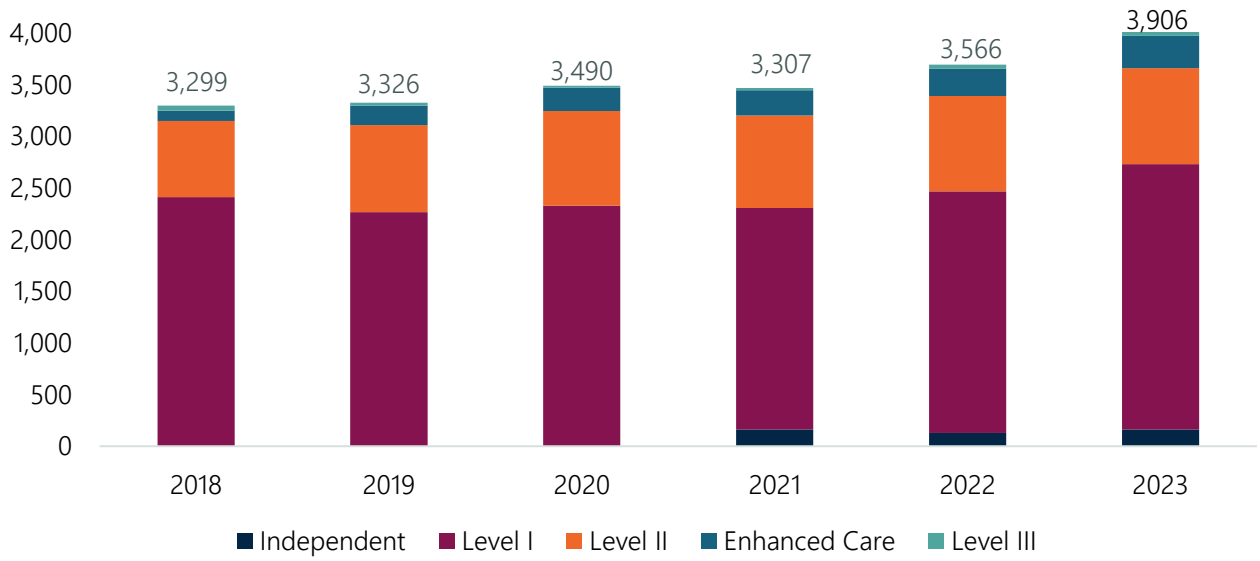
4.2.1 Current Context

Demand for Personal Care Homes

PCHs primarily provide support to Level I, Level II, and Enhanced Care residents according to the current LOC framework in NL. The Enhanced Care option in PCHs was introduced in October 2016 to allow individuals with care needs beyond Level II to receive care in the community. PCH residents whose care needs increase to Level III may wait in a PCH for LTC placement. Residents designated as independent have no care needs but have either entered to remain with their spouse or have chosen to pay privately.

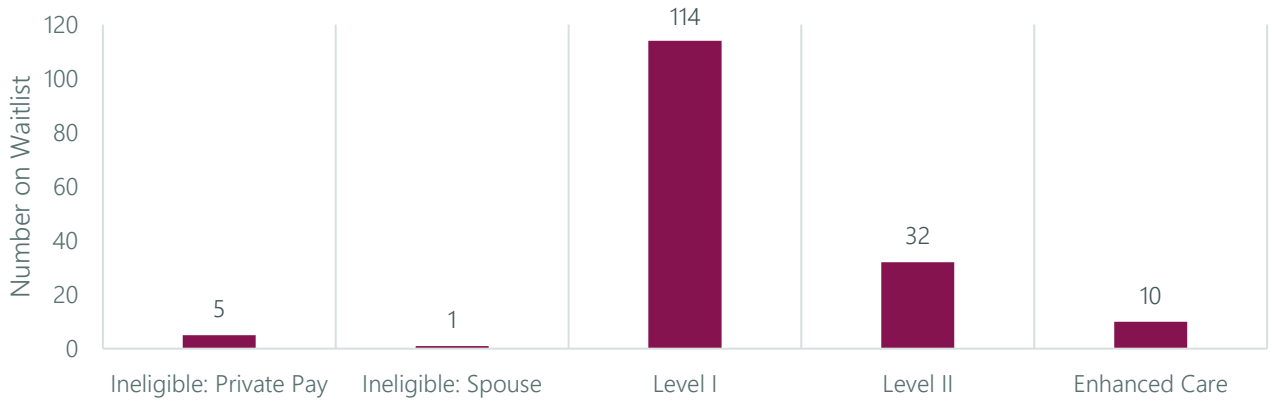
Figure 23 summarizes the total number of residents by level of care from 2018 to 2023. Data for the Independent classification was not collected prior to 2021; and data for 2020 and 2021 may be affected by the impacts of COVID-19 restrictions. The number of Enhanced Care residents increased by 225% from 97 in 2018 to 315 in 2023. The number of Level III residents saw small fluctuations year to year but remain a relatively small proportion of the resident population.

Figure 23: Total Number of PCH Residents per Level of Care, 2018 to 2023



As of January 2024, the number of individuals waiting for a PCH bed was 162 with 114 assessed with Level I care, 32 assessed with Level II care and 10 assessed with Enhanced Care needs (Figure 24). The waitlist for PCH beds is being driven by a combination of individuals waiting for their preferred choice of home and variance in bed availability in different areas of the province.

Figure 24: Waitlist for PCH Placement, January 2024



The DHCS had a demand projection study completed in 2019 which forecasted the demand for PCHs to be between 4,446 and 4,666 beds by 2028, between 6,118 and 6,719 beds by 2038, and between 6,857 and 7,795 beds by 2048. Overall, the demand for PCH beds is projected to nearly double by the year 2048.

Direct Care Hours in Personal Care Homes

Table 11 shows the current budgeted allocation of DCHs for PCHs by resident level of care.

Table 11: PCH Direct Care Hours by Resident Level of Care

Level of Care	Hours of Care Per Day	Support Staff Hours
Level I	1.5 hours	0.5 hours
Level II	1.5 hours	0.5 hours
Level II Enhanced Care	3.0 hours	0.5 hours
Level III	3.4 hours	0.5 hours

Staffing hours may be arranged to best meet the care needs of residents and, if necessary, may be increased on the recommendation of NLHS. Most PCHs are staffed with unlicensed and/or untrained staff which makes caring for higher acuity residents a challenge even when a home receives funding to provide additional hours of care. However, some operators have included trained and/or licensed regulated staff such as RNs, LPNs, and PCAs into their skill mix to help care for higher acuity residents.

Resident Acuity Level Data

The RAI-HC provides health assessments on the health conditions of PCH residents including:

- Method for Assigning Priority Levels (MAPLe)
- Activities of Daily Living (ADLs)
- Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS)
- Depression Rating Scale (DRS)
- Cognitive Performance Scale (CPS)

The Method for Assigning Priority Levels (MAPLe) is a decision-support tool in prioritizing individuals who require community- or facility-based services. MAPLe assigns one of five priority levels to each home care client based on information from the RAI-HC assessment. The criteria used to calculate MAPLe levels include worsening of decision-making, meal preparation difficulty, cognitive performance scale, and medication management difficulty[55].

Table 12 shows that the percentage of individuals assessed with moderate needs represent the highest proportion of PCH residents, increasing from 43.8% in 2021/22 to 53.4% in 2022/23. In contrast, the percentage of individuals assessed with low needs and mild needs remains low, decreasing from 21.3% in 2021/22 to 13.8% in 2022/23. The increasing number of residents with moderate needs is likely due to increased uptake of Enhanced Care in a PCH. The percentage of individuals assessed with very high needs remained low, at just over 14%. Overall, individuals assessed with 'high', and 'very high' needs accounted for 32% percent of assessed cases in 2022/23 and did not change from the previous year.

Table 12: CIHI Data, PCH: MAPLe, 2021 to 2023

MAPLe Scale	2021/22	2022/23
Low need	13.5%	8.3%
Mild need	7.8%	5.5%
Moderate need	43.8%	53.4%
High need	19.8%	17.9%
Very high need	14.4%	14.1%

Table 13 shows the percentage of PCH residents assessed into the specific ADL categories in 2021/22 and 2022/23. The Supervision and Limited Assistance categories were combined to a single category. The percentage of PCH residents assessed as independent in preforming ADLs declined from 54.8% in 2021/22 to 46.9% in 2022/23, while the percentage of residents requiring supervision increased from 24.7% in 2021/22 to 32.8% in 2022/23. The percentage of extensive to total dependence remained low. This indicates a shift in need for more supervision and assistance in ADLs in PCHs and demonstrates that there has been very little change in the highest care need categories.

Table 13: CIHI Data, PCH: Activities of Daily Living (ADL), 2021/22 to 2022/23

ADL Scale	2021/22	2022/23
Independent	54.8%	46.9%
Supervision/Limited	24.7%	32.8%
Extensive	14.6%	14.1%
Dependent/Total Dependent	5.9%	6.2%
Total dependence	0.9%	1.0%

Table 14 shows the percentage of PCH residents in each CHESS outcome scale level in 2021/22 and 2022/23. Like LTC, PCH CHESS Scale data suggests most residents are relatively stable.

Table 14: CIHI Data, PCH: Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS), 2021/22 to 2022/23

CHESS Scale	2021/22	2022/23
No instability (0)	42.8%	41.0%
Score (1)	31.0%	28.6%
Score (2)	17.3%	18.6%
Score (3)	7.3%	9.0%
Score (4)	1.5%	2.4%
Highest instability (5)	0.0%	0.3%

Table 15 shows the percentage of PCH residents in each DRS outcome scale level in 2021/22 and 2022/23. The percentage of PCH residents assessed with some depressive symptoms increased from 21.1% in 2021/22 to 25.9% in 2022/23, while the percentage of residents with no depressive symptoms decreased from 66.8% to 63.1%. These changes suggest there is a need for mental health supports for PCH residents in NL.

Table 15: CIHI Data, PCH: Depression Rating Scale, 2021/22 to 2022/23

DRS Scale	2021/22	2022/23
No depressive symptoms (0)	66.8%	63.1%
Some depressive symptoms (1 or 2)	21.1%	25.9%
Possible depressive disorder (3 or more)	12.0%	11.0%

Table 16 shows the percentage of PCH residents in each CPS outcome scale level between 2021/22 and 2022/23. Overall, the percentage of PCH residents assessed as being relatively intact was 63.5% in 2021/22 and 63.4% in 2022/23. The percentage of residents assessed with severe cognitive impairment was 4% in 2021/22 and 6% in 2022/23, while the percentage of residents assessed with mild/moderate impairment ranged from 32% to 30%.

Table 16: CIHI Data, PCH: Cognitive Performance Scale (CPS), 2021/22 to 2022/23

CPS Scale	2021/22	2022/23
Relatively intact	63.5%	63.4%
Mild / Intact	31.8%	29.7%
Severe	3.9%	6.2%

Since CIHI data has only been separated for PCH residents since 2021 trending cannot be surmised, but comparison of MAPLe, ADL, and DRS indicators between 2021/22 and 2022/23 suggest that the acuity of PCH residents in NL has remained consistent over this time frame.

Personal Care Home Demonstration Projects

NL has introduced new demonstration projects to be delivered in PCHs. These will increase community based supportive care options.

- Community Based Rehabilitation and Restorative Care
- Enhanced Dementia Care
- Adult Day Program

Community Based Rehabilitation and Restorative Care

The Rehabilitation and Restorative Care project provides short-term residential care for individuals in need of timely rehabilitation and restorative services post an acute episode or planned hospital stay. Its objective is to support recovery and facilitate a safe return home, ultimately improving hospital flow. Services may last up to eight weeks and are coordinated by NLHS staff in collaboration with clients and service providers. NLHS assists clients in identifying their needs and developing a personalized care plan to achieve their health goals. Currently, two PCHs are involved in this demonstration project including one in the Central Zone and one in the Eastern Rural Zone.

Enhanced Dementia Care

Enhanced Dementia Care introduces a live-in care solution tailored for seniors and adults with moderate to advancing dementia, bridging a critical gap in community services. This demonstration project is designed for individuals requiring supervision and support with daily activities and provides a secure environment with staff trained in dementia care. The project has a resident-centered approach and prioritizes dignity and autonomy to support residents with daily tasks and meaningful recreational activities. This demonstration project is currently available in one PCH in the Eastern Urban Zone.

Adult Day Program

The Adult Day Program offers support to older adults living at home by providing non-residential respite care outside the home environment. The project offers meaningful occupation and support for individuals needing assistance with daily activities due to cognitive or physical challenges. One PCH is participating in the Eastern Urban Zone.

The Short Stay Option in Personal Care Homes

The Short Stay Option aims to offer urgent and short-term placements up to 30 days for individuals facing challenges in returning to their previous living arrangements after presenting to acute care. This option provides a temporary solution for individuals whose needs can be safely addressed in a PCH with or without additional supports, or for those in the community at risk of acute care admission. During this period, intensive case management and long-term planning are undertaken which may involve returning to the previous living arrangement with or without supports, longer-term placement in the same or a different PCH, or transition to LTC. This option allows for enhanced utilization of PCHs to support the delivery of services in a more suitable environment for clients.

4.2.2 What We Heard

Focus group participants were asked to share their experience on a variety of quality of care topics including:

- Clinical oversight and access to primary care
- Access to allied health services
- Training and qualifications
- Increased resident acuity
- Access to PCHs in remote areas

Focus Group Findings

Clinical Oversight and Access to Primary Care

Focus group participants shared that access to a physician or nurse practitioner for residents in PCHs is inconsistent and sometimes lacking. In addition, there were concerns with clinical oversight due to limited RN and LPN usage in PCHs. There was a perception that residents' care needs are becoming more complex, requiring more instances of delegation of nursing tasks, such as medication administration and wound care, to unlicensed workers.

Access to Allied Health Services

Focus group participants indicated that there were challenges accessing allied health services in PCHs including occupational therapy, physiotherapy, audiology, and mental health resources.

Training and Qualifications

Focus group participants commented on the inadequate training and qualifications of PCH staff. Participants perceived that staff were not equipped with the clinical skills or knowledge needed to support increasing PCH resident acuity and care needs resulting in increased reliance on community health nurses to support their needs.

Increased Resident Acuity

Focus group participants perceived that resident acuity was increasing for PCH residents and identified the following challenges:

- Staff had limited training, skills, and knowledge to care for complex care needs.
- Resident fear of other residents who may wander.
- Limited number of appropriate recreational programs and activities to support residents with higher care needs.

Focus group participants also expressed concerns with low staffing levels overnight in many PCHs. They noted the risks posed to staff and residents in homes given the perceived increase in the frequency of responsive behaviours.

Access to Personal Care Homes in Remote Areas

Focus group participants shared that there are challenges with accessing PCHs in remote areas. This presented challenges for families and ECPs trying to care for loved ones at home as long as possible with limited supports or making the difficult decision to move to a PCH several hundred kilometres away.

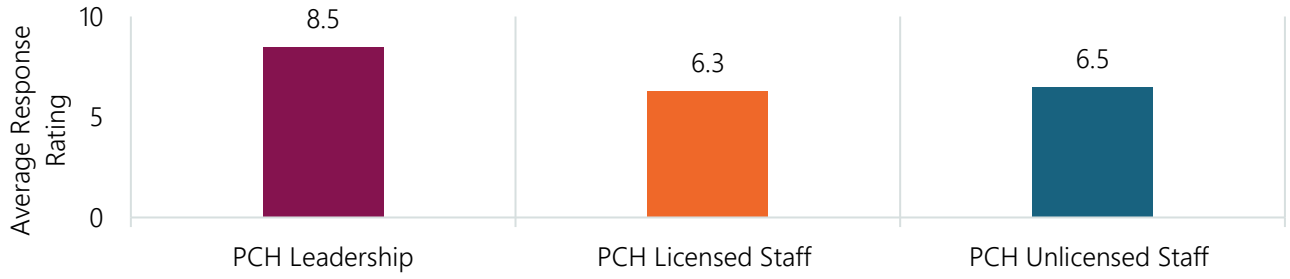
Survey Findings

The following section summarizes the survey results related to quality of life in PCHs for four stakeholder groups including:

- PCH Leadership – 24 survey respondents
- PCH Licensed Staff – 24 survey respondents
- PCH Unlicensed Staff – 31 survey respondents
- PCH Residents, Family, and ECPs – 126 survey respondents

The average rating provided by PCH leadership for overall resident quality of care was 8.5 out of 10 (Figure 25), notably higher than the average rating provided by PCH unlicensed staff (6.5 out of 10) and PCH licensed staff (6.3 out of 10).

Figure 25: Average Ratings for PCH Quality of Care (Scale 0 to 10)

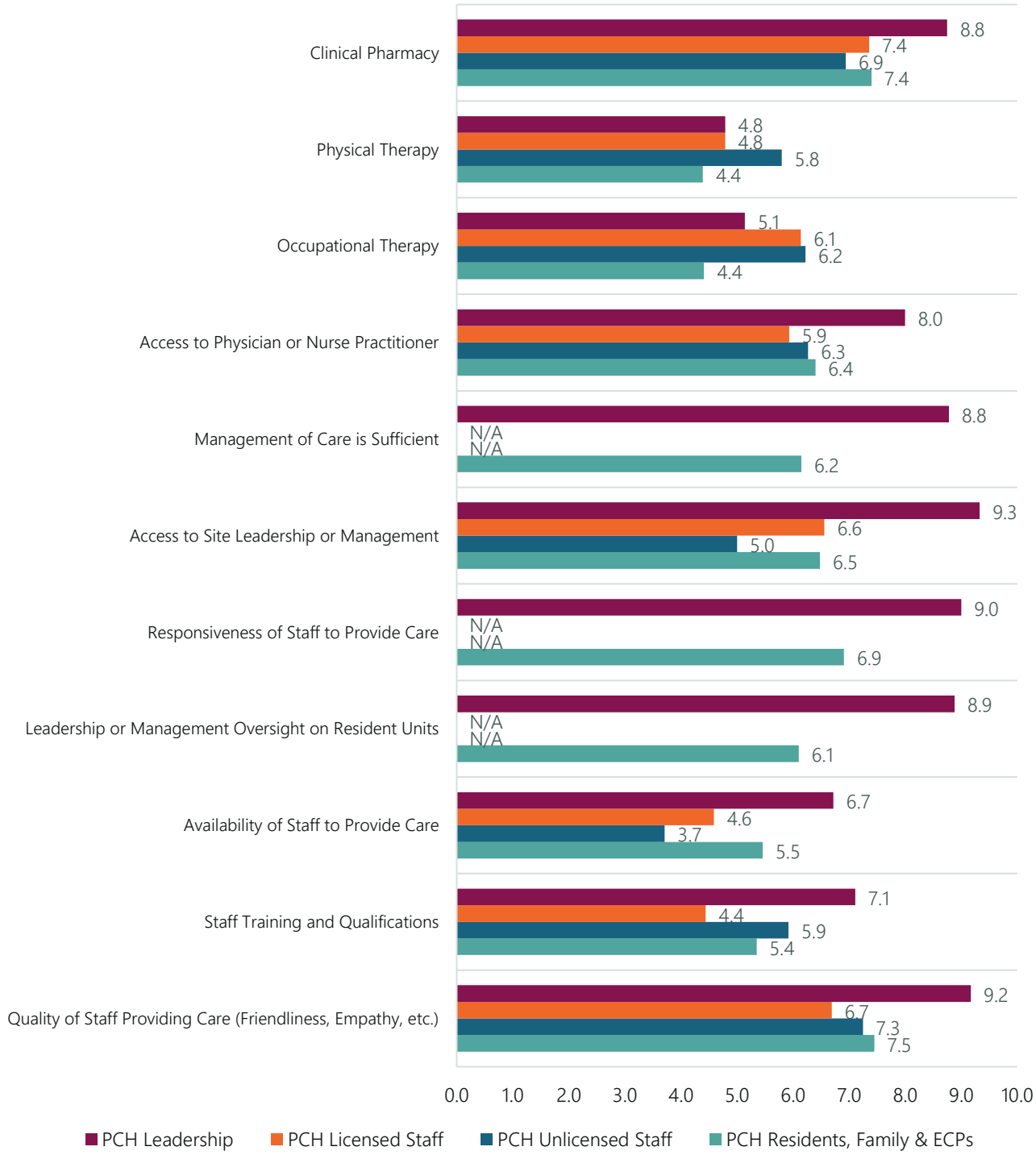


Survey respondents were asked to rate quality of care for a variety of categories using a scale of 0 (needs improvement) to 10 (strength). Overall, the average ratings provided by PCH Leadership were higher for most categories (except physical therapy and occupational) than the average ratings provided by PCH Residents, Family, and ECPs, PCH Unlicensed Staff, and PCH Licensed Staff (Figure 26). The highest rated categories by PCH Residents, Family, and ECPs included quality of staff providing care, clinical pharmacy, and responsiveness of staff to provide care. The lowest rated categories by PCH Residents, Family, and ECPs were physical therapy and occupational

therapy, which were also rated significantly lower by PCH Leadership. Other dimensions rated as requiring improvement by PCH Residents, Family, and ECPs included staff training and qualifications and availability of staff to provide care.

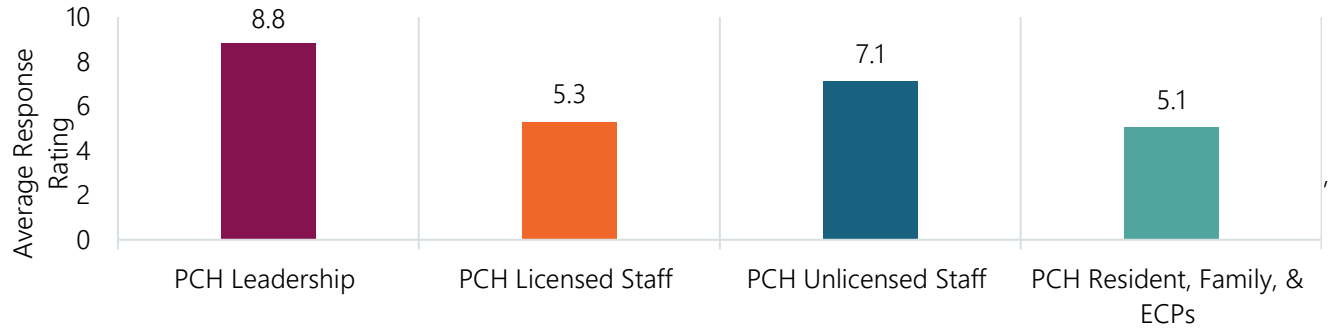
Figure 26: Average Ratings for Quality of Care Categories in PCHs (Scale of 0 to 10)

NA - indicates question was not asked



PCH survey participants were asked to rank the level of influence that residents, family, and ECPs had on making informed choices and decisions on PCH services from 0 (no level of influence) to 10 (high level of influence). PCH Leadership provided an average rating 8.8 out of 10, significantly higher than the average rating provided by Residents, Family and ECPs at 5.1 out of 10 and PCH Licensed Staff at 5.3 out of 10 (Figure 27).

Figure 27: PCH Resident, Family, and Caregiver Inclusion in Decision Making (Scale 0 to 10)



Overall, 83% of PCH Residents, Family, and ECPs were comfortable with bringing forward concerns to PCH staff and leadership in their home, while 16% were not.

Opportunities for Improvement

Focus group participants and survey respondents provided the following opportunities to improve PCH resident quality of care:

- Improve access to clinical services both in the community and in PCHs (physicians and nurse practitioners).
- Increase training and education for staff in PCHs to better support complex care needs and increased resident acuity as needed.
- Increase staffing levels to be more reflective of higher resident acuity.
- Increase staffing levels overnight to ensure safety and security of residents.

> ***"Enlist the support of specialists to visit homes on a rotational basis to address health concerns. Perhaps a mobile unit that could provide dental, ophthalmology, foot care services would be beneficial."***

4.3 Leading Practices and Other Jurisdiction Research

The following section identifies emerging, leading, and best practices identified through literature review and interviews with representatives from other provinces to improve resident quality of care, based on the opportunities for improvement identified from the findings in Sections 4.1 and 4.2 above.

4.3.1 Leading Practices

The HSO National LTC Standard defines care as actions taken in any setting to address a resident's social, physical, personal, emotional, psychological, cultural, spiritual, and medical needs to support their health and well-being (page XIII)[3].

Assessment and Care Planning

A comprehensive approach that integrates assessment and care planning models is needed to effectively manage changing acuity levels in LTC homes (Section 4.1.1) and PCHs (Section 4.2.1) in NL and to improve the continuum of care in the province.

The HSO National LTC Standard recommends the use of evidence-based assessment tools to thoroughly evaluate a resident's needs, covering basic care, mental health, physical health, and social needs (criterion 4.1.1)[3]. This information is gathered in collaboration with the resident or, if necessary, their substitute decision maker, and other ECPs with consent. The HSO National LTC Standard recommends the use of needs assessment tools to evaluate a resident's:

- Health upon admission (criterion 4.1.2)
- Basic needs (criterion 4.1.3)
- Mental health needs (criterion 4.1.4)
- Physical health needs (criterion 4.1.5)
- Social needs (criterion 4.1.6)

Further, the HSO National LTC Standard recommends ongoing needs assessments to identify changing health status and care needs, including maintaining an up-to-date medication profile (criteria 4.1.7 and 4.2.10).

The RAI-HC and RAI-LTCF assessment tools are internationally validated person-centred assessment tools[57]. RAI-HC is used for assessing people with chronic and post-acute needs and informs and guides comprehensive care and service planning in home and community-based settings. RAI-HC focuses on an individual's quality of life by assessing their needs, strengths, preferences and provides the basis for an outcome-based assessment of the individual's response to care or services. RAI-LTCF is used for assessing people in LTC homes and evaluates the needs, strength, and preferences of an individual through measurement of key domains of function, mental and physical health, social support, and service use. GNL currently uses the RAI-HC and RAI-MDS 2.0 assessment tools and will be implementing updated versions of RAI-HC and RAI-LTCF supported by CIHI.

Care Training Programs

Dementia Care

The Gentle Persuasive Approach (GPA) is a training program designed to help health care workers intervene in an effective manner that is non-punitive, respectful, and self-protective[58]. It is used across Canada including in NL and is particularly beneficial for caring for dementia residents in LTC and PCHs. The GPA helps care providers understand the meaning behind each behavioral display, most of which are time-limited and episodic[59] and can help care providers better understanding the person's remaining abilities and the cause of their deficits.

The Alzheimer Society of Newfoundland and Labrador offers an e-learning program, the Dementia Passport, to support healthcare providers in the delivery of high-quality care to people living with dementia. GNL has provided funding to support personal care home and home support workers to avail of this training[60].

Palliative and End-Of-Life Care

The Learning Essential Approaches to Palliative Care (LEAP) courses are designed to equip healthcare professionals with essential competencies necessary for providing palliative and end-of-life care[61]. NLHS offers LEAP training to

health professionals and GNL has partnered with Pallium Canada to offer LEAP training for up to 10,000 PCH workers, home support workers and personal care attendants.

Care Practices

The findings from the focus groups, surveys, and internal environmental scan (see Sections 4.1 and 4.2) show opportunities to improve care practices in NL including personal care, pain management, and resident safety in both LTC and PCH settings.

The HSO National LTC Standard recommends a team-based approach is employed in conducting regular assessments of skin, nails, and mouth (criteria 4.2.3 and 4.2.4)[3]. Homes should also ensure that residents have access to dental health professionals for both preventive and acute care when necessary.

Pain Management

The HSO National LTC Standard recommends that homes adopt a comprehensive approach to address residents' pain, focusing on physical, psychosocial, and pharmacological strategies (criterion 4.2.5):

- Physical interventions involve activities like exercises and repositioning, along with the use of specialized equipment to alleviate discomfort.
- Psychosocial strategies target thoughts and emotions through activities and, occasionally, mindfulness meditation.
- Pharmacological interventions are employed when necessary to relieve pain.

Responsive Behaviours

The HSO National LTC Standard recommends understanding the resident's history, preferences, and routines; maintaining a daily routine; assisting with exercise; and engaging in calming activities like music or pet visitations to manage responsive behaviours (criterion 4.2.7)[3]. Homes should adopt a trauma-informed and culturally safe approach, avoiding antipsychotics and sedatives as first-line treatments. Care teams should also collaborate to identify causes and non-pharmacological approaches to calm and redirect residents when possible.

The use of restraints should only be used as a short-term measure to prevent risk of harm to self or others, or to allow essential medical treatments, with informed consent required from capable residents or their substitute decision maker except in emergencies (criterion 4.2.8)[3]. Homes should adhere to a least-restraint approach, ensuring care upholds residents' rights, dignity, and autonomy while complying with legal requirements.

The HSO National LTC Standard recommends teams are engaged in educational efforts to understand the proper use of antipsychotic medications, particularly in treating medical conditions and their limited role in managing responsive behaviors (criterion 4.2.11) [3]. Teams should focus on assessing the risks and benefits of these medications, replacing inappropriate use with non-drug interventions where possible, and knowing when to involve mental health professionals.

Access to Other Services

Focus group and survey participants mentioned the need to have better access to services outside of LTC and PCHs (see sections 4.1.2 and 4.2.2). To address this gap, the HSO National LTC Standard recommends[3]:

- Establishing formal agreements with external health providers to ensure residents receive care from the right professionals when needed (criterion 4.3.3).

- Ensuring timely and safe access to external services, which may be provided on-site or off-site (criterion 4.3.7).
- Ensuring efforts are made to deliver necessary care in the most suitable setting by the appropriate team, whether it's urgent care in an emergency department, rehabilitation in an outpatient setting, or planned care like dental services in a community clinic (criterion 4.3.6).
- Coordinating access to non-medical services, including arrangements for in-person or virtual assistance. This may involve providing transportation to appointments (criterion 4.3.5).
- Assigning a designated team member to plan and coordinate external consultation, including, but not limited to dentists, optometrists, or medical specialists, considering transportation needs and whether accompaniment is necessary (criterion 4.3.10).

4.3.2 Other Jurisdictional Research

The following notable practices from British Columbia, Alberta, Ontario, and Nova Scotia were gathered through interviews and secondary research. These practices have been taken into consideration to inform the recommendations in Section 4.5.

Direct Care Hours and Staffing Ratios

Table 17 summarizes the average direct care hours and average staffing mix ratios in LTC homes in NL, British Columbia, Alberta, Ontario, and Nova Scotia.

Table 17: LTC Direct Care Hours and Staffing Mix Ratio Comparison

Jurisdiction	Total Direct Care Hours	Average Nursing Care Direct Hours and Ratio		Average Allied Health Hours and Ratio	
Newfoundland and Labrador	3.77 hours	**Total Care Hours**	**3.4**	**Total Hours**	**0.36**
		RN/LPN	53% (1.8 hours)	Licensed	51% (0.18 hours)
		PCA	47% (1.6 hours)	Non-Licensed	49% (0.18 hours)
British Columbia	3.36 hours	**Total Care Hours**	**3.0**	**Total Hours**	**0.36**
		RN/LPN	20% (0.6 hours)	Licensed	40% (0.14 hours)
		PCA	80% (2.4 hours)	Non-Licensed	60% (0.22 hours)
Alberta (By March 2025)	4.0 hours	**Total Care Hours**	**3.6**	**Total Hours**	**0.4**
		RN/LPN	26% (1.04 hours)	Licensed	56% (0.22 hours)

Jurisdiction	Total Direct Care Hours	Average Nursing Care Direct Hours and Ratio		Average Allied Health Hours and Ratio	
		HCAs	74% (2.56 hours)	Non-Licensed	44% (0.18 hours)
Ontario **(By March 2025)**	4.6 hours	**Total Care Hours**	**4.0**	**Hours**	**0.6**
		Flexible mix, but PSWs are majority of direct care hours		No available information on allied health ratio	
Nova Scotia	4.1	**Total Care Hours**	**4.1**	No available information on allied health ratio	
		RN/LPN	26.8% (1.1 hours)		
		CCA	73.2% (3.0 hours)		

British Columbia

British Columbia funds an average of 3.36 DCHs per resident day for LTC. Of this total, 3.0 DCHs are designated for direct nursing care with 20 percent (0.6 hours) provided by RNs or LPNs and 80 percent (2.4 hours) provided by PCAs. Additionally, 0.36 DCHs are dedicated to allied health services, which are divided between professionals (40 percent or 0.14 hours) and non-professional staff (60 percent or 0.22 hours). Allied health professionals provide specialized assistance such as OT, PT, dietician, social work, and speech language therapy services. Assistant positions, such as OT Assistants, are available to offer support with administrative work for professionals.

Assisted living services in British Columbia provide housing, hospitality, and regulated assistance for adults who can live independently but require a supportive environment due to physical or functional health challenges[62]. No standard framework was provided for assisted living DCHs.

Alberta

Prior to the Continuing Care Transformation (CCT) currently in progress, the average level of funded DCHs provided to LTC operators through the Patient-Care Based Funding (PCBF) system remained at 3.37 hours per resident day for nursing, personal care and therapy services based on an average Case Mix Index (CMI) of 100. The Facility-Based Continuing Care (FBCC) review recommended that the province increase DCHs for LTC to 4.5 hours per resident day to improve the quality of care for residents. Table 18 summarizes the breakdown of the original funded hours and the FBCC Review Recommendations.

Table 18: Alberta's Direct Care Hours: Original Funded and FBCC Recommendation

Staffing Type	Original Funded Hours	FBCC Review Recommended DCHs
RN	0.52	0.67
LPN	0.37	0.50
HCA*	2.13	2.88
Professional Therapies	0.19	0.25
Non-Professional Therapies	0.16	0.20
Total Hours of Care	**3.37**	**4.50**

* HCAs provide personal care and other essential services such as daily activities and promoting overall well-being.

Alberta Health (AH) is currently adjusting the funding model to support the increase of direct care hours from 3.37 to 4.0 by 2025 (Table 17). Operators will continue to receive extra care funding to support current operations until a new-hours-of-care model is finalized. AH is planning to slowly increase the direct care hours as funding and resources are limited. Simultaneously, the province is adjusting under-funded facilities to meet the current standard prior to increasing the direct care hours in the province. AH is also working towards increasing the supply of HCAs in the province through bursary programs with a return of service requirement.

Ontario

The *Fixing Long Term Care Act, 2021*[63] set targets for the minimum number of hours of direct care provided to residents in LTC homes, gradually increasing direct care to 4.0 hours per resident day by March 31, 2025. The Act also included a requirement for an additional 0.6 hours of direct care from allied health care professionals by March 31, 2023.

The *Fixing Long Term Care Act, 2021* was informed by multiple sources including the *Long Term Care Staffing Study* conducted by Ontario's Ministry of Long Term Care in 2020[64] which set a target of 4.0 DCHs per resident per day. The study also emphasized the importance of flexibility in staffing guidelines to accommodate variations in resident needs, staff availability, and workload management. The study recommended "that the ministry establish staffing guidelines to allow some degree of flexibility", as well as the adoption of guidelines for staffing ratios, such as one PSW to eight residents for day and evening shifts, with a gradual progression towards more favorable ratios over time. Further, the presence of registered nursing staff and increased access to allied health professionals were proposed strategies for enhancing the quality of care provided to residents.

Nova Scotia

Nova Scotia has implemented a minimum of 4.1 DCHs per resident day for LTC homes. Three hours are provided by Continuing Care Assistants (CCAs), and the remaining 1.1 hours are provided by RNs and LPNs. The care teams in LTC include:

- CCAs to provide personal care and other essential services such as daily activities and promoting overall well-being. CCAs are unregulated but certified positions.

- LPNs to provide the daily care, such as medical administration, wound care, and assisting with activities of daily living, of residents.
- RNs to provide the clinical support, such as assessment, planning, and evaluation of care.

The province introduced Long Term Care Assistants (LTCAs) following a Ministry Review in 2018 to provide basic care to residents and to delegate some of the responsibilities of CCAs to improve resident care. The LTCA positions were valuable during the COVID-19 pandemic. There are also plans to train CCAs with wound care to share responsibilities with LPNs. Lastly, Nova Scotia is considering expanding clinical oversight for RNs to include UTI and IV treatments. The goal is to maximize the clinical capacity of licensed staff, such as LPNs and RNs, while promoting quality of care through CCAs and untrained individuals.

4.4 Quality of Care Conclusions

The following conclusions have been drawn for LTC and PCH quality of care based on the findings in the preceding sections.

4.4.1 Long Term Care Home Conclusions

1. As a result of concerns raised during the COVID-19 pandemic the DHCS requested homes operated by NLHS conduct LTC resident quality of care audits. Audits continue to be completed on a quarterly basis.
2. NL launched a three-year *Dementia Care Action Plan* for the period from 2023 to 2026 to improve awareness of dementia, improve coordination and quality of supports and services, and support professional development of staff.
3. Focus group and survey respondents identified a need to improve clinical leadership in LTC homes.
4. Stakeholders indicated that accessing allied health services and clinicians such as physiotherapy, occupational therapy, social work, behaviour management, dietetic services, audiology, dental hygiene services, and speech language pathology in LTC is challenging and requires improvement.
5. In 2022/23 over 55% of LTC residents were assessed with a depression rating scale of one or higher, which indicates a potential or actual problem with depression. Focus group and survey respondents also reported a need to improve access to mental health and addictions services.
6. Focus group participants and survey respondents perceived that increasing hours of care could improve the overall quality of care provided to LTC residents. Other provinces in Canada have also recently made investments to increase direct hours of care in LTC including Alberta, Ontario, and Nova Scotia.
7. NL currently has a higher proportion of RNs and LPNs (53%) in the direct care hour staff mix compared to other Canadian jurisdictions (ranges from 20% to 30%). Shifting the staff mix towards a higher proportion of PCAs could allow RNs and LPNs to work to their full scope of practice and align the staff mix in NL with other Canadian provinces.
8. Focus group participants and survey respondents identified a need to enhance teamwork and collaboration in LTC to ensure residents, families and ECPs are included as part of the care team.
9. Stakeholders identified a need to improve the use of technology and digital health services in LTC homes.

4.4.2 Personal Care Home Conclusions

1. NL has introduced several new programs to increase community based supportive care options. Recent demonstration projects introduced by DHCS include Community Based Rehabilitation and Restorative Care, Enhanced Dementia Care, and Adult Day Programs. In addition, the Short Stay Option in PCHs offers urgent and short-term placements in PCHs for individuals facing challenges in returning to their previous living arrangements after presenting to acute care.
2. DHCS recently increased the subsidy rates for eligible residents based on the level of care required (I, II, Enhanced, or III).
3. Focus group participants identified a need for increased clinical oversight by community health nurses due to a perceived increase in resident care needs and higher demand for delegation of nursing tasks to unlicensed personal support workers, such as medication administration and wound care.
4. Data accessed from CIHI for MAPLe, ADL, and DRS shows increasing acuity of PCH residents, consistent with level of care data trends. There is an opportunity to improve assessment and care/support planning to better address needs of PCH residents, especially those with higher care/support needs.
5. Stakeholders identified a need to improve training and education of PCH staff to better support care needs and increasing resident acuity.
6. Focus group participants and survey respondents indicated challenges with accessing occupational therapy, physiotherapy, and mental health resources.
7. Stakeholders identified a need to increase PCH staffing levels overnight to support resident safety and security.

4.5 Quality of Care Recommendations

The findings from Sections 4.1 to 4.4 above identified several opportunities to improve the quality of care in LTC homes and PCHs in NL. A total of six recommendations for improvement were developed. Each recommendation includes:

- A description of the recommendation.
- The key actions required to implement the recommendation.
- The expected benefits of implementing the recommendation.
- Implementation roadmap for the recommendation.
- The financial considerations of the recommendation.

Recommendation #8: Establish quality of care as a main priority of continuing care.

Sections 4.1 and 4.2 show that there are improvements required for resident quality of care. Leading practices and literature (Section 4.3) also support implementing the improvements identified in the key actions below.

Key Actions Required:

1. Prioritize continuous quality of care improvement initiatives, informed by CIHI data, clinical safety reporting, resident and family experience surveys, and LTC survey reports from Accreditation Canada.
    a. Ensure leadership and staff are aware of the importance of performance reporting and monitoring to inform quality initiatives and are engaged in quality initiative actions.

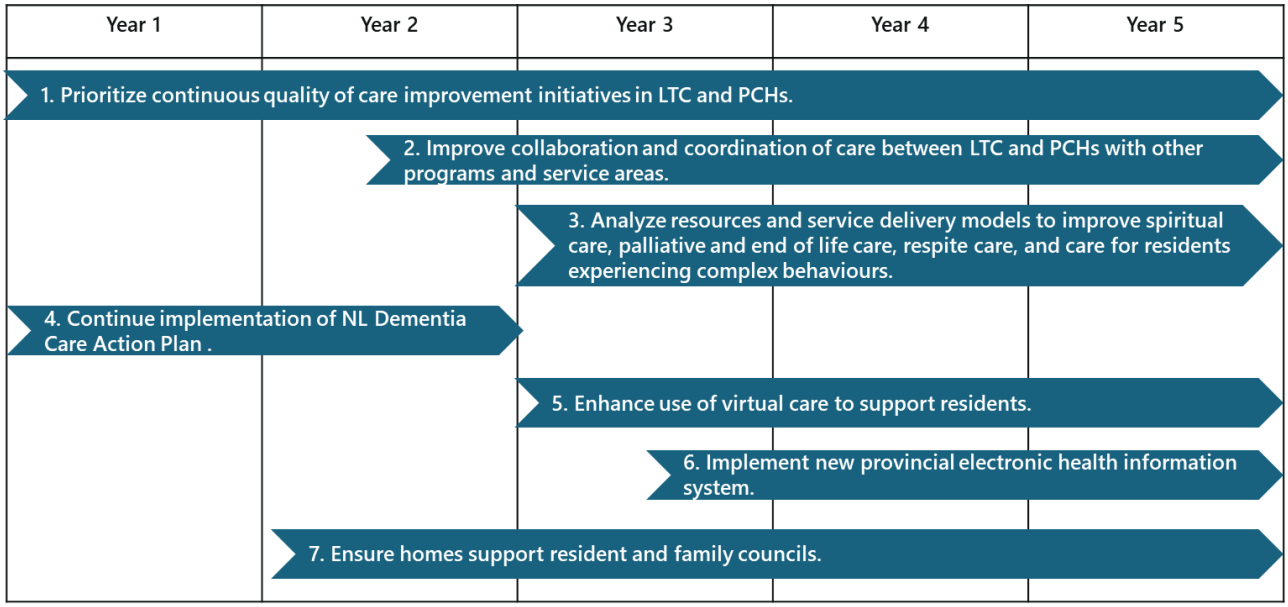
b. Ensure action is taken to improve CIHI quality indicators where NL is performing lower than the national average (e.g., experiencing pain, using restraints).

2. Improve collaboration and coordination of care between LTC and PCHs with other programs and service areas such as primary care and community care.
3. Analyze existing resources and service delivery models to improve spiritual care, palliative and end of life care, respite care, and care for residents experiencing complex behaviours.
4. Continue implementation of the NL Dementia Care Action Plan to enhance the quality of care for individuals and families living with dementia.
5. Enhance use of virtual care to support residents access to services, especially in remote and rural areas.
6. Implement the new provincial electronic health information system to standardize care and improve communication and information sharing.
7. Ensure homes support resident and family councils to address systemic quality of care and quality of life concerns.

Expected Benefits:

The expected benefits of this recommendation include improved collaboration and continuity between service providers resulting in improved resident quality of care.

Implementation Roadmap:



Financial Considerations:

Financial considerations for this recommendation include existing staff time to support the key actions identified.

Recommendation #9: Improve assessment and support/care planning for residents.

A comprehensive approach that integrates assessment and care planning models is needed to effectively manage resident care needs in LTC homes (Section 4.1.1) and PCHs (Section 4.2.1) in NL. Leading practices and literature (Section 4.3) also support implementing the improvements identified in the key actions below.

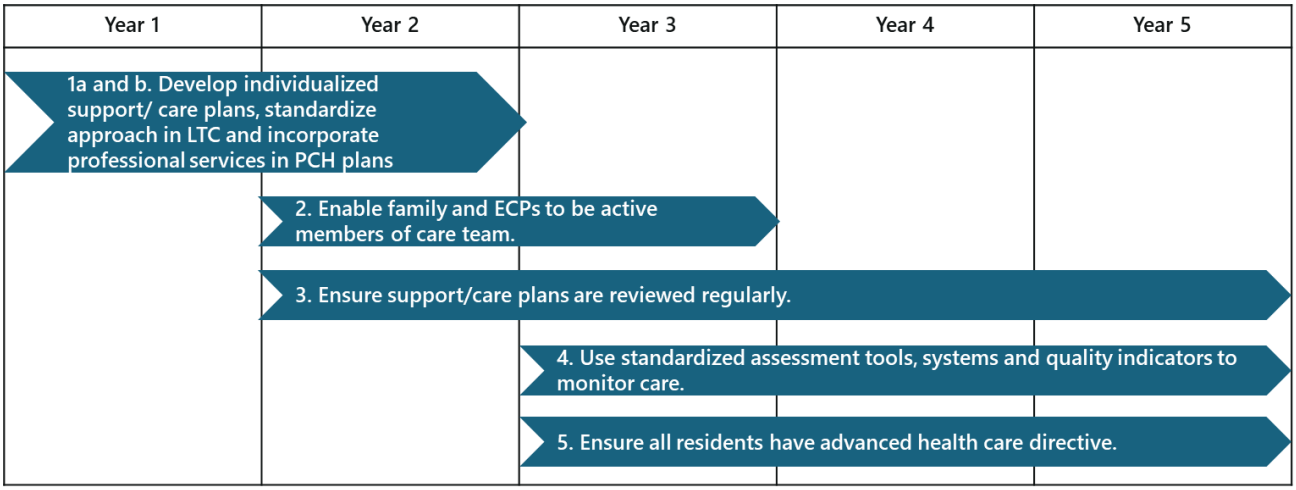
Key Actions Required:

1. Develop individualized support/care plans through collaboration with residents, families, ECPs, and care team members to identify residents' care goals and holistic care needs.
    a. In LTC, standardize the approach for the development, implementation, and review of the care plan with all members of the care team to ensure consistency and involvement.
    b. In PCHs, identify required programs and incorporate professional services into residents' individualized support plans.
2. Enable families and ECPs to be active and respected members of the care team including providing support for all aspects of care delivery. This may include training to support bathing, eating, and other personal care aspects.
3. Ensure residents support/care plans are reviewed and updated regularly to reflect any changes in the resident's health status. Ensure support/care plans are communicated with the care team.
4. Use standardized assessment tools, systems, and quality indicators to monitor key aspects of care.
5. Ensure all residents have an advanced health care directive that is reviewed and updated as required.

Expected Benefits:

The expected benefits of this recommendation include the appropriate assessment and admission of residents at a level of care that is more reflective of their care needs.

Implementation Roadmap:



Financial Considerations:

Financial considerations for this recommendation include existing staff time to support the key actions identified.

Recommendation #10: Improve access to medical, therapeutic, and other health related services.

Sections 4.1.2 and 4.2.2 indicate that residents experience challenges accessing medical, therapeutic, and other health related services. Leading practices and literature (Section 4.3) also support implementing the improvements identified in the key actions below.

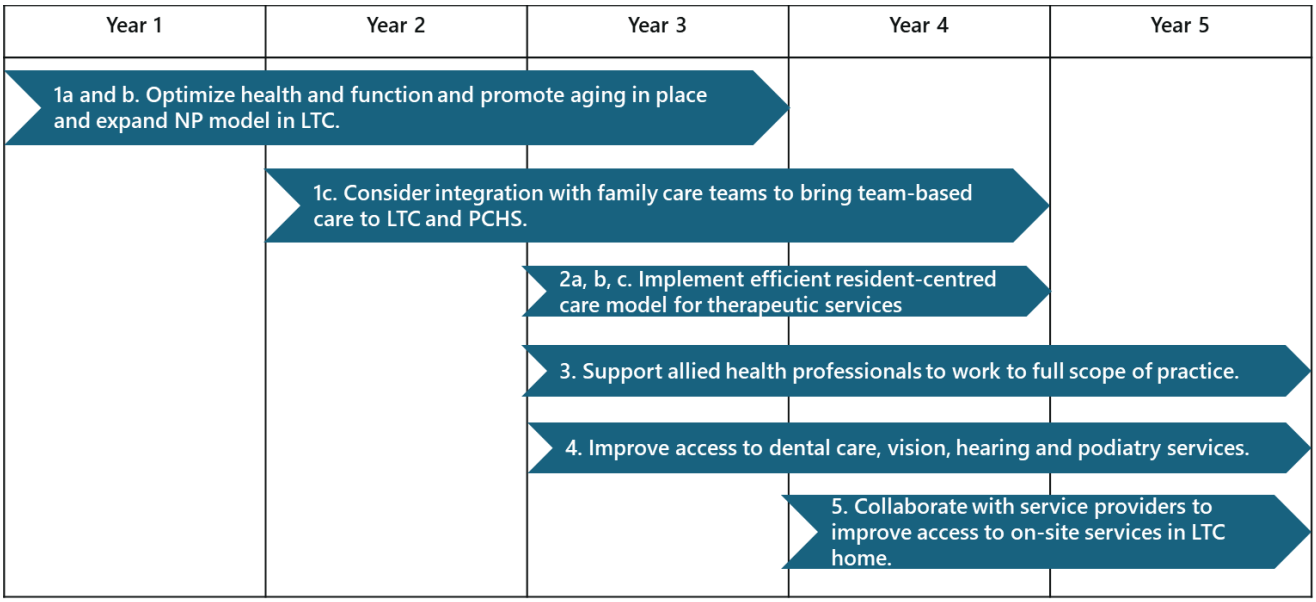
Key Actions Required:

1. Improve access to primary care clinicians and geriatric care services.
    a. Optimize health and function and promote aging in place.
    b. In LTC, expand the nurse practitioner model.
    c. Consider integration with family care teams that is aimed to bring team-based primary care to LTC and PCHs.
2. Implement an efficient, resident-centred care model for the delivery of therapeutic services.
    a. Ensure service delivery hours align with resident needs.
    b. Explore the use of technology, especially in rural and remote settings.
    c. Explore alternative staffing models to ensure access to services is timely and efficient. This may include a service delivery model where staff work across programs.
3. Support allied health professionals to work to their full scope of practice by increasing assistant roles to shift administrative duties.
4. Improve access to services such as dental care, vision, hearing, and podiatry.
5. Collaborate with service providers to improve access to on-site services in LTC homes.

Expected Benefits:

The expected benefits of this recommendation include improved access to medical, therapeutic, and other health services resulting in improved care outcomes for residents.

Implementation Roadmap:



Financial Considerations:

The estimated annual costs to increase access to therapeutic services by increasing the number of physiotherapists, occupational therapists, behavioural management specialists, and dieticians; as well as adding physiotherapy support

workers and occupational therapist assistants to enable professionals to work to their full scope of practice is $2.3 million. Detailed assumptions are provided in Appendix 2.

Recommendation #11: Improve access to mental health and addictions supports and resources.

Sections 4.1.2 and 4.2.2 indicate that residents and families experience challenges accessing mental health and addictions supports and services in LTC and PCHs. Additionally, stakeholders identified that residents moving into a LTC home often are not able to maintain access to the mental health and addictions supports they had when living in the community. Leading practices and literature (Section 4.3) also support implementing the improvements identified in the key actions below.

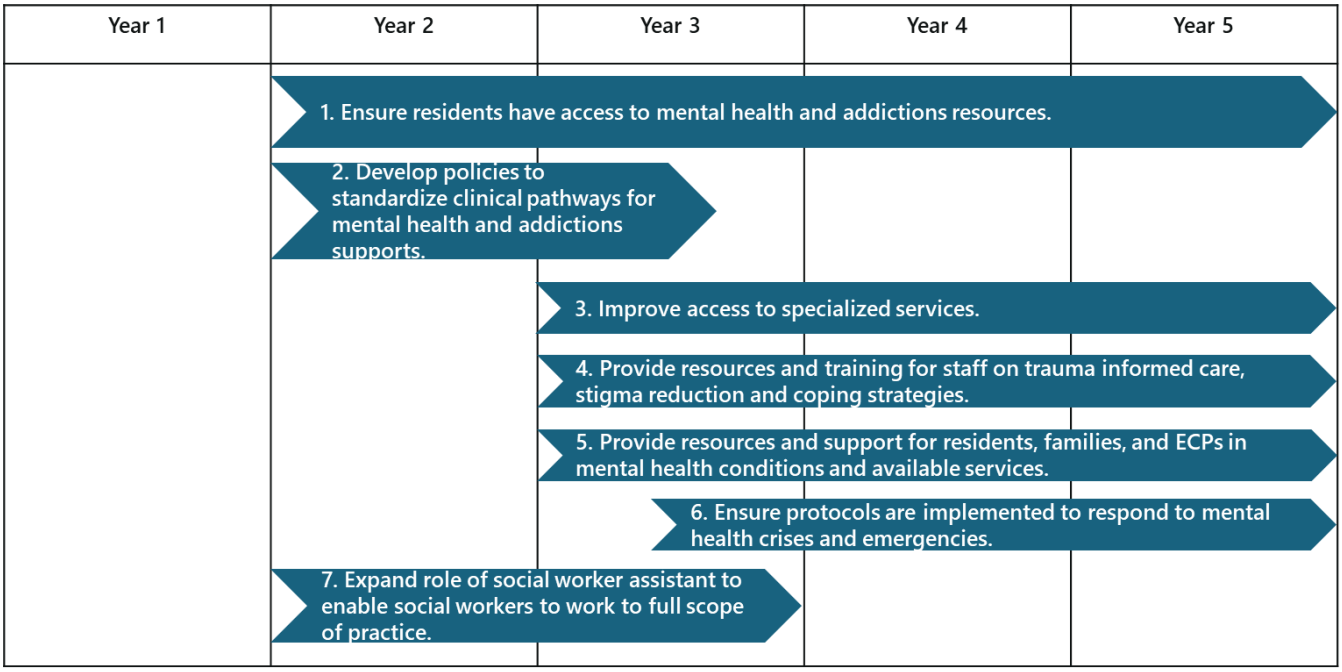
Key Actions Required:

1. Ensure residents have access to mental health and addictions resources based on their assessed need.
2. Develop policies to ensure there are standardized clinical pathways for specialized mental health and addictions supports. Ensure staff have the appropriate knowledge to differentiate between complex mental health or addictions needs and emotional well-being supports.
3. Improve access to specialized services such as, social workers, psychologists, geriatric psychiatrists, behaviour management specialists, and mental health and addictions counsellors.
4. Provide resources and training for staff on trauma informed care, stigma reduction and coping strategies.
5. Provide resources and support for residents, families, and ECPs on mental health conditions, available services, and strategies for promoting mental wellness.
6. Ensure protocols and procedures are implemented to respond to mental health and addictions crises and emergencies.
7. Expand the role of the social work assistant to enable social workers to work to their full scope of practice and provide support for residents, families, ECPs.

Expected Benefits:

The expected benefits of implementing this recommendation include improved access to mental health and addictions supports for residents, families, ECPs, and staff.

Implementation Roadmap:



Financial Considerations:

The estimated annual cost to expand the role and number of social worker assistants to enable social workers to work to their full scope of practice is $1.1 million. Detailed assumptions are provided in Appendix 2.

Recommendation #12: In LTC, increase the direct hours of care for residents and adjust the skill mix and staffing model to ensure staff are working to full scope.

Other jurisdiction practices and leading practices (Section 4.3) suggest increasing the direct care hours provided to residents to facilitate improved quality of care in LTC homes. Section 4.1.2 also indicated that stakeholders felt that additional staff could help support improving quality of care for long term care residents.

Key Actions Required:

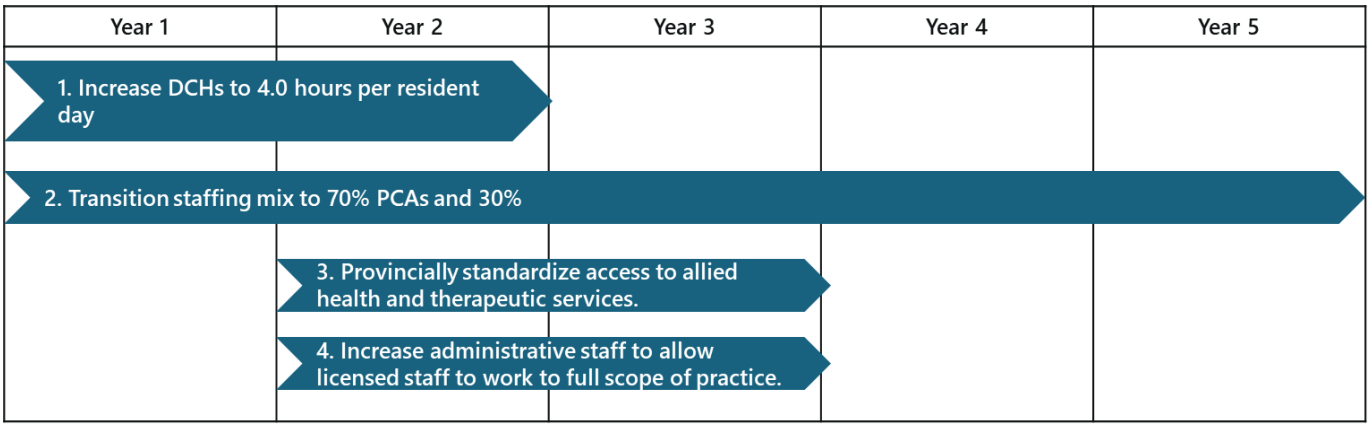
1. In year 1 increase the average direct care hours for nursing (i.e., PCAs, LPNs, and RNs) in LTC from 3.4 hours per resident day to 3.7 hours per resident day and by year 2 increase to 4.0 hours per resident day by increasing hours for PCAs.
2. Over a five-year period, transition the staffing mix to 70% PCAs and 30% RN/LPN.
3. Provincially standardize access to allied health and therapeutic services.
4. Ensure the delivery of care is based on a model that is a team-based care approach.
5. Increase administrative or support staff to allow licensed staff to work to full scope (as aligned with Recommendations #10 and #11).

Expected Benefits:

The expected benefits of this recommendation include increased direct care hours for residents, improved ability for staff to provide a higher quality of care to residents, reduced burnout, improved staff satisfaction, and higher-quality

outcomes should be achieved when appropriate staffing mix is applied. It is anticipated that increasing hours of care from PCAs will result in less responsive behaviours and consequently a reduction in inappropriate chemical and physical restraints.

Implementation Roadmap:



Financial Considerations:

The estimated annual cost to increase the average direct care hours for nursing care (i.e., PCAs, LPNs, and RNs) in LTC from 3.4 hours per resident day to 3.7 hours per resident day in year 1 is $11.5 million, and $23.1 million in year 2 to further increase direct care hours to 4.0 hours per resident day (Appendix 2). The increase in direct care hours will be achieved by increasing the average PCA hours per resident day from 1.59 to 1.89 in year 1 and up to 2.19 hours per resident day in year 2. The increase in PCA direct care hours will require the addition of 492.8 FTE PCA staff members by year 2 across the province and will change nursing skill mix to 55% PCAs and 45% RNs/LPNs. Over the next five years, the skill mix ratio for nursing staff will move towards 70% PCAs and 30% RNs/LPNs through attrition of RN/LPNs and replacing those positions with PCAs.

Recommendation #13: In PCHs, ensure residents are supported to safely age in place.

Section 4.2.2 shows that there is a need to improve clinical oversight of PCH resident care. Leading practices and literature (Section 4.3) also support implementing the improvements identified in the key actions below.

Key Actions Required:

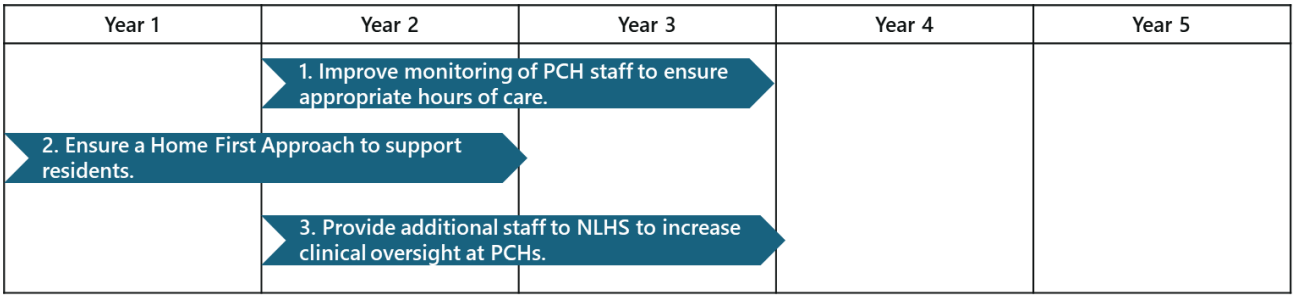
The following three key actions have been identified to support implementation of the recommendation including:

1. Improve the current monitoring and reporting process related to staffing to ensure appropriate hours of care are implemented.
2. Ensure a Home First approach is implemented to support residents when additional needs are identified.
3. Provide additional staffing to NLHS to dedicate resources to increase clinical oversight of residents in PCHs.

Expected Benefits:

The expected benefits of this recommendation are improved health outcomes for PCH residents and improved coordination and collaboration of services.

Implementation Roadmap:

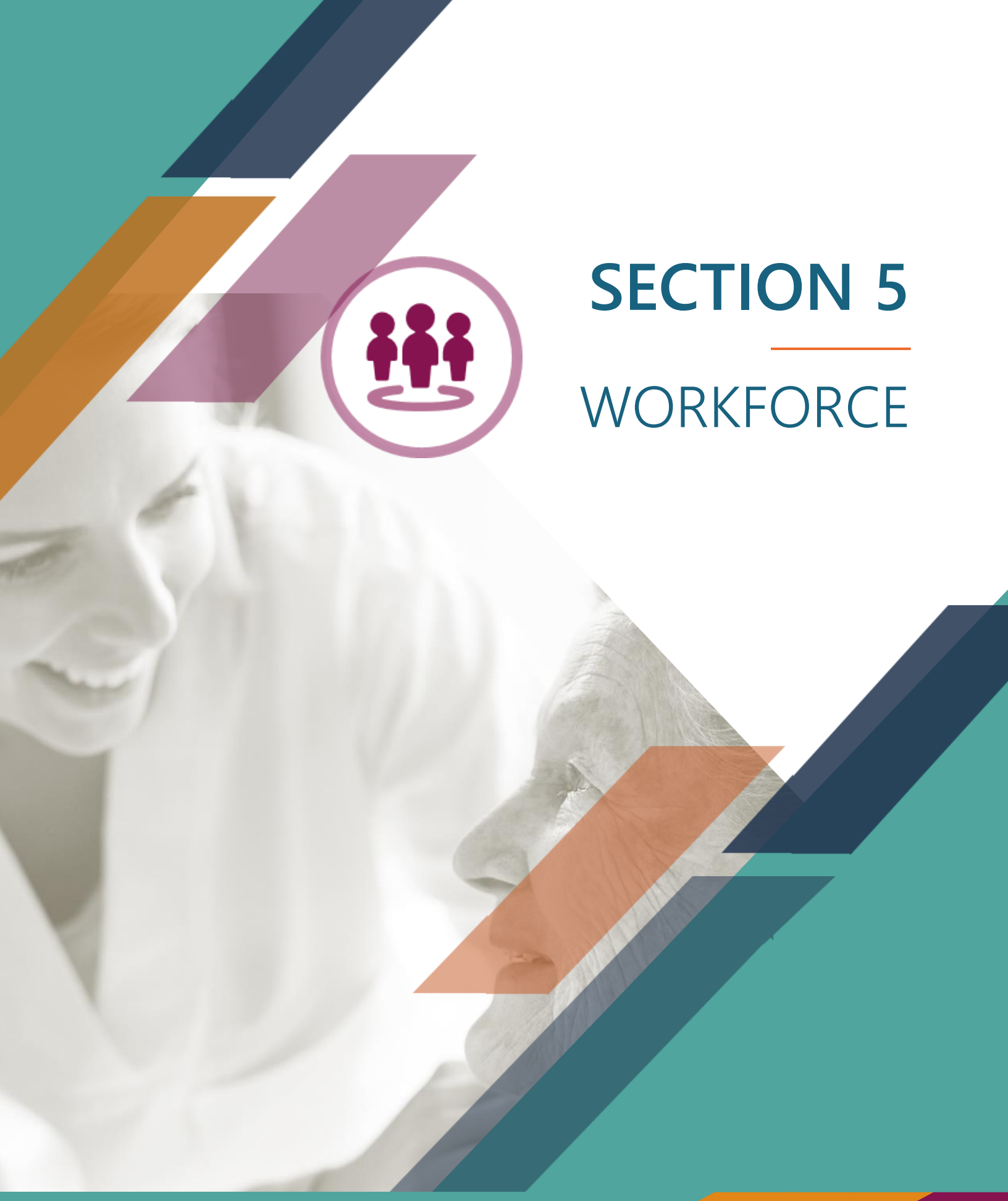


Financial Considerations:

The estimated annual costs associated with providing additional LPN staff to NLHS to provide clinical leadership to PCHs is $609,623. Detailed assumptions are provided in Appendix 2.

SECTION 5

WORKFORCE



5 Workforce

Health Accord NL identified high vacancy rates within the health workforce and challenges with recruitment and retention in a variety of positions in the sector[1]. This Review explores factors affecting attitudes and workplace culture in LTC and PCHs and identifies opportunities to improve quality of work life and recruitment and retention initiatives in the province.

5.1 Long Term Care Findings

The following section describes the current context and stakeholder engagement findings for the LTC workforce.

5.1.1 Current Context

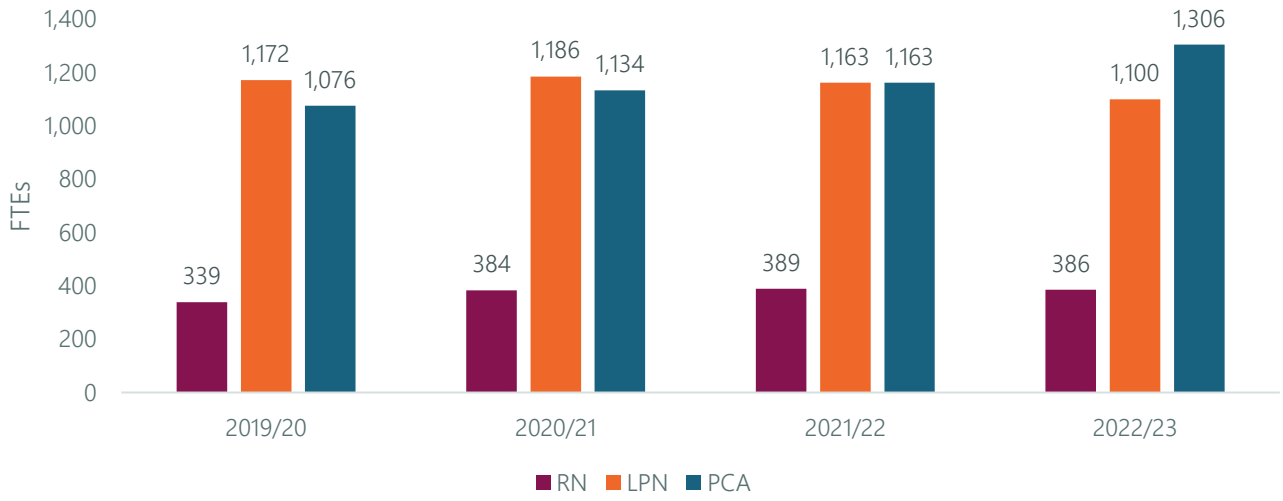
Nursing Workforce Characteristics

The LTC nursing workforce in NL includes direct care staff (RNs, LPNs, and PCAs) and non-direct care staff (clinical educators, care facilitators, RAI coordinators, and clinical nurse specialists). In addition, LTC homes are staffed with allied health staff, administration staff, food services staff, clerical support staff, environmental services staff, laundry/linen staff, infrastructure staff, and site leadership/management.

The following are key characteristics of the LTC nursing workforce based on data provided by the DHCS:

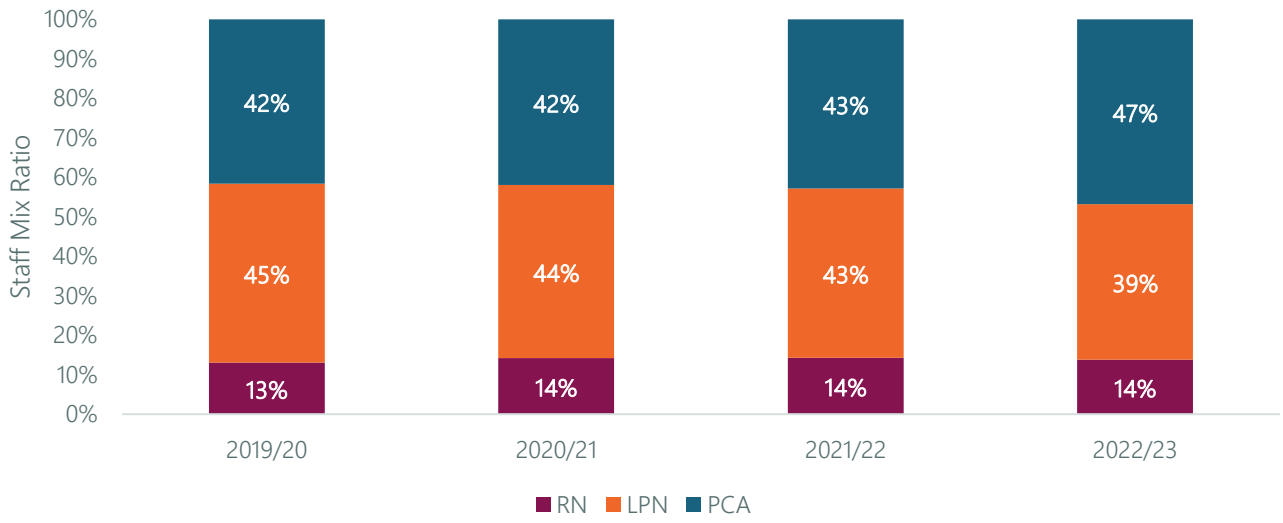
- There has been a shift in the staff mix for the nursing workforce in LTC homes. Prior to 2021/22, LPNs made up the largest portion of the nursing workforce followed closely by PCAs. However, by 2022/23, there were more PCA full-time equivalent (FTE) staff than LPN FTE staff in LTC homes (Figure 28).
    - Overall, the total capacity of the nursing workforce in LTC increased by 8% from 2,587 FTEs in 2019/20 to 2,792 FTEs in 2022/23.
        - The total number of RN staff increased by 14% from 339 FTEs in 2019/20 to 386 FTEs in 2022/23.
        - The total number of LPN staff decreased by 6% from 1,172 FTEs in 2019/20 to 1,100 FTEs in 2022/23 and according to the DHCS has been impacted by a significant number of vacant positions.
        - The total number of PCA staff increased by 21% from 1,076 FTEs in 2019/20 to 1,306 FTEs in 2022/23.
        - Additional LTC bed capacity increased when a new home opened in the Western Zone in 2020 and two new homes opened in the Central Zone in 2022, contributing to the increases observed for RNs and PCA staff.

Figure 28: Total Actual FTE Comparison for RN, LPN and PCA, 2019/20 to 2022/23



The ratio of actual RN/LPN/PCA FTE staff in LTC shifted from 13%RN/45%LPN/42%PCA in 2019/20 to 14%RN/39%LPN/47%PCA in 2022/23 (Figure 29). The observed change in the ratio was impacted by a shortage of LPN staff, which were filled with PCA staff to maintain staffing levels.

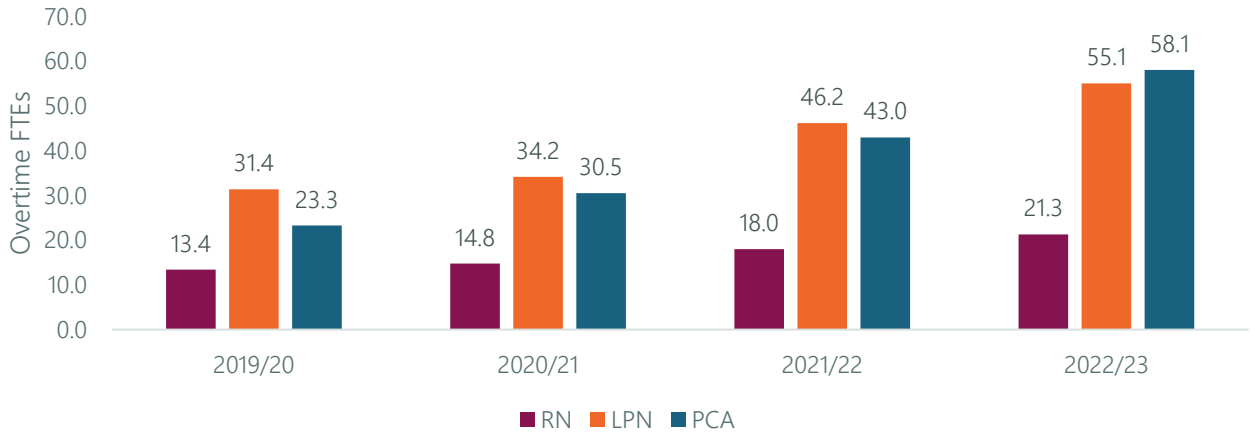
Figure 29: Actual Staff Mix Ratio Comparison for RN, LPN, and PCA, 2019/20 to 2022/23



Overtime Analysis

Based on data provided by the DHCS, overtime for PCAs, LPNs and RNs working in LTC has increased significantly between 2019/20 to 2022/23 (Figure 30). The amount of overtime for PCAs increased by 149% from 23.3 FTEs in 2019/20 to 58.1 FTEs in 2022/23, while overtime for LPNs increased by 75% from 31.4 FTEs to 55.1 FTEs and overtime for RNs increased by 59% from 13.4 FTEs in 2019/20 to 21.3 FTEs in 2022/23. The observed increases in overtime utilization by RNs, LPNs, and PCAs suggests a strain on staffing resources and emphasizes the importance of addressing the staffing challenges identified through stakeholder engagement (Section 5.1.2).

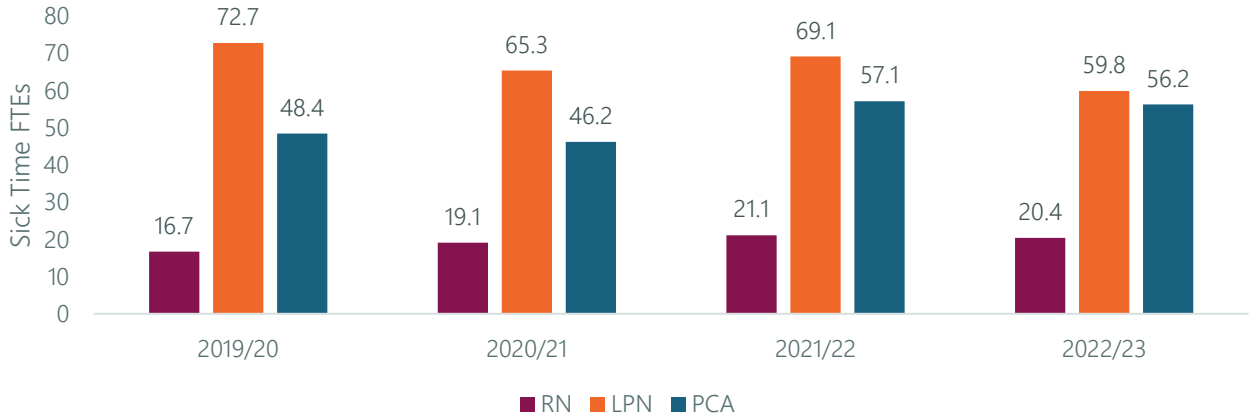
Figure 30: RN, LPN and PCA Overtime Utilization, 2019/20 to 2022/23



Sick Time Analysis

Figure 31 shows that sick time for RNs and PCAs has been increasing between 2019/20 to 2022/23, while sick time for LPNs has been decreasing. The sick time data does not include sick time due to COVID-19. However, staff were required to take sick time for any symptoms during the pandemic which may have impacted the data for 2020/21 to 2021/22. The amount of sick time for RNs increased by 22% from 16.7 FTEs in 2019/20 to 20.4 FTEs in 2022/23, while sick time for PCAs increased by 16% from 48.4 FTEs in 2019/20 to 56.2 FTEs in 2022/23 (Figure 31). Conversely, sick time for LPNs decreased by 18% from 72.7 FTEs to 59.8 FTEs in 2022/23 but remains the staff group with the highest utilization

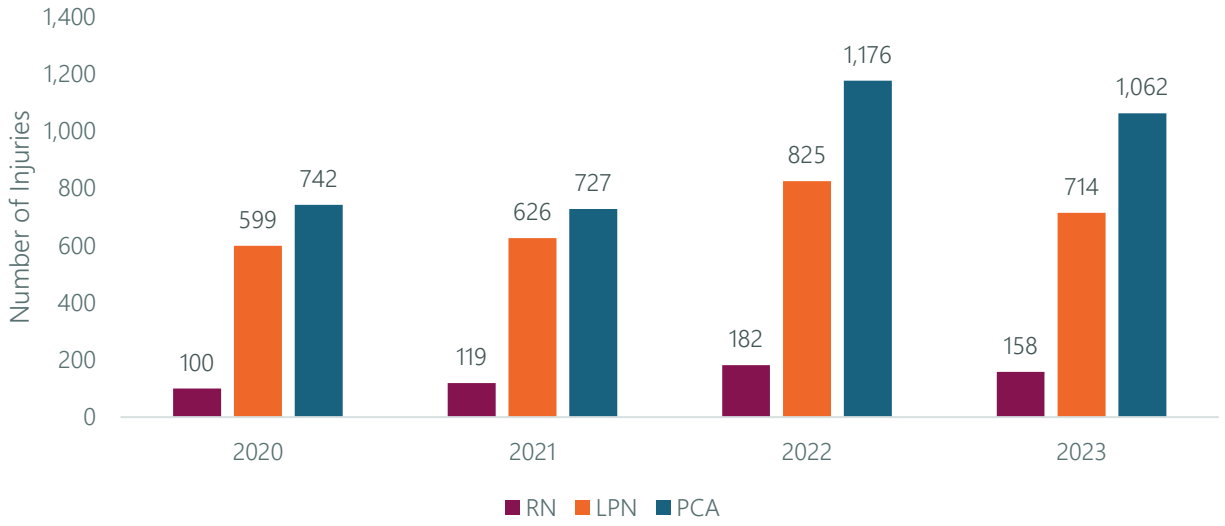
Figure 31: RN, LPN and PCA Sick Time Utilization, 2019/20 and 2022/23



Workplace Injuries

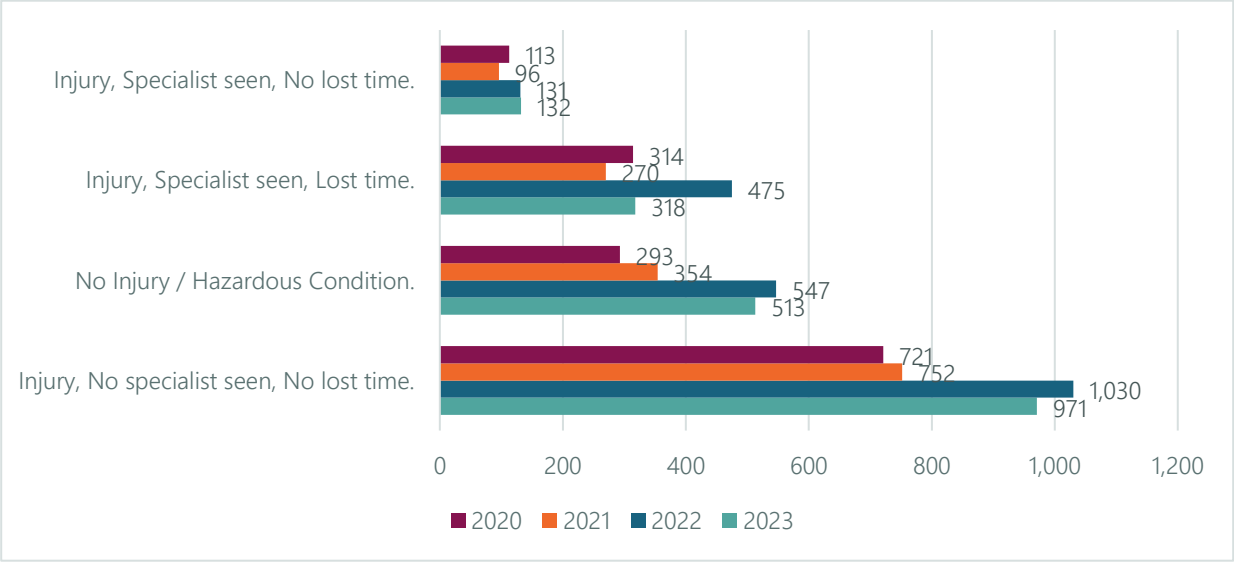
Provincial workplace injury data reveals an increasing trend in reported workplace injuries from 2020 to 2023 (Figure 32). Reported workplace injuries for RNs, LPNs, and PCAs were highest in 2022.

Figure 32: Number of Reported Workplace Injuries by Position from 2020 to 2023



There was an 58% increase in reported workplace injuries for RNs from 100 in 2020 to 158 in 2023. LPN reported workplace injuries increased by 19% from 599 in 2020 to 714 in 2023, and PCA reported workplace injuries increased 43% from 742 in 2020 to 1,062 in 2023 (Figure 33). This trend has declined slightly among all groups between 2022 and 2023. The portion of injuries resulting in lost time decreased from 22% of reported injuries in 2020 to 16% of reported injuries in 2023 (Figure 33). Further, the number of reported injuries resulting in lost time was relatively the same in 2020 (314 reported injuries) and 2023 (318 reported injuries) and was significantly higher in 2022 (475 reported injuries).

Figure 33: Breakdown of Reported Workplace Injuries by Type from 2020 to 2023



Allied Health Workforce

The allied health workforce in LTC is composed of occupational therapists, physiotherapists, physiotherapist support workers, recreation therapy workers, recreation specialists, social workers, social work assistants, dieticians, and speech-language pathologists. Some homes do not have dedicated allied health workers and are shared with community services or acute care, especially homes within or attached to health centres and in rural areas with a low number of LTC beds.

Table 19: Summary of Allied Health Workforce FTEs

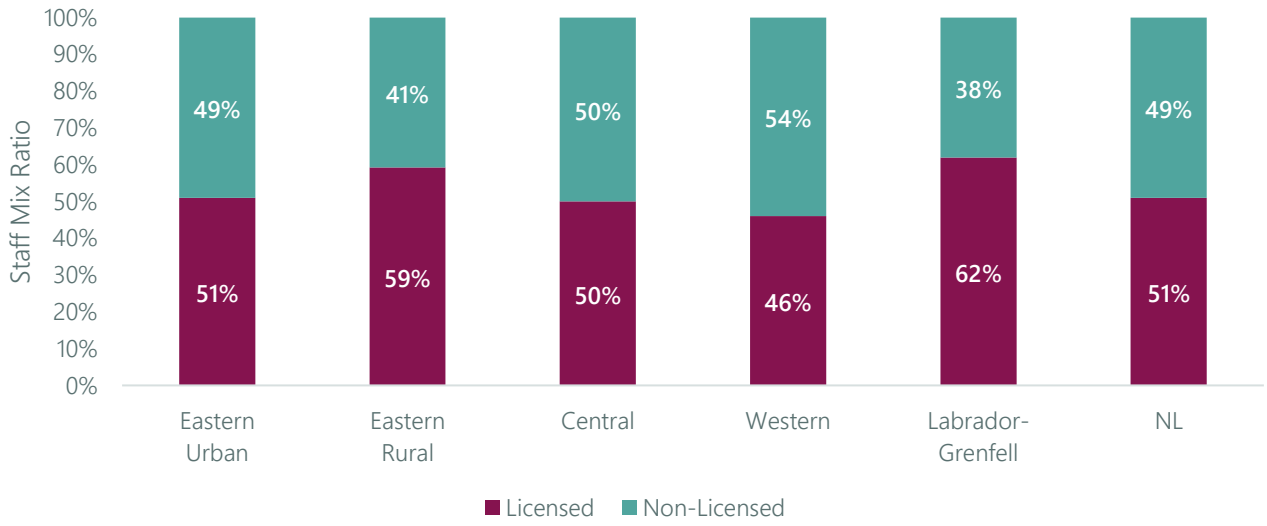
Position	Eastern Urban	Eastern Rural	Central	Western	Labrador-Grenfell	Total FTEs
Occupational Therapists	4.7	2.8	1.6	2.6	0	11.7
Physiotherapists	5.7	1.7	2.2	2.3	0	11.9
Recreational Specialist	9.0	6.0	8.0	4.0	2.0	29.0
Social Worker	12.1	6.2	7.1	6.1	2.4	33.9
Dietician	4.3	2.7	3.1	3.1	0	13.2
Speech Language Pathologist	1	0.5	0	0	0	1.5
Recreation Therapy Worker	24.3	10.0	14.0	14.8	1.1	64.2
PT/OT Support Worker*	10.3	3.7	8.3	4.8	1.6	28.7
Social Worker Assistant	0.5	0	0	2	0	2.5
Total FTEs	**71.9**	**33.6**	**44.3**	**39.7**	**7.1**	**196.6**
Average hours per resident per day	**0.37**	**0.34**	**0.37**	**0.38**	**0.25**	**0.36**

* No information available for LTC homes attached to health centers, so the number may be higher but likely would not change the average hours per day significantly.

The following are key characteristics of the LTC allied health workforce based on information provided by DHCS:

- A total of 196.6 FTE staff comprises the allied health workforce in LTC with a provincial average of 0.36 hours of care per resident day (Table 19).
    - The hours of care per resident per day are relatively consistent across the province, except in Labrador-Grenfell Zone, which provides the lowest at 0.25 hours per resident day.
    - The staffing mix ratio for allied health staff in LTC is 51% licensed staff to 49% non-licensed staff (Figure 34).
- Allied health professions in some health zones provide services in LTC and acute care settings, as these services are considered integrated program areas.

Figure 34: LTC Allied Health Staff Mix Ratio by Health Zone, Licensed versus Non-Licensed Staff



Workforce Strategy

Health Sector Recruitment and Retention Strategy

NL is adopting a competitive approach in the national and international labour market to improve the workforce by March 31, 2026. Over $23 million was allocated in the 2023 budget to attract healthcare professionals to the province through initiatives like the Come Home Campaign, which targets Newfoundlanders and Labradorians living away. Further, efforts are being directed towards expanding post-secondary health programs and creating career pathways through funding, bursaries, and bonuses tied to return-in-service commitments. NL has set objectives to strengthen recruitment and retention initiatives by increasing graduates from health education programs, enhancing assessment programs for physicians, streamlining licensing processes, and reducing staff vacancies.

DHCS has contracted an external consultant to complete a review of the pressing issues driving healthcare staffing challenges to better understand staffing shortages within the healthcare sector and develop a Health Human Resources (HHR) plan to address staffing challenges in the province.

Nursing Recruitment and Retention

The GNL, RNUNL, and NLHS completed an analysis in 2022 to develop innovative solutions to address nursing recruitment and retention challenges in the province. More than 130 people participated in the two-day Nursing

Think Tank event and contributed to recommending short-term measures to improve the workplace and the recruitment and retention of RNs and Nurse Practitioners in NL. The *Nursing Think Tank* summary report identified many solutions, including:

- Supporting growth and advancement of nurses through mentorship programs for seasoned and newer staff.
- Providing financial incentives to mentors who train nursing students.
- Providing financial reimbursement for continued education.
- Providing access to education leave for educational purposes.
- Incorporating rotational scheduling to support skill development across different areas.

Internationally Educated Nurses (IENs)

NL has recruited over 200 IENs since 2022 to work in various health sector facilities across the province, with ongoing efforts to recruit more. Many of these nurses are contributing to LTC, PCH, and acute care facilities[65].

NLHS developed an orientation plan to foster integration of IENs within the provincial healthcare system, including:

- Appointing a dedicated clinical educator to support IENs during orientation and in clinical settings.
- Encouraging IENs to complete a Competency Self-Assessment Form to identify their nursing skills and guide their proficiency attainment.
- Discussing cultural and practice differences throughout orientation to understand integration challenges.
- Ensuring consistency throughout the preceptorship period to develop supportive relationships.
- Increasing patient workloads gradually to help IENs adjust to the patient care model and healthcare delivery differences in NL.

5.1.2 What We Heard

Focus group participants were asked to share their feedback on a variety of workforce topics including:

- Workplace culture
- Recruitment and retention challenges
- Workplace morale
- Flexibility
- Agency staff
- Skill mix and staffing model changes
- Scope of practice
- Positions that should be expanded in LTC homes
- LTC leadership and management structures
- Training
- Negative perception of LTC as a career choice
- Equity, diversity, and inclusion (EDI)
- Administrative burden
- Communication

Focus Group Findings

Workplace Culture

Focus group participants identified several challenges related to workplace culture. There was a perceived lack of team-based culture within LTC, and many staff felt that they worked in silos. Further, there were challenging dynamics between RNs, LPNs, and PCAs including limited input from LPNs and PCAs into resident care planning and rounding with clinical health teams that may include RNs, NPs, and physicians.

There was also a perception of increased workplace injuries for staff due to unsafe work environments, increased resident responsive behaviours, limited access to proper equipment, and limited training. Participants felt that workplace injuries were increasing and that there is a culture of under-reporting workplace events or injuries due to a fear of being blamed or a perception that it is just "part of the job".

Finally, participants shared that workplace culture is also negatively impacted in situations where staff either work in multiple care settings or in a LTC facility that is attached to an acute care centre. It was reported that staff are often pulled into the acute care setting when needs increase, which often leaves LTC to work "short". This has created a perception that the needs of LTC residents are less valued than those in acute care.

Recruitment and Retention Challenges

Focus group participants shared that there were challenges with the recruitment and retention of various positions in LTC and that it can be especially challenging to attract and recruit staff in rural and remote areas. It was reported that many LTC staff were perceived to be leaving their positions to work for staffing agencies due to higher pay and more flexibility with work schedules. Some participants also shared that they were unable to take annual vacation and leave due to high position vacancies and limited coverage contributing to burnout and high turnover. Further, there was limited staff available to cover sick calls, vacations, and short-and-long term leaves.

Focus group participants also reported challenges with the recruitment process including:

- Staff are applying for positions but not hearing back regarding their application.
- The process is slow resulting in missed opportunities to hire qualified candidates for vacant positions.

Participants perceived that the requirement to have NLHS human resources involved in the recruitment process has made things slower. Historically managers would be more directly involved in the hiring process which allowed them to control the process flow more efficiently. Overall, participants reported that there were chronic staffing vacancies in LTC which created challenges with delivering funded hours of care.

Workplace Morale

Focus group participants shared that there were several elements impacting staff morale in LTC such as high-turnover, high levels of burnout, and challenges maintaining a work-life balance. There was a perceived increase in sick time usage due to burnout and staff avoiding mandated overtime.

Flexibility

Focus group participants felt there was a need to engage staff to better understand preferences regarding shifts, workplace supports, and other workplace improvements. There was a desire from staff to have more flexibility related to shift preference; full-time, part-time, or casual shifts; and hours of work. Staff schedules in LTC are very structured with mostly 12-hour shift rotations, and staff desire more flexibility and shift options to better support work-life balance. Participants expressed that 12-hour shifts can be challenging to schedule around childcare services.

Agency Staff

Focus group participants reported that utilization of agency nurses negatively impacted continuity of care for residents because they are unable to establish relationship with residents and other direct care staff. Further, it was felt that agency staff negatively impact workplace culture due to perceived pay inequities and strained dynamics between staff. The use of agency staff was perceived to come at a higher cost than employing a permanent employee for the same position.

One perceived benefit to using agency staff was that they provide crucial coverage for RNs to take vacation and paid leave which can positively impact work-life balance.

Skill Mix and Staffing Model Changes

Focus group participants shared that changes were needed to the skill mix and staffing model to better support resident care needs. One area identified was the need for more recreation support on evenings and weekends.

Participants also identified a need for additional staffing during peak hours such as mornings and mealtimes to support residents who require increased support for bathing, eating, and recreational activities. Participants also identified that there was a decrease in staffing levels on overnight shifts which raised safety concerns.

The current staffing model was perceived to be nursing heavy and that other positions should be included in the model to better support resident care needs. Allied health positions were recommended as an area to be expanded upon in LTC because dieticians, audiologists, behaviour management specialists (BMS), SLPs, OTs, PTs, and social workers were spread between many homes, including some in large geographic areas. It was reported that in general OTs and PTs were spread very thin between LTC homes and that LTC residents receive less OT and PT services than they would living at home in the community even though their needs might be higher. Participants perceived that allied health services and supports were more focused on being reactive than proactive to resident needs.

Scope of Practice

Focus group participants shared that many staff were not working to their full scope of practice. Some participants shared that this may be due to a high focus on task-based care; covering other vacant positions, sick calls, or vacation time; role confusion between PCAs, LPNs, and RNs, especially when staff transfer between health zones. Some participants reported challenging dynamics between LPN's and RN's due to confusion regarding scope of practice.

Positions that Should be Expanded in Long Term Care Homes

Focus group participants identified many positions that should be expanded or added into LTC homes or the community to better support resident care needs and families and ECPs including:

- Clinical Navigators
- Physical Therapy Assistants
- Recreation Supports, Recreational Therapy Assistants
- Allied Health Professionals (Audiology, Physiotherapy, Occupational Therapy, Speech Language Pathology)
- Mental Health and Addictions Support Workers and Clinicians
- Dietary Staff
- Behaviour Management Specialists

LTC Leadership and Management Structures

Focus group participants reported that leadership and management structures were inconsistent at LTC homes in the province. There was a perception that some sites were "top heavy" with several personnel in non-care related roles such as managers, clinical educators, clinical facilitators, and resident care coordinators. These positions were scheduled during daytime hours which resulted in limited access to leadership and supervision to support a 24/7 care model. Participants shared that access to managers was more limited at larger LTC homes compared to smaller homes.

Training

Focus group participants reported that the ability to complete staff training courses during working hours was challenging due to limited backfilling resulting in staff completing training outside of working hours on their personal time.

Focus group participants also identified areas for enhanced or additional training including:

- More on the job or hands-on training opportunities.
- Training and education for PCAs to identify early signs of resident cognitive and physical decline.
- Leadership competency training for LPNs to better support them as leaders on their units.
- Enhanced mental health and addictions training for staff.
- Crisis intervention training.

Participants felt that training related to core competencies and annual requirements should be completed during working hours.

Negative Perception of LTC as a Career Choice

Focus group participants indicated that there were challenges with the perception of LTC careers, with many future and current staff viewing LTC as a short-term option until finding a role in acute care or another setting. LTC is generally the first rotation for nursing students which had implications including an assumption of a smaller scope of practice. Negative perceptions of LTC careers included:

- LTC homes are unsafe and a degrading environment for staff.
- There is less dignity and respect for LTC staff.

Equity, Diversity, and Inclusion (EDI)

Focus group participants shared that there have been initiatives utilized to support IENs to work in LTC as PCAs while training and eventually writing the exam to become an LPN. With the influx of diverse backgrounds, there have been some challenges related to racism towards staff. Participants shared that residents' sometimes express difficulty with understanding international staff and, in some cases, there may be language barriers.

Participants noted that there were instances of unconscious biases related to ageism, racism, and discrimination in LTC homes including:

- Racism and discrimination from residents towards staff from Black, Indigenous, People of Colour (BIPOC) and LGTBQ2S+ communities.
- Ageism, racism and discrimination from staff and other residents towards residents.
- Racism and discrimination internally among staff.

Administrative Burden

Focus group participants identified a high level of administrative burden for managers, social workers, and nurses due to significant paperwork and human resources tasks. They believed there was an opportunity to digitize some of the current processes and make technology enhancements to reduce administration time. At some LTC homes LPN's have become "floor leaders" and the RN's role has shifted to be more focused on administrative tasks.

Communication

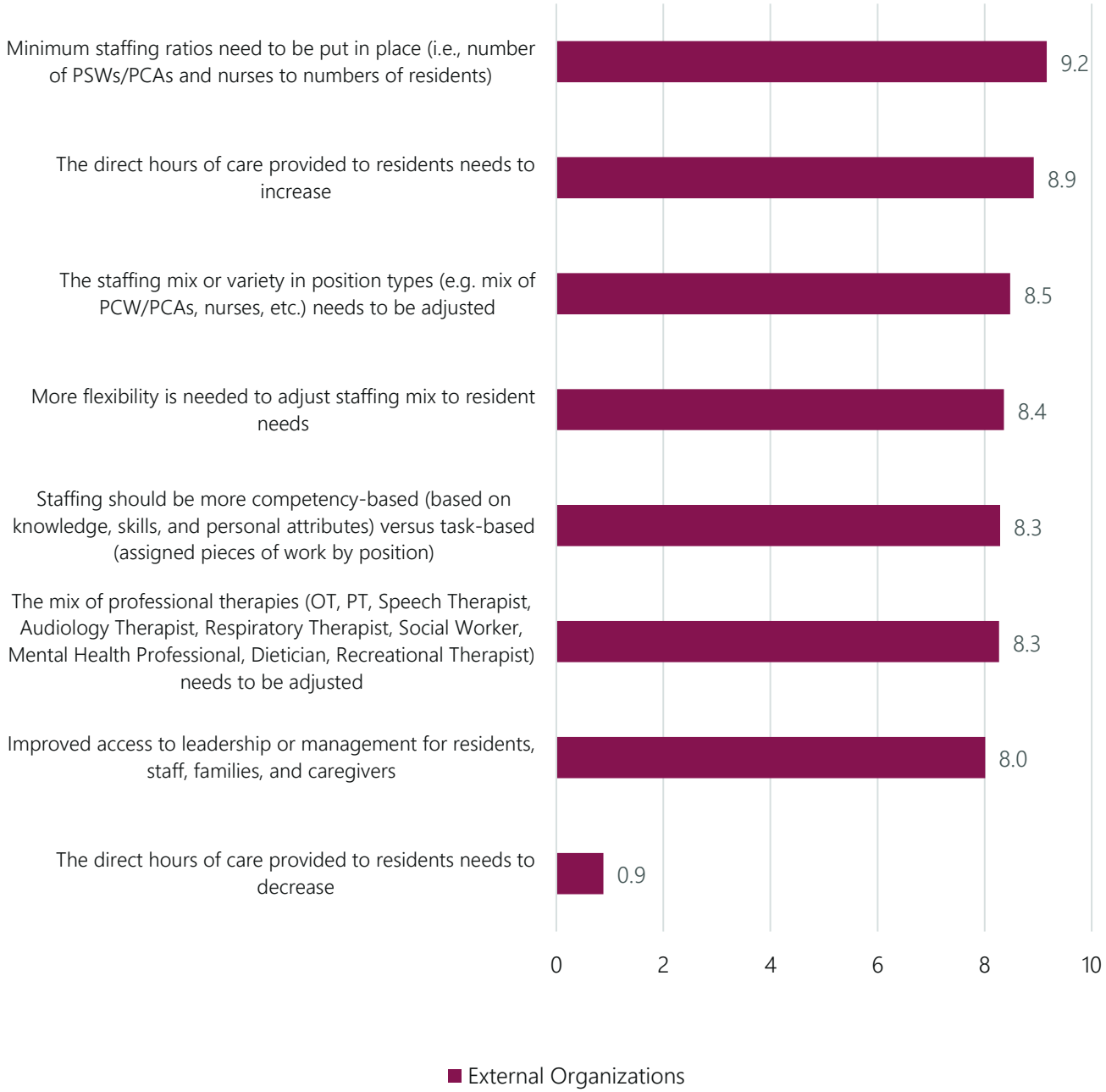
Focus group participants reported challenges related to communication in LTC including inconsistent communication between staff, site leadership, managers, families, ECPs, and residents. This included the frequent use of medical terminology or jargon which made it challenging for residents who may not have a family member or ECP to provide support on decision making.

Survey Findings

External Stakeholders

External organization survey participants rated a variety of staffing model changes for LTC and PCHs from 0 (doesn't require improvement) to 10 (very important improvement area). The average ratings for all staffing model changes, except decreasing direct care hours, ranged from 8.0 to 9.2 out of 10 (Figure 35), suggesting that they should all be considered opportunities for improvement. A total of 1,674 individuals responded to the public survey and 167 individuals responded to the external organization survey.

Figure 35: Staffing Model Changes, External Organizations Survey Results (Scale 0 to 10)



External organization survey participants also rated the importance of a variety of workplace improvements from 0 (doesn't require improvement) to 10 (very important improvement area) and identified all improvement options as priorities, with average ratings ranging from 8.4 out of 10 for increasing staff wages to 9.1 out of 10 for increasing the number of full-time positions (Figure 36).

Figure 36: Average Ratings for the Importance of Workplace Improvements, External Organizations (Scale 0 to 10)

LTC Leadership and Staff

The following section summarizes the survey results related to workplace improvements in LTC homes for three stakeholder groups including:

- LTC Leadership – 76 survey respondents
- LTC Licensed Staff – 286 survey respondents
- LTC Unlicensed Staff – 238 survey respondents

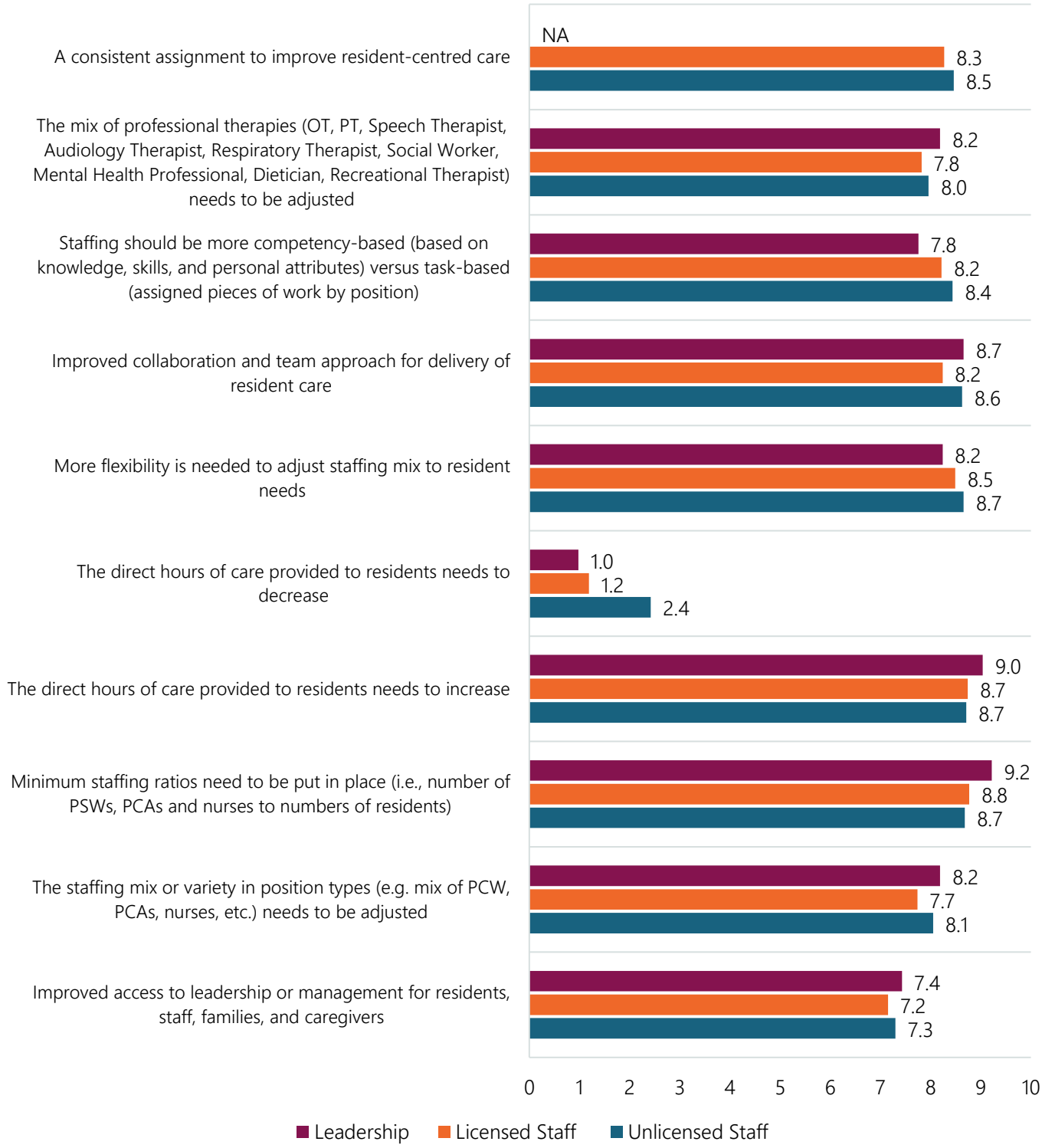
LTC licensed and unlicensed staff rated their level of satisfaction with the working environment at their home from 0 (needs improvement) to 10 (strength). The average rating for licensed staff was 4.0 out of 10 compared to 4.4 out of 10 for unlicensed staff. These low ratings demonstrate a need to improve staff satisfaction in LTC.

LTC staff and leadership also rated the level of staff morale in LTC from 0 (needs improvement) to 10 (strength). The average rating for licensed staff was 3.2 out of 10 compared to 3.4 out of 10 for unlicensed staff. The average rating for leadership was 3.6 out of 10. These low ratings demonstrate a need to improve the workplace environment for LTC staff.

LTC leadership and staff then rated the importance of a variety of staffing model changes from 0 (doesn't require improvement) to 10 (very important improvement area). Most options, except for decreasing care hours, had an average rating above 7 out of 10 suggesting they are all important (Figure 37), with minimum staffing ratios and direct hours of resident care identified as the highest areas for improvements.

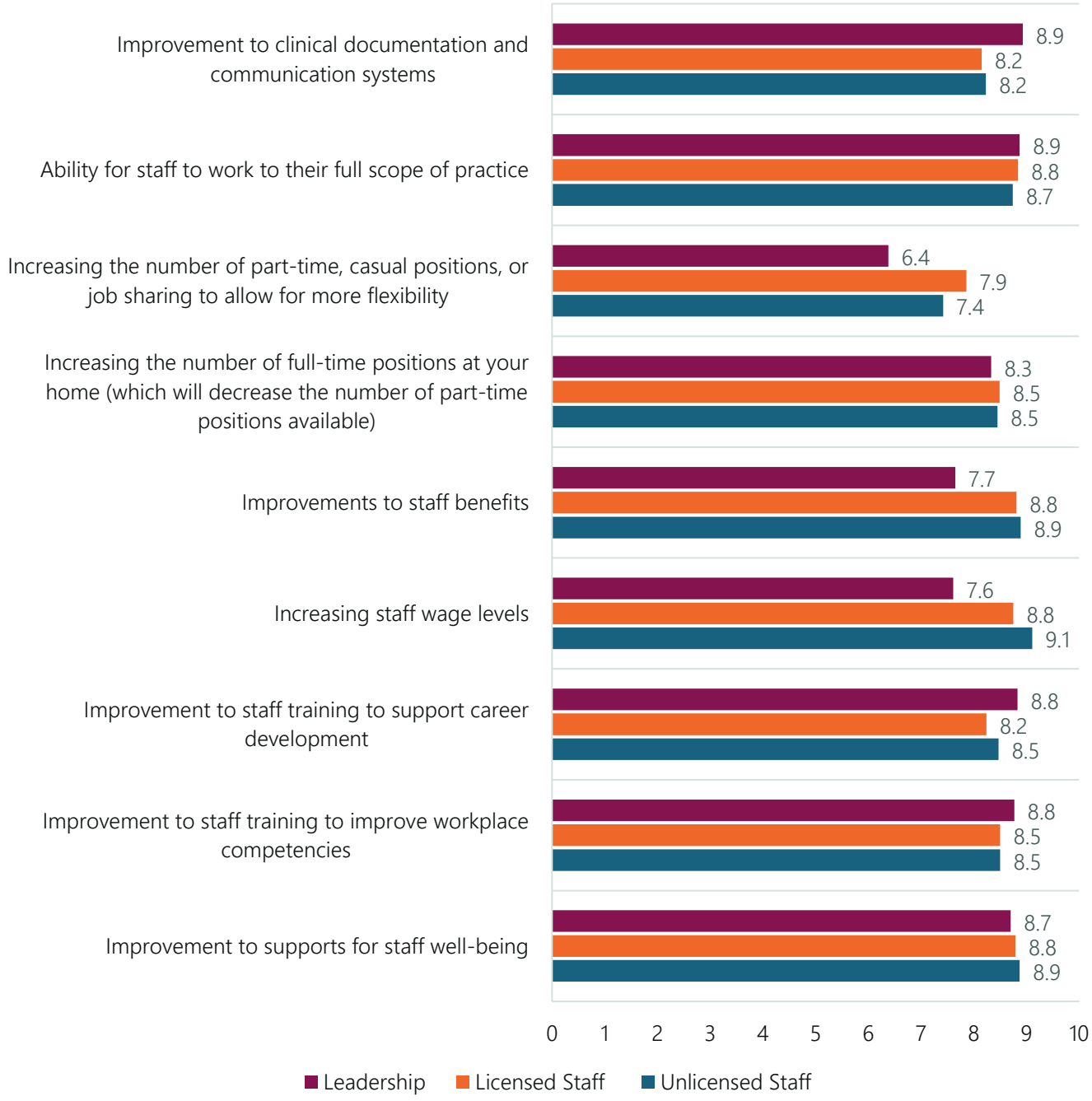
Figure 37: Average Ratings for LTC Staffing Model Changes (Scale of 0 to 10)

NA - indicates question was not asked



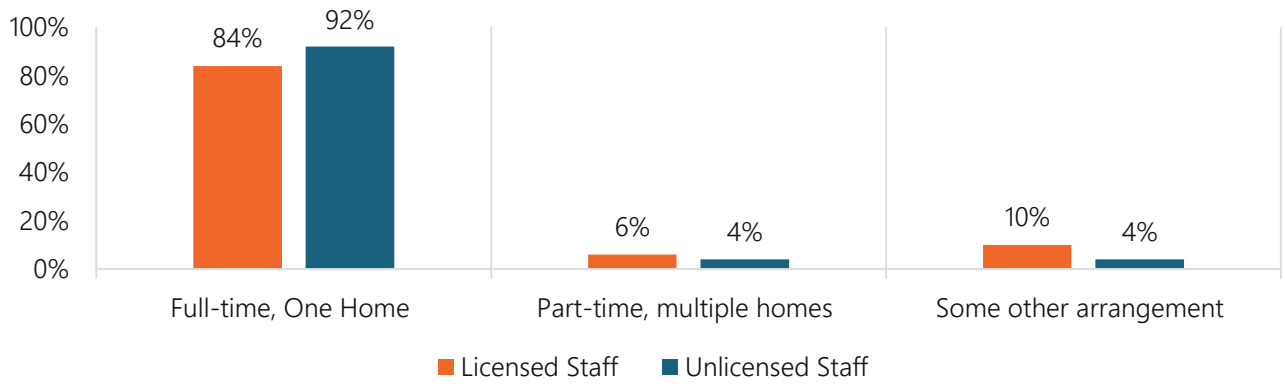
LTC leadership and staff also rated the importance of a variety of workplace improvements from 0 (doesn't require improvement) to 10 (very important improvement area). The average ratings for most improvements were above 8 out of 10 (Figure 38), with the ability for staff to work to their full scope of practice, improvements to staff well-being, and improvements to staff training to improve workplace competencies identified as the highest areas for improvement.

Figure 38: LTC Workplace Improvements (Scale of 0 to 10)



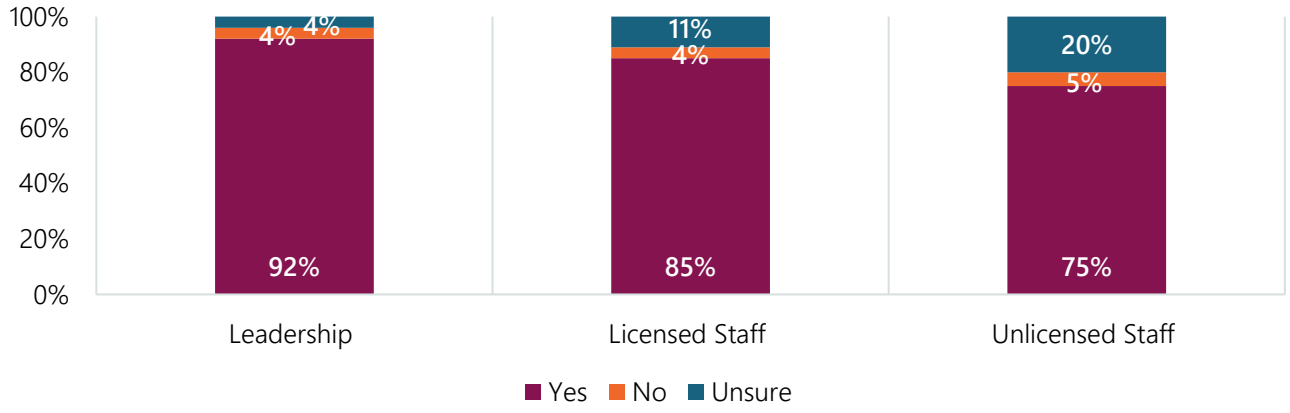
LTC licensed and unlicensed staff survey participants were asked to share their preferred working arrangement of full-time at one home, part-time at multiple homes, or another arrangement. Overall, 84% of licensed staff and 92% of unlicensed staff answered full-time, one home (Figure 39).

Figure 39: Staff Preference for Workplace Arrangements in LTC Homes



LTC leadership and staff were also asked if there should be regulations for unlicensed PCAs or PSWs. Most survey participants believe that there should be regulations for unlicensed PCAs/PSW's with 92% of LTC leaders, 85% of licensed staff, and 75% of unlicensed staff answering "yes" (Figure 40).

Figure 40: Survey Respondent Perceptions Regarding Regulations for Unlicensed PCAs/PSWs



Opportunities for Improvement

Drawing on the findings from the focus group and survey responses, the following opportunities were offered to improve the LTC workplace environment and to better support the people who work there.

- Increase wages to support recruitment and retention efforts and appropriately reflect the responsibilities of staff.
- Provide more incentives and bursaries for staff to complete existing training and education courses.
- Share information on LTC careers with high school students to help showcase career choices in LTC.

- Celebrate diversity in the workforce and improve recognition and appreciation for staff.
- Increase staffing levels in LTC to provide more supports for staff and to increase the ability for staff to take vacation and leave to reduce burnout and improve morale.
- Increase frequency of hands-on training and education opportunities and ensure that training is paid for and offered during working hours. Increase training specific to dementia for all staff and increase leadership training for LPNs and RNs.
- Provide more hands-on wellness, mental health, and support services for staff.

> ***"Currently the staffing in most facilities is unable to meet the bare minimum of resident care. It is far from providing the quality of life each of us should expect."***

- Shift the focus to resident-centred care which will support improving relationships with residents.
- Increase understanding of roles and scope of practice for staff, managers, and leadership.
- Provide additional management positions, human resources, and administrative support for management and improve access to management and leadership.
- Improve the staffing mix to better support resident care needs.
- Reduce sharing of staff between LTC and acute care settings.
- Increase technology usage and supports to reduce administrative burden.
- Improve teamwork and collaboration amongst all levels of staff in LTC.
- Reduce mandated overtime requirements.

5.2 Personal Care Home Findings

The following section describes the current context and stakeholder engagement findings for the PCH workforce.

5.2.1 Current Context

There was limited data available regarding the workforce in PCHs which limited the ability to analyze characteristics and trends related to staffing levels by position, sick leave utilization, and overtime utilization in the workplace.

The 2007 Personal Care Home Operational Standards articulate the staffing requirements for PCHs in NL. Table 20 summarizes the staff requirements for PCHs with up to 30 residents. PCHs with over 30 residents will ensure having:

- A minimum of 2 staff on duty always.
- Sufficient staff to provide 1.5 hours of care and supervision each day depending on resident needs.
- Adequate domestic, security and administrative staff as evidenced by outcomes.

PCHs with more than 60 residents will ensure having:

- A minimum of 3 staff on duty always.
- Sufficient staff to provide 1.5 hours of care and supervision each day depending on resident needs.
- Adequate domestic, security and administrative staff as evidenced by outcomes.

Table 20: Staffing Requirements for PCHs with up to 30 Residents

	# of PCH Residents				
Hours of Day	**1-10**	**11-15**	**16-20**	**21-25**	**26-30**
8am to 4pm	1 staff	1.5 staff	2 staff	2 staff	3 staff
4pm to 12am	1 staff	1.5 staff	1.5 staff	2 staff	2 staff
12am to 8am	1 staff	1 staff	1 staff	2 staff	2 staff

The standards also state that any staff member that is available to help or supervise residents including recreation therapy, or that accompanies groups of residents outside the PCH, may be considered as part of the 1.5 hours of daily care.

Another study that does provide some insights into the PCH workforce is a Home and Personal Support Worker Survey conducted in 2019 to understand the training and education needs of the province's home and personal support workers (HPSW). According to the survey, Certificate of Conduct, First Aid Training, and Tuberculosis Testing were the top three job requirements for their position. In addition, 38% of survey respondents who work in PCHs have a high school/adult basic education (ABE) background and 34% have a college diploma or certificate. The most common training programs provided by employers were First Aid Training, training for Alzheimer's disease and other dementias, and confidentiality and ethical practice training.

5.2.2 What We Heard

Focus group participants were asked to share their feedback on a variety of workforce topics including:

- Recruitment and retention of staff
- Increased resident acuity
- Training and education
- Clinical leadership and oversight
- Workplace culture

Focus Group Findings

Recruitment and Retention of Staff

Focus group participants identified that PCH staff feel they are underpaid which has caused challenges with staff recruitment and retention. Participants noted that many homes did offer flexibility when it came to hours of work, shift selection and scheduling which was viewed positively.

Increased Resident Acuity

Focus group participants perceived that resident acuity was increasing in PCHs resulting in higher demands on staff. It was perceived that staff do not have the knowledge and skills to support care needs such as medication-administration and dementia care. Further, focus group participants noted multiple instances whereby paramedics

were called to aid with residents who have fallen because the home does not have the necessary resources to assist them from the floor.

Training and Education

Focus group participants shared that staff require more training and education to support resident care needs including the ability to identify early signs of resident decline, support mental health and addictions, administer medications more safely, and better support dementia care for residents.

Clinical Leadership and Oversight

Focus group participants identified that clinical leadership requires improvement in PCHs as resident acuity increases. Currently, paramedics and community health nurses provide support and clinical oversight for many PCHs. It was felt that as more Level II, Enhanced Care, and Level III residents are living in PCHs, the staffing mix should be reviewed to increase clinical oversight. Participants also identified that there are limited staffing levels in some homes overnight.

Workplace Culture

Focus group participants from some PCHs reported enjoying their jobs and caring for residents, and that staff had support from management and leadership.

Survey Findings

The following section summarizes the survey results related to workplace improvements in PCHs for three stakeholder groups including:

- PCH Leadership – 24 survey respondents
- PCH Licensed Staff – 24 survey respondents
- PCH Unlicensed Staff – 31 survey respondents

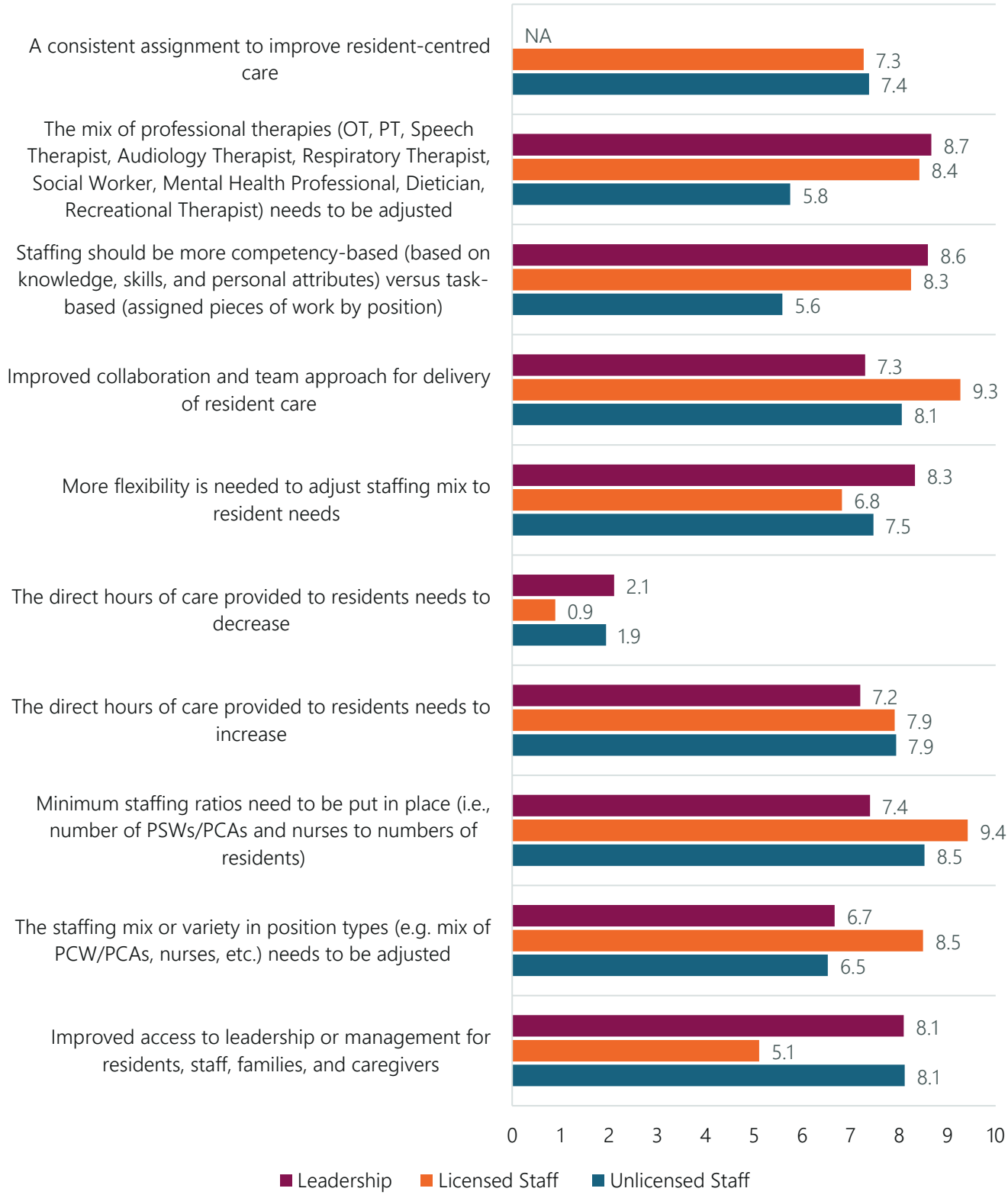
PCH licensed and unlicensed staff were asked to rate their level of satisfaction with the working environment at their home from 0 (needs improvement) to 10 (strength). The average rating for licensed staff was 6.6 out of 10 compared to 5.4 out of 10 for unlicensed staff. These findings suggest there is an opportunity to improve staff satisfaction in PCHs.

PCH leadership and staff also rated the level of staff morale in PCHs from 0 (needs improvement) to 10 (strength). The average rating for licensed staff was 6.0 out of 10 compared to 4.5 out of 10 for unlicensed staff. In contrast, the average rating for PCH leadership was 8.0 out of 10, demonstrating a disconnect between PCH leadership and staff. These ratings demonstrate a need to improve the workplace environment for PCH staff.

PCH leadership and staff then rated the importance of a variety of staffing model changes from 0 (doesn't require improvement) to 10 (very important improvement area). Figure 41 shows that minimum staffing ratios, competency-based staffing, the mix of professional therapies, and improved collaboration and team approach for delivery of resident care were identified as the highest areas for improvement.

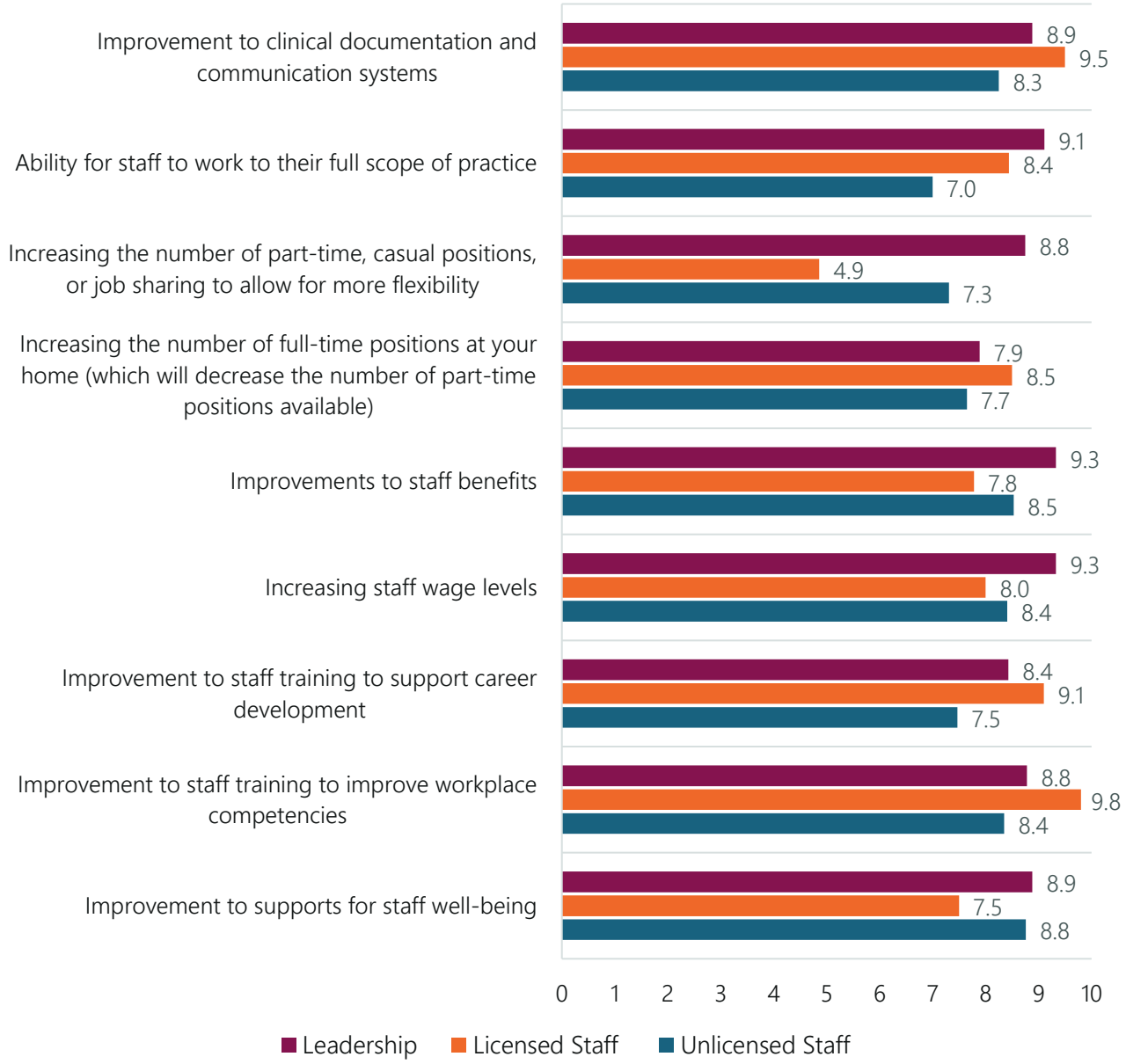
Figure 41: Staffing Model Changes in PCHs (Scale of 0 to 10)

NA - indicates question was not asked



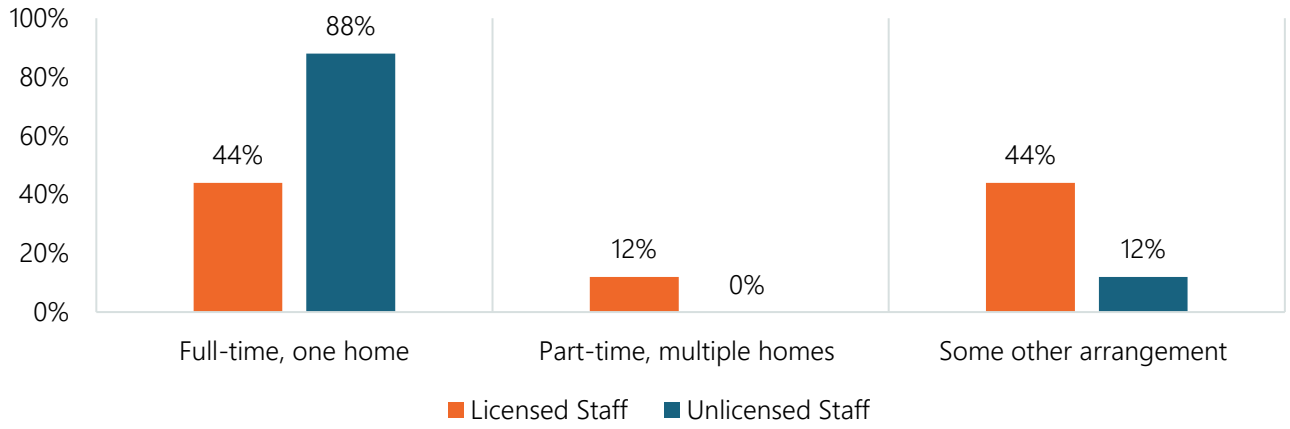
PCH leadership and staff also rated the importance of different workplace improvement areas using a scale from 0 (doesn't require improvement) to 10 (very important improvement area). Figure 42 shows that improvement to staff training to improve workplace competencies, improvement to staff training to support career development, improvements to staff benefits, and improvement to supports for wellbeing were identified as the highest areas for improvement.

Figure 42: PCH Workplace Improvement Areas (Scale of 0 to 10)



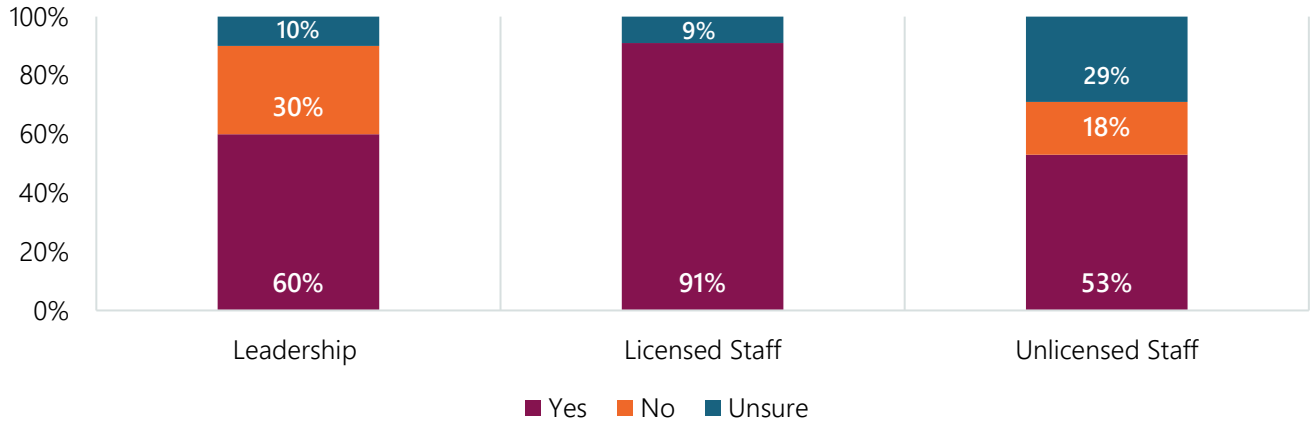
PCH licensed and unlicensed staff survey participants were asked to share their preferred working arrangement of full-time at one home, part-time at multiple homes, or another arrangement. Overall, 44% of licensed staff compared to 88% of unlicensed staff answered full-time, one home (Figure 43), demonstrating a significant difference in preferences for working arrangements.

Figure 43: Staff Preference for Workplace Arrangements in PCHs



LTC leadership and staff survey participants were also asked if they thought there should be regulations for unlicensed PCAs or PSWs. Figure 44 shows that stakeholder responses were varied with 91% of licensed staff answering yes compared to 60% of PCH leadership and 53% of unlicensed staff.

Figure 44: Survey Respondent Perceptions Regarding Regulations for Unlicensed PCAs/PSWs



Opportunities for Improvement

Drawing on the findings from the focus group and survey responses, the following opportunities were offered to improve the PCH workplace environment and to better support the people who work there.

- Increase the frequency and amount of training and education for PCH staff.
- Increase wages and benefits for PCH staff to improve retention efforts, improve morale, and reduce burnout.

- Increase PCH staffing levels.
- Improve skill and staffing mix in PCHs.
- Increase access to allied health including physiotherapy, occupational therapy, recreation therapy, speech language pathology, audiology, and mental health supports.
- Shift to have allied health professionals support a community in multiple settings rather than supporting several PCHs in different communities to reduce their transportation time and improve continuity of care for residents.
- Increase appreciation and respect towards PCH staff.

"The number one priority is SAFETY of residents and quality of care. There needs to be a higher staff to resident ratio and minimum training requirements for staff."

5.3 Leading Practices and Other Jurisdiction Research

The following section identifies emerging, leading, and best practices identified through literature review and interviews with representatives from other provinces to improve the workforce, based on the opportunities for improvement identified from the findings in Sections 5.1 and 5.2 above.

5.3.1 Leading Practices

Career Development Training and Education

The Nursing Think Tank (see Section 5.1.1) identified support for career growth and advancement through mentorship and continuing education as a solution to improve the recruitment and retention of RNs in NL.

The HSO National LTC Standard suggests that continuous learning activities boost confidence, job satisfaction, and retention while offering opportunities for career advancement[3]. It also suggests that LTC leaders play a crucial role in facilitating continuous learning by aligning learning activities with the home's mission, residents' needs, and staff roles. LTC leaders can provide training on topics such as resident-centered care, cultural sensitivity, and team-based approaches and encourage involvement in initiatives like leading changes, mentorship, and participating in external learning (criterion 5.1.4)[3]. The Standard also recommends that staff participate in continuous learning during working hours, and when possible, incentives and recognition are provided to promote participation. These practices should be taken into consideration for improving workplace training in both LTC and PCH settings in NL.

The Eastern Zone's Leadership Development Programs is grounded in the LEADS framework and provides formal and informal opportunities for employees and managers to grow and develop at all levels[66]. The program has been recognized as a leading practice in organizational leadership development across Canada. It includes formal programs for emerging leaders, new manager track, learning leaders, and executive apprenticeship, and reimburses managers for a Canadian College of Health Leaders (CCHL) membership. Further, there is a strategic alliance in place with the CCHL that allows graduates of the leadership development programs to work towards obtaining their Certified Health Executive designation.

Continuing Care Staffing Skill Mix

Various reports and commissions in Canada have highlighted the critical issues of staffing levels, skill mix, and compensation in LTC homes that were amplified during the COVID-19 pandemic. The study *Teaming up for long term care: Recognizing all long term care staff contribute to quality care* published by Canadian College of Health Leaders

notes that governments across Canada are being urged to increase the number of nurses and care aides in LTC to improve staffing ratios[67]. However, low pay for direct care workers remains a significant concern despite some provinces implementing short-term wage increases for essential workers. The study suggests that more direct care staff are needed and must be provided with better pay and workplace conditions.

5.3.2 Other Jurisdictional Research

The following notable practices from British Columbia, Alberta, Ontario, and Nova Scotia were gathered through interviews and secondary research. The practices identified from these provinces related to training and education, leadership, and management structure, and improving the workplace have been taken into consideration to inform the recommendations in Section 5.5.

British Columbia

Training and Education

The Health Career Access Program (HCAP) in BC provides an entry point for individuals with little to no experience in the health care sector to pursue a career[68]. HCAP aims to facilitate employment by offering paid training as part of the employment process and could provide an alternative model for training PCAs in NL. The program focuses on two pathways:

- Health Care Assistant (HCA): This pathway trains individuals to become HCAs, who play a crucial role in providing direct care to patients.
- Mental Health and Addictions Worker: This option prepares individuals to work in mental health and addictions support roles.

Through HCAP, BC covers the cost of post-secondary education and provides a weekly stipend[69] to remove financial barriers and allow individuals to pursue a career in health care.

Alberta

Workforce Strategy

Alberta's Continuing Care Transformation (CCT) includes initiatives to offer workforce support, such as education and mental health programs and funding to address recruitment and retention challenges in the province. These initiatives include practices that could be incorporated by NL to improve the workforce and workplace in LTC and PCHs. The initiatives are focused on:

- Programs to support HCA education, including a tuition bursary program for HCA students that provides up to $9,000 in financial assistance in exchange for a commitment to work for an Alberta continuing care provider; as well as funding to support the delivery of a First Nation-infused HCA curriculum at two Indigenous post-secondary institutions in the province.
- Maintaining a $2 wage increase for HCAs that was introduced during the COVID-19 pandemic.
- Increasing funding for hours of care in continuing care facilities to improve resident quality of care and life and support staff.
- Providing $2.5 million in funding for continuing care staff well-being and mental health support projects at sites across the province.

In addition, AH has developed a Continuing Care Workforce Working Group to provide input and support the development and prioritization of recommendations to inform future continuing care workforce actions.

Regulation of Health Care Aides

Alberta is moving towards regulation of HCAs in the province through the College of Licensed Practical Nurses (CLPNA). The CLPNA has been working with the Government of Alberta, HCAs, and a broad group of stakeholders from across the province to make the transition to regulation[70].

Ontario

Workplace Strategy

The *Long Term Care Staffing Study* conducted by the Ontario Ministry of Long Term Care in 2020 identifies several strategies to attract and prepare suitable individuals for employment and provide opportunities for their ongoing learning and growth[64]. The strategy includes practices that could help improve recruitment and retention of LTC and PCH staff in NL including:

- Recruiting individuals with attributes such as empathy, patience, and teamwork skills who are passionate about continuing care. Strategies include improving the public perception of LTC careers through positive campaigns and fostering stronger relationships between secondary schools and LTC homes.
- Supporting new graduates who enter the LTC sector so they do not leave shortly after starting employment.
- Enhancing educational and training programs for healthcare workers to better prepare students for LTC and PCH settings by providing onsite experiences for students, increasing placement hours, and offering preceptorship roles to provide mentorship and guidance.
- Providing continuing education opportunities to keep skills up to date and enhance professionalism. Micro-credentialing programs and job laddering initiatives can offer employees opportunities for advancement and specialization within the continuing care sector.

Training and Education

The *Specialized Educator Certificate in Long Term Care*, offered by the Ontario Centres for Learning, Research, and Innovation in Long Term Care (CLRI), is a program designed to enhance the knowledge and skills of educators working in LTC settings. The certificate aims to support LTC educators in upgrading their teaching abilities through experiential learning and collaboration with peers[71]. It focuses on evidence-based practices and innovative educational approaches specific to the LTC sector.

The *Clinical Nursing Leadership* (CNL) eLearning program enhances the clinical leadership skills of nurses working in LTC[72]. Similar courses could be provided to healthcare educators and nurses in NL to improve mentorship and training and encourage nurses to take on more of a leadership role in LTC and PCHs.

Management and Medical Leadership Structure

The *Long Term Care Staffing Study* discusses how effective medical and administrative leadership plays a pivotal role in setting workplace culture, providing direction, and ensuring access to necessary expertise for quality resident care [64]. The study highlights several priority areas for attention that NL can consider including:

- Clarifying the role and accountability of medical leadership in LTC to ensure consistent leadership across the province. Medical leaders provide advice on matters of medical care and should work closely with the individual who provides day-to-day on-site clinical care leadership.

- Expanding the use of nurse practitioners (NPs) to augment clinical leadership, provide direct care, and improve medication management.
- Strengthening infection prevention and control (IPAC) expertise in all homes, particularly considering lessons learned from the COVID-19 pandemic. This may involve deploying centralized or regional IPAC teams to support homes in enhancing their infection control measures.
- Accessing specialized geriatric expertise by connecting homes with geriatricians and leveraging external resources either in-person or through virtual options.

Regulation for Personal Support Workers

According to Section 5.2.2, many survey respondents perceived that there should be regulations for unlicensed staff in LTC and PCHs. NL could consider Ontario's plan to establish an independent regulatory body to oversee the role of PSWs should it decide to pursue regulation for PCAs. The proposed regulatory framework aims to ensure safe, competent, and ethical care while accommodating the diverse roles and settings in which PSWs operate[73]. The framework also includes codes of ethics, complaints resolution processes, discipline procedures, and appeals mechanisms. Overall, the proposed framework aims to elevate the standards of PSW care, enhance public trust, and promote continuous quality improvement.

Nova Scotia

Training and Education

Nova Scotia introduced a bursary program for continuing care assistants (CCAs) during the COVID-19 pandemic[74]. This initiative is intended to encourage more individuals to enter the field by providing successful applicants with a $4,000 bursary to enroll in continuing care programs. The program's objective was to eliminate financial barriers for students and boost enrollment in continuing care programs, with priority given to communities facing significant staffing needs and programs with vacancies. The province reinstated the bursary program based on the program's intake success during the initial two years of implementation. This program is like the bursary programs implemented in British Columbia and Alberta and could provide an alternative approach for training PCAs in NL.

Nova Scotia has also implemented the Continuing Care Assistant Progressive Education Plan to allow students to complete the CCA course by attending three days a week of in-class instruction and being paid to work two days a week in continuing care settings which allows students to gain practical experience while continuing their education.

The CCA Scope of Practice and Competency Framework[75] defines the scope of practice for CCAs including roles, responsibilities, functions, and competencies. To become a certified CCA, a person must attain the required competencies by completing all components of the CCA education program through a licensed educational provider and passing the CCA Certification Exam.

An important component of the CCA training curriculum includes Dementia: Understanding the Journey course[76]. The course contains 27 content hours and is divided into nine sessions. The course is open to wide variety of learners including home care workers, facility-based workers, volunteers, families or friends of those with dementia, and leaders and Board members of organizations.

Leadership Training

The *Leadership for Nurses in Long Term Care* program offered by the Nova Scotia Health Authority[77] is designed to provide frontline RNs and LPNs with essential skills and knowledge to excel in leadership roles within the LTC sector. Nurses can complete the program part-time in four weeks, while managers undergo a condensed two-week version

of the program. Managers are granted access to the course content which is supplemented by a specialized Manager's Leadership Guide, enabling them to provide support and guidance to nursing staff. NL could consider offering a similar part-time leadership course tailored for LTC and PCH settings.

Continuing Care Assistant Regulation

Nova Scotia passed the *Continuing Care Assistants Registry Act* in April 2021 to establish a mandatory registry for all CCAs in the province to collect workforce planning data including the name, place of work, and status (full-time, part-time, or casual) of CCA workers. The registry went live in February 2022 and is administered by Health Association Nova Scotia.

5.4 Workforce Conclusions

The following LTC and PCH workforce conclusions have been drawn based on the findings in the preceding sections.

5.4.1 Long Term Care Home Conclusions

1. NL is committed to improving workforce recruitment and retention. The DHCS has completed or is in the process of completing multiple health sector workforce studies, such as the Nursing Think Tank and the Strategic Health Human Resources (HHR) plan. These investments demonstrate the province's commitment to improving the health sector workforce in NL including LTC.
2. NL has been proactive in recruiting internationally educated nurses (IENs) to address LTC staffing challenges. The standardized pathway currently in practice supports nurses to seamlessly transition into their roles and assists with filling LTC workforce gaps.
3. Stakeholders identified challenges with workplace culture in LTC homes including siloed workplace dynamics which limited input from certain staff roles in care planning.
4. Staff rated workplace morale and workplace satisfaction below 5 out of 10. Elements impacting workplace morale included high-turnover, high levels of burnout among staff, and challenges with maintaining a work-life balance.
5. Focus group participants identified challenges related to racism towards staff, especially internationally recruited employees.
6. Focus group participants noted inconsistencies in leadership and management structures within LTC homes across the province which can influence staff culture and behaviours. There were perceptions of some LTC homes being "top heavy" having several personnel in non-care related roles such as managers, clinical educators, clinical facilitators, and resident care coordinators. Additionally, access to managers was perceived as more limited in larger homes compared to smaller ones. This has created task-based cultures at LTC homes and limited access to leadership, negatively impacting staff morale and satisfaction.
7. Stakeholders identified opportunities to improve awareness of LTC careers to high school students, as well as to provide more incentives and bursaries for staff and/or students to complete training and education.
8. Stakeholders identified opportunities to increase the frequency of hands-on training and education and to ensure that training is paid for and offered during working hours.
9. Stakeholders identified a need to provide additional mental health and wellness supports for LTC staff to improve their overall well-being.

5.4.2 Personal Care Home Conclusions

1. Focus group participants expressed a need for personal support workers to receive training to better support residents' care needs, including mental health, addictions, and dementia care, as well as for identifying early signs of resident decline. Stakeholders also reported a need to increase the frequency and amount of training offered to PCH staff to improve workforce retention.
2. Unlicensed staff rated workplace morale and workplace satisfaction below 5.5 out of 10. Elements impacting workplace morale included high-turnover, high levels of burnout among staff, and challenges with maintaining a work-life balance.
3. Stakeholders perceived that increasing wages and benefits for PCH staff would improve recruitment and retention of the workforce. DHCS recently introduced a requirement for PCHs to compensate their staff at a minimum wage rate of $18.00 per hour as of April 1, 2024.

5.5 Workforce Recommendations

The findings from Sections 5.1 to 5.4 above identified several opportunities to improve the LTC and PCH workforce and workplace in NL. A total of five recommendations for improvement were developed. Each recommendation includes:

- A description of the recommendation.
- The key actions required to implement the recommendation.
- The expected benefits of implementing the recommendation.
- Implementation roadmap for the recommendation.
- The financial considerations of the recommendation.

Recommendation #14: Implement a workforce strategy to improve the recruitment and retention of staff.

Sections 5.1 and 5.2 show that there were challenges with recruiting and retaining LTC and PCH staff across the province. Leading practices and literature (Section 5.3) also support implementing the improvements identified in the key actions below.

Key Actions Required

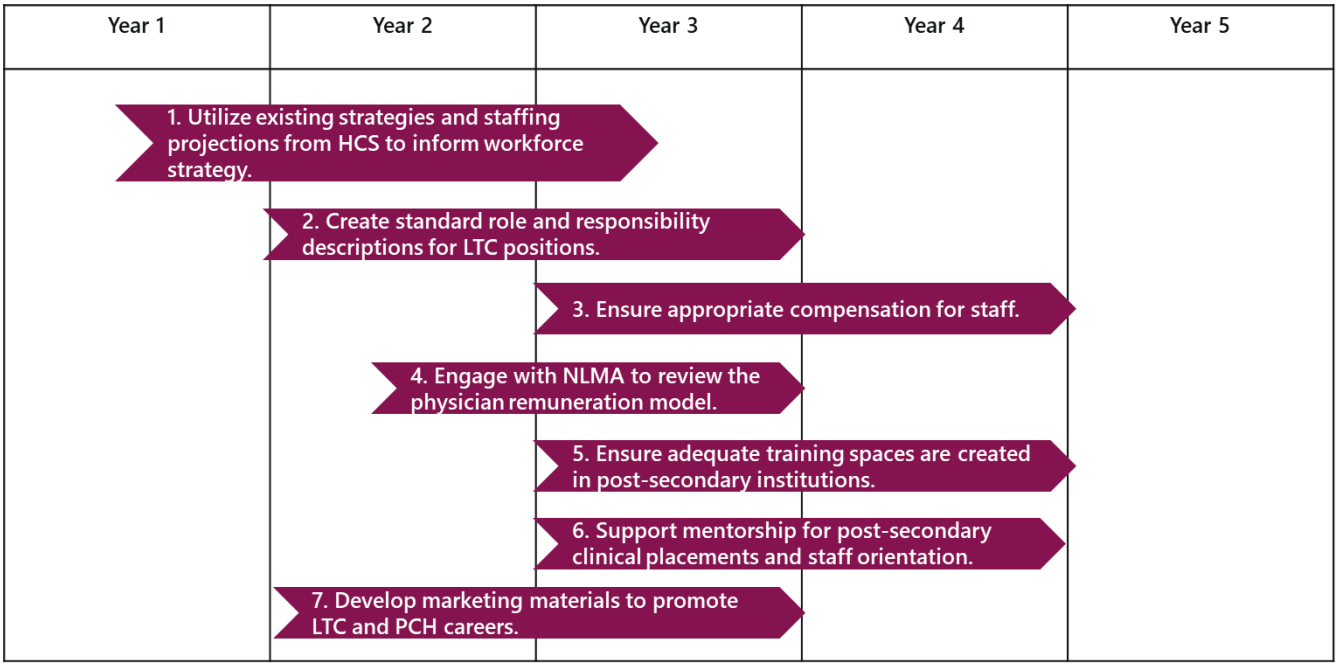
1. Utilize the strategies and staffing projections identified in a separate HCS review currently under way to inform the workforce strategy.
2. In LTC, create standard role and responsibility descriptions for PCAs, LPNs, RNs, NPs, and allied health providers to improve role clarity and ensure staff are working to full scope.
3. Ensure appropriate compensation for staff which reflect the roles and responsibilities of their position.
4. Engage with NLMA to review the physician remuneration model to support physician recruitment and retention.
5. Ensure that adequate training spaces are created in post secondary institutions to support the increased demand for positions.

6. Enhance and support mentorship for post-secondary clinical placements and orientation of new staff.
7. Develop marketing materials to promote careers in LTC and PCHs.

Expected Benefits

The expected benefits of implementing this recommendation include improved recruitment and retention of qualified staff to support the needs of LTC and PCH residents across the province.

Implementation Roadmap



Financial Considerations

The financial considerations for this recommendation include existing staff time to support the implementation of the workforce strategy.

Recommendation #15: Develop an engagement strategy to improve workplace morale, workforce culture, and flexibility for staff.

Sections 5.1.2 and 5.2.2 indicate that improvements are needed in areas related to workplace morale, workforce culture and flexibility for staff. Leading practices and literature (Section 5.3) also support implementing the improvements identified in the key actions below.

Key Actions Required

1. Engage staff, unions, and other stakeholders in the co-development of strategies that promote a positive, safe workplace environment and emphasize a team culture.
2. Cultivate a learning culture and provide professional development opportunities for all staff such as:
    a. Encourage continuing education and career-laddering for staff that desire further education.
    b. Provide opportunities that empower all team members to be leaders.

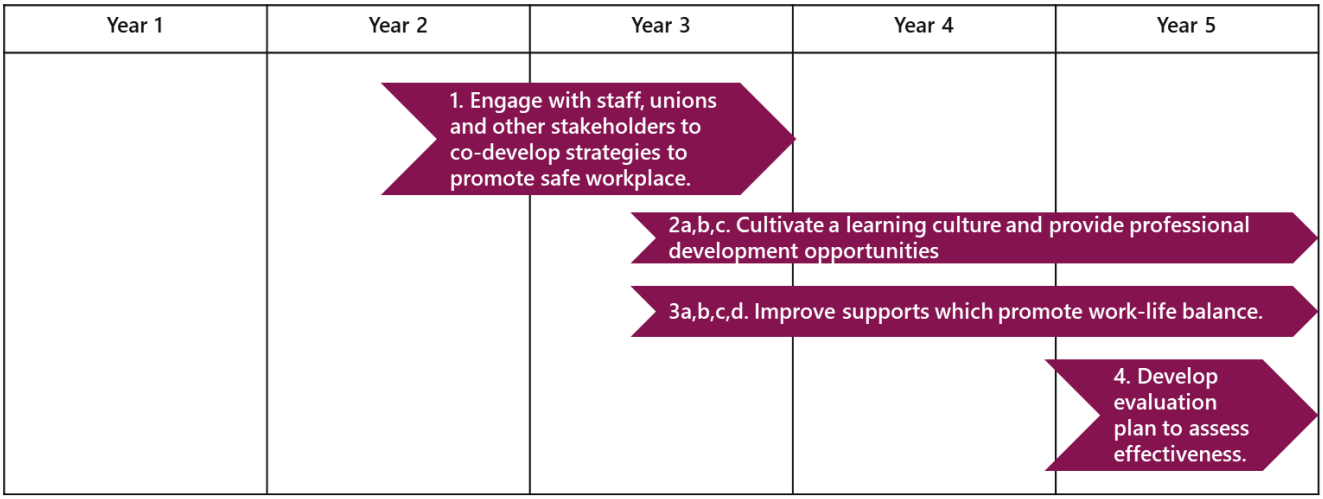
c. Improve communication, performance evaluation, and ongoing feedback between leadership and front-line staff.

3. Improve supports which promote work-life balance such as:
    a. Explore options to support childcare and caregiving responsibilities.
    b. Provide access to wellness programs and mental health supports.
    c. In LTC, improve the flexibility and choice of positions such as full-time, part-time, and casual positions.
    d. In LTC, develop and implement a self-scheduling model, where feasible.
4. Develop an evaluation plan to monitor and assess the effectiveness of workforce engagement strategies implemented.

Expected Benefits

The expected benefits of implementing this recommendation are improved workplace conditions, improved employee satisfaction, and improved resident quality of care.

Implementation Roadmap



Financial Considerations

Financial considerations for this recommendation include existing staff time to support training, education, change management, and culture change. Training cost estimates are provided with Recommendation 17.

Recommendation #16: Implement an Equity, Diversity, and Inclusion (EDI) strategy to ensure that staff, residents, and family work and live in an environment free from ageism, racism, sexism, and discrimination.

Sections 5.1.2 and 5.2.2 indicate that there are challenges in LTC and PCHs related to ageism, racism, and sexism.

Key Actions Required

1. Collaborate with residents, families, and staff to co-develop an EDI strategy.

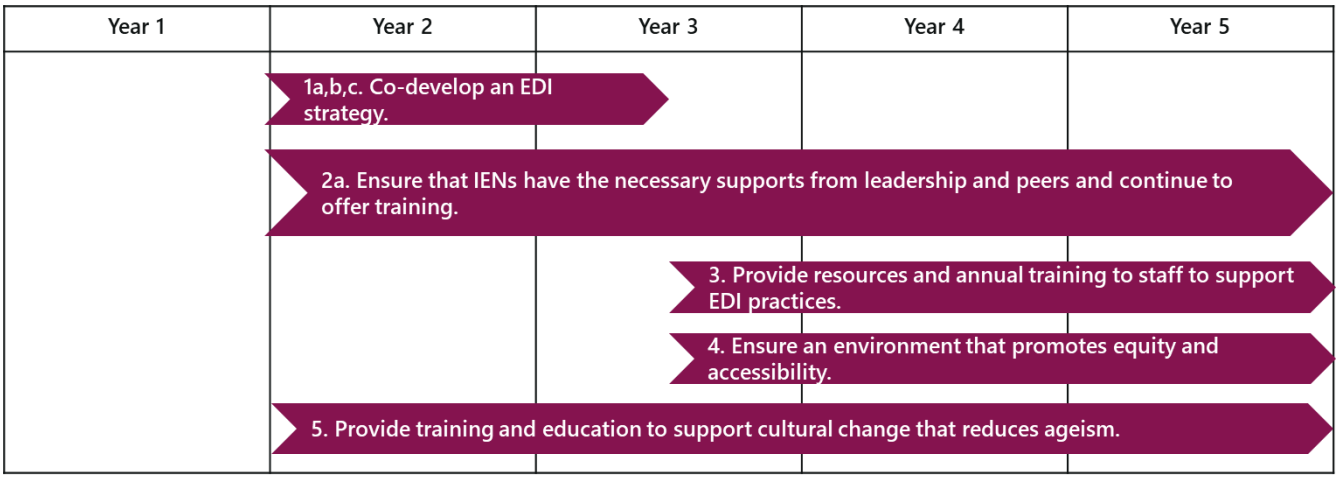
a. Include the guiding principles identified in the HSO standards that focus on resident and staff diversity.
b. Engage cultural groups and local communities to ensure that their perspectives are included in the development of the strategy.
c. Ensure there is a process to raise concerns or provide feedback.

2. Ensure that IENs have the necessary supports from leadership and peers to enable them to be successful in their roles.
    a. Continue to offer training and education as part of the NLHS IEN orientation.
3. Provide resources and annual training to staff that support EDI practices.
4. Ensure an environment that promotes equity and accessibility that reflects the needs of individuals with disabilities where they live and work.
5. Provide training and education to support a culture change that reduces ageism.

Expected Benefits

The expected benefits of implementing this recommendation include improved acceptance and cultural competency awareness for staff, residents, family and ECPs that interact with LTC and PCHs.

Timing



Financial Considerations

The financial considerations for this recommendation include existing staff time to support EDI training initiatives and investments in training tools and resources across the province. The estimated training costs for EDI are including in the estimated costs for Recommendation 17.

Recommendation #17: Enhance staff training and education.

Sections 5.1.2 and 5.2.2 indicate that LTC and PCH staff desire additional training and education to better care for residents. Leading practices and literature (Section 5.3) also support implementing the improvements identified in the key actions below.

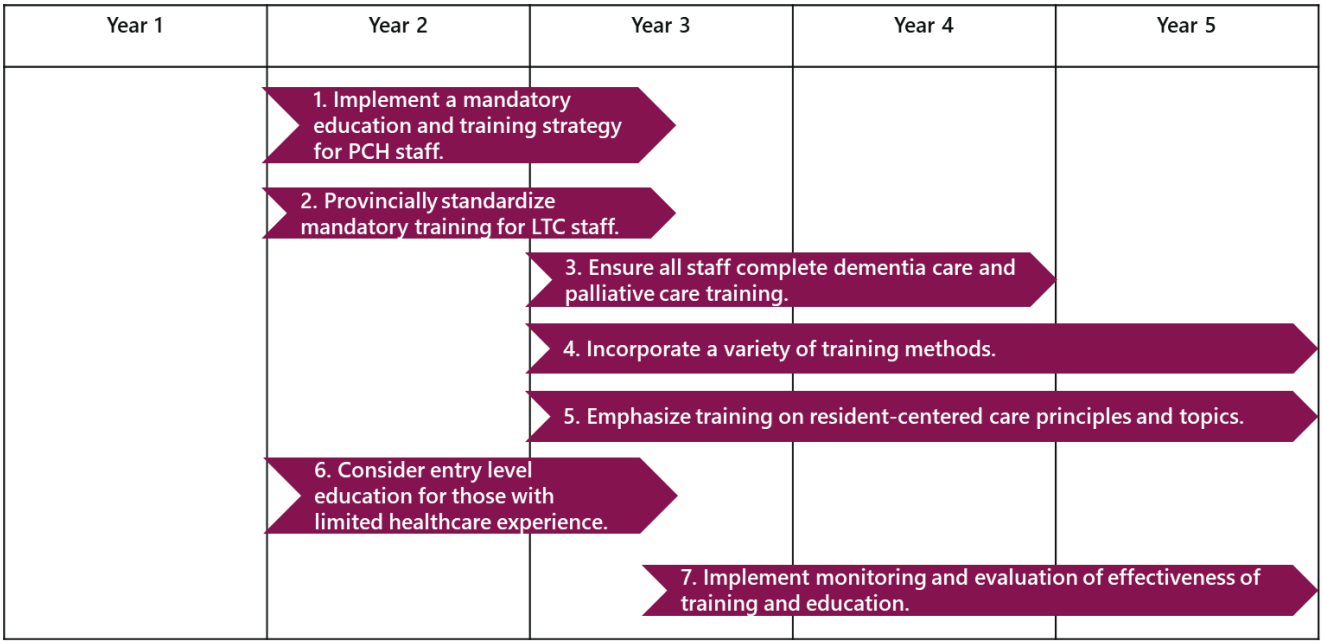
Key Actions Required:

1. Implement a mandatory education and training strategy for PCH staff.
2. Provincially standardize the mandatory training for LTC staff.
3. Ensure all staff complete dementia care and palliative and end of life care education.
4. Incorporate a variety of training methods to accommodate different learning styles and preferences.
5. Emphasize training on resident-centered care principles including topics such as trauma informed care, cultural competence, effective communication, and promoting empathy and compassion. Provide training resources to support leaders in engaging staff to embrace resident-centered care principles.
6. Consider offering entry level education or programs for individuals with limited experience in the healthcare sector.
7. Implement mechanisms for monitoring and evaluating the effectiveness of training and education.

Expected Benefits:

The expected benefits for the implementation of this recommendation include improved quality of care for residents, increased awareness of training and education programs available to staff, and improved workplace morale for staff as they will have enhanced skills to better support them in their roles.

Implementation Roadmap:



Financial Considerations:

The estimated investments to support training programs for LTC and PCHs include $708,450 over 5 years to provide dementia training to LTC and PCH staff; $5 million over 3 years to provide EDI, leadership, palliative end of life care, and other resident-centred care topic training for LTC staff and management; and $8 million over 4 years to provide provincially mandatory training to PCH staff. Detailed assumptions are provided in Appendix 2.

Recommendation #18: In LTC, support leaders to effectively lead and manage.

Section 5.1.2 indicates that there are variations in the organizational and leadership structures throughout the province for LTC which has led to challenges with role clarity and leadership support to staff. Leading practices and literature (Section 5.3) also support implementing the improvements identified in the key actions below.

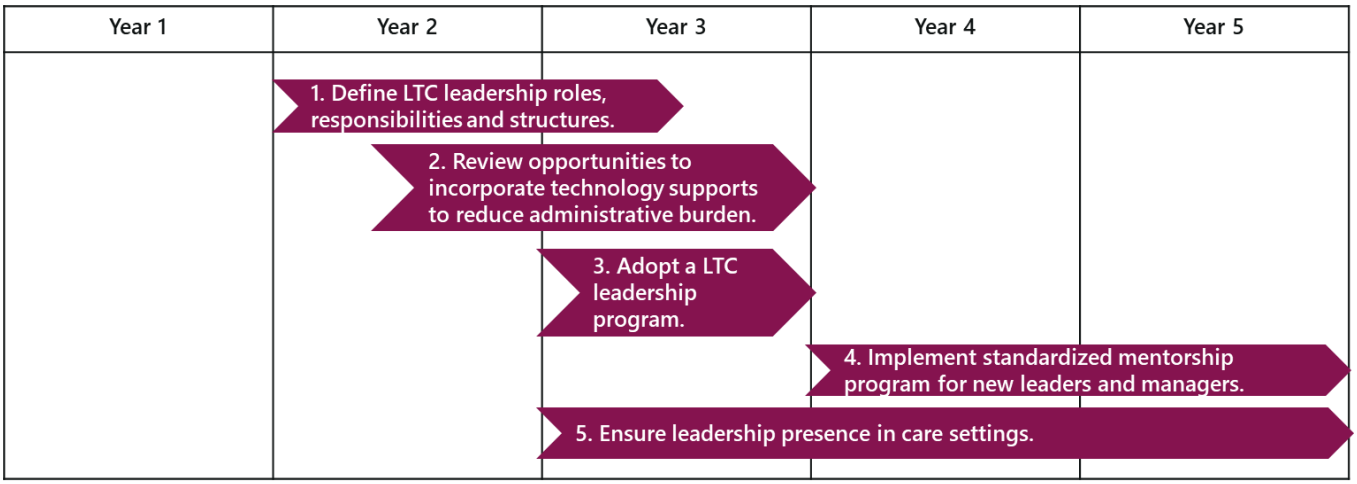
Key Actions Required:

1. Create standard definitions for leadership roles, responsibilities, and structures for LTC homes across the province.
2. Review opportunities to incorporate technology supports to reduce administrative burden for leaders.
3. Adopt a standard LTC leadership training program.
4. Implement a standardized mentorship program to support new leaders and managers.
5. Ensure leadership presence in care settings to support staff and residents, including on evenings and weekends.

Expected Benefits:

The expected benefits of implementing this recommendation include increased access to leadership and managers for residents and staff, consistent organizational structures that support the operational requirements of the home, and consistent roles and responsibilities for leaders across the province.

Implementation Roadmap:



Financial Considerations:

The estimated annual cost of increasing management capacity by 20% in LTC homes to ensure leadership presence on evenings and weekends is $1.5 million. Detailed assumptions are provided in Appendix 2.

SECTION 6

GOVERNANCE

6 Governance

6.1 Long Term Care Findings

The following section describes the current context and stakeholder engagement findings for governance of LTC homes in NL, including the admission process.

6.1.1 Current Context

All long term care homes are publicly funded and operated by NLHS except for one privately owned home where some beds are publicly subsidized. The Long Term Care Operational Standards outline the government's expectations for the delivery of LTC services across NL. The government sets out the requirements in the standards to acknowledge the unique and complex needs of individuals to ensure the delivery of safe, quality care. NLHS is mandated to adhere to the Standards to ensure homes operate within the established criteria and are committed to continuous quality improvement. The current Standards were developed in 2005, and the province is in the process of drafting revised standards for LTC.

The Standards include language to support resident quality of life in LTC where homes empower a resident's independence, rights, dignity, privacy, and freedom of choice, through:

- Maintaining control of routines, such as sleep time.
- Being greeted and referred to by their name.
- Providing access to the outdoors.
- Providing access to services and appointments outside of the home.
- Providing access to transportation.
- Providing meal choices prepared to meet resident's customary or cultural needs and traditions.

The Standards also outline expectations for providing access to medical services, dental care, physiotherapy services, clinical nutrition, and therapeutic recreation services for residents, including transportation to access these services.

Oversight in LTC is the responsibility of NLHS and DGSNL. NLHS employs a clinical safety reporting system and client relations reporting process to provide quality assurance. DGSNL inspects LTC homes for compliance with standards concerning fire and life safety, environmental health and food safety. Food safety inspections are available to the public on the government website. In addition, all homes, including the private home, are accredited through Accreditation Canada.

Admission Process

The admission process for LTC homes is through a single-entry system. A registered nurse, licensed practical nurse, or social worker completes a comprehensive clinical assessment using the RAI-HC to determine clinical eligibility and the appropriate care setting in accordance with the NL Level of Care Framework. The Level of Care Framework categorizes individuals into four distinct levels, ranging from I to IV. The majority of LTC residents are assessed as requiring Level III care yet have a broad range of clinical care needs that could be better classified in an updated Level of Care framework.

Long Term Care Services Fees

LTC residents undergo a financial assessment, in accordance with the Financial Assessment Policy for Long Term Care and Community Support Services, to determine eligibility for subsidies towards the cost of services. The maximum any resident pays for LTC is $2,990 per month and residents retain a minimum of $150 personal allowance.

Long Term Care Leadership Structure

There are differences in the leadership structures overseeing LTC home operations across NLHS and the types and responsibilities for leadership positions vary within and between Zones. Each Zone has a LTC Director who oversees the LTC Program, and for some this would also include overseeing the PCH Program. Some, but not all Zones, have Regional and Program Managers who support various initiatives within LTC including quality and clinical education.

Office of the Seniors' Advocate Newfoundland and Labrador[78]

The Office of the Seniors' Advocate works with seniors, service providers and other key stakeholders in NL to identify, review, and analyze systemic issues. The Office:

- Works collaboratively with seniors' organizations, service providers, and others to identify and address systemic issues.
- Makes recommendations to government and government agencies respecting changes to improve services to and for seniors.

The Office is independent of the House of Assembly of NL and was established by the *Seniors' Advocate Act* in July 2017.

Health Accord for Newfoundland and Labrador

The *Health Accord for Newfoundland and Labrador* (HANL) was completed in June 2022 with a focus on transforming the healthcare system in the province and includes short-term, medium-term, and long-term goals. One area of focus outlined in Health Accord NL was Aging Population which included awareness and intervention of health challenges related to NL's aging population. Health Accord NL included the following calls to action:

- A program dedicated to support the frail elderly to empower LTC homes with strong connections across the continuum of care with a well-trained, empowered, and fairly compensated workforce.
- An integrated continuum of care based on a resident-centred care philosophy, considering the social and health supports needed as people age including building and maintaining physical and mental function and capability.
- Steps to end agism and build age-friendly communities by providing education on stereotypes, including education at the early school age level, and developing and implementing policies, plans, and resources that enable the community to be engaged in creating and supporting age-friendly communities.
- Develop and implement provincial legislation and ensure policies and regulations are modernized to ensure consistent quality care, accountability and the rights of older adults are protected[1].

6.1.2 What We Heard

Focus group participants were asked to share their feedback on a variety of governance areas including:

- Management and leadership structure.
- Accreditation and operational standards.
- Legislative oversight for LTC homes.
- Assessment and placement process.
- Mental health and addictions.
- Admissions process.
- Information on LTC homes.
- Community supports.
- System integration and coordination.
- Accountability, transparency, and independence.
- Collaboration and engagement with Indigenous communities.

Focus Group Findings

Management and Leadership Structure

Focus group participants shared that there were a variety of different organizational structures used across the province with some LTC homes having a "flat" organizational structure and some having multiple layers of managers and leadership. Participants shared that in their experience, flat organizational structures seemed to be more conducive to resident-centred care and a positive workplace culture.

Participants reported that varying leadership experience influenced workplace culture. Some participants expressed that managers seemed to be overburdened with administrative tasks and were unable to support front line staff which contributed to a task-based culture. Some participants also identified that there was inconsistent knowledge of operational and financial accountabilities by LTC home managers and directors.

Accreditation and Operational Standards

Focus group participants perceived the current accreditation process to be beneficial. However, some homes do not follow accreditation standards on a regular basis and are more focused on preparing for accreditation six months to a year before a site visit. It was felt that there should be regular reporting and standards to ensure LTC home accountability on a regular basis. Participants shared that operational standards should also outline:

- Defined resident care hours and what supports and services are included in the hours.
- Standard terminology for LTC to ensure consistency across the province for staff, leadership, residents, family and ECPs.

Participants also indicated that there is limited public transparency and insight into LTC home operational standards.

Legislative Oversight for Long Term Care Homes

Focus group participants perceived that there were limited operational standards and regulations for LTC homes in the province, and that operational standards and regulations should be grounded in legislation. It was also noted that legislation and operational standards should be aligned with the National HSO Long Term Care Standard.

Assessment and Placement Process

Focus group participants identified challenges related to the assessment and placement process for LTC residents including:

- Long wait times for placement into a LTC home.
- Placement is offered far from a residents' family or home community.
- Accessing spaces for couples can be difficult sometimes resulting in separation.
- Assessments are sometimes inaccurate resulting in inappropriate resident placement.

Participants reported that there had been changes in the assessment process moving from a team approach to a single assessor. There were some perceived limitations with this approach as other health professionals such as OTs and PTs are not providing input into the assessment which could result in gaps in resident information upon placement. Some participants reported that Indigenous Health providers used to have more input into the assessment process which helped support continuity of care for residents from Indigenous communities.

Participants also perceived that the assessment process had a medical model focus which requires significant administrative input and that a future assessment model should be more holistic and include multi-disciplinary input and trauma informed care. The current medical assessment was felt to be extensive and could be streamlined to reduce administrative burden and admission wait times. Participants shared that the assessments may sometimes be inaccurate and require immediate reassessment once a resident is placed.

Participants felt that further consideration was needed to review appropriate living situations to support the social, recreational, emotional, and physical needs of residents. Some participants shared examples such as older adults and young people living in the same home, or a high proportion of residents living with dementia. These types of living arrangements had impacts on resident quality of life and social interactions. Lastly, participants reported that extended wait times for LTC beds have led to some individuals accessing LTC services by going through acute care to be placed sooner.

Mental Health and Addictions

Participants shared that there was limited input for mental health and addictions in the assessment process.

Admissions Process

Focus group participants expressed concerns around admissions taking place late at night, or in some cases, overnight. This process can have negative impacts on resident quality of care and can be disorienting.

Participants also reported that the vacancy rate for LTC beds is low in NL and some LTC homes may delay admissions which further increases the wait time for LTC admission. In some instances, directors and operators are refusing a resident admission if they feel it may be an inappropriate placement in their LTC home.

Information on Long Term Care Homes

Focus group participants shared that there were gaps in the information available to families and education of providers on what programs and services are available in LTC homes. It was believed that a navigator role would be helpful for providing appropriate and timely information to families and residents about the types of programs and services available in LTC homes.

Community Supports

Focus group participants felt that there could be more flexibility with home supports available in the community to help people stay in their homes as long as possible. Participants also shared that additional housing options for seniors, day programs, and supportive living would be beneficial for communities. Additional caregiver supports would also be beneficial to help reduce caregiver burnout.

Participants also identified that greater effort could be made to keep residents connected to their community through enhanced coordination with transportation, inclusion at local events, and access to local practitioners (massage therapy, chiropractic care, etc.).

System Integration and Coordination

Focus group participants identified that there are challenges with overall system integration between primary care, acute care, and LTC. One of the challenges identified was limited information sharing due to uncoordinated documentation and information sharing systems.

Some participants also identified challenges related to coordination of equipment, medical supplies, and medications for Indigenous people between the Federal Non-Insured Health Benefits program and provincial LTC homes.

Accountability, Transparency, and Independence

Focus group participants shared that accountability measures and protection for residents could be enhanced. Reports of resident abuse and neglect evaluated or investigated under the Adult Protection Act should be reviewed independently, and a resident's safety should be a priority. Participants also shared that it is important for residents, families, and ECPs to understand the process of who to contact if they have a concern without any fear of retribution when concerns are expressed. It was noted that the use of an independent body was an important part of the investigation process, and that greater transparency was needed into investigations to improve public trust in the LTC system.

Collaboration and Engagement with Indigenous Communities

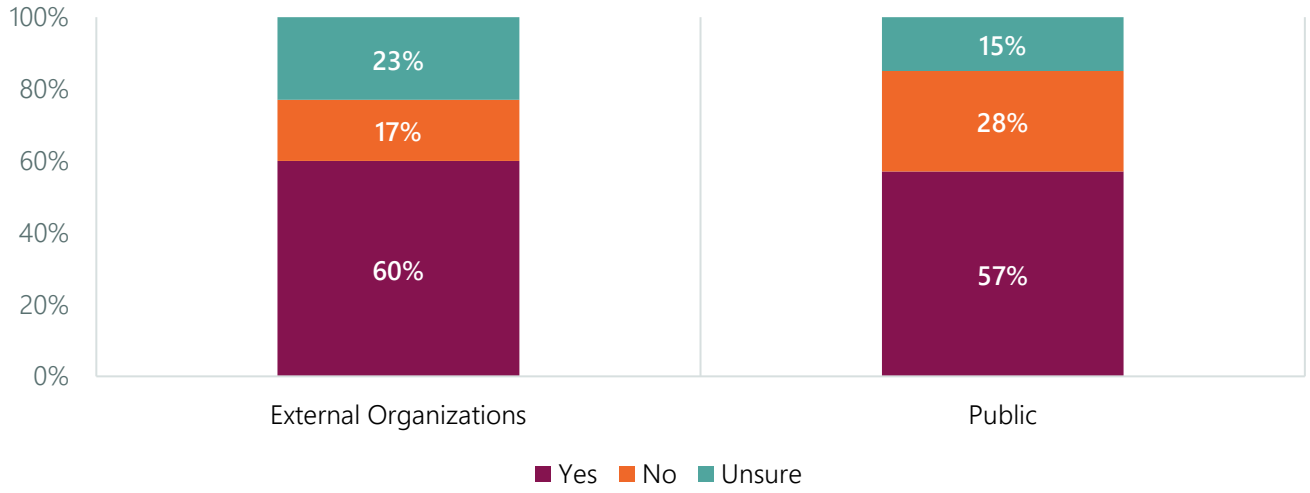
Focus group participants shared that there was opportunity to improve collaboration between Indigenous Governments and NLHS. Participants also identified a need for more engagement with Indigenous people in the LTC system to gain a better understanding of service and support gaps.

Survey Findings

Public and External Stakeholders

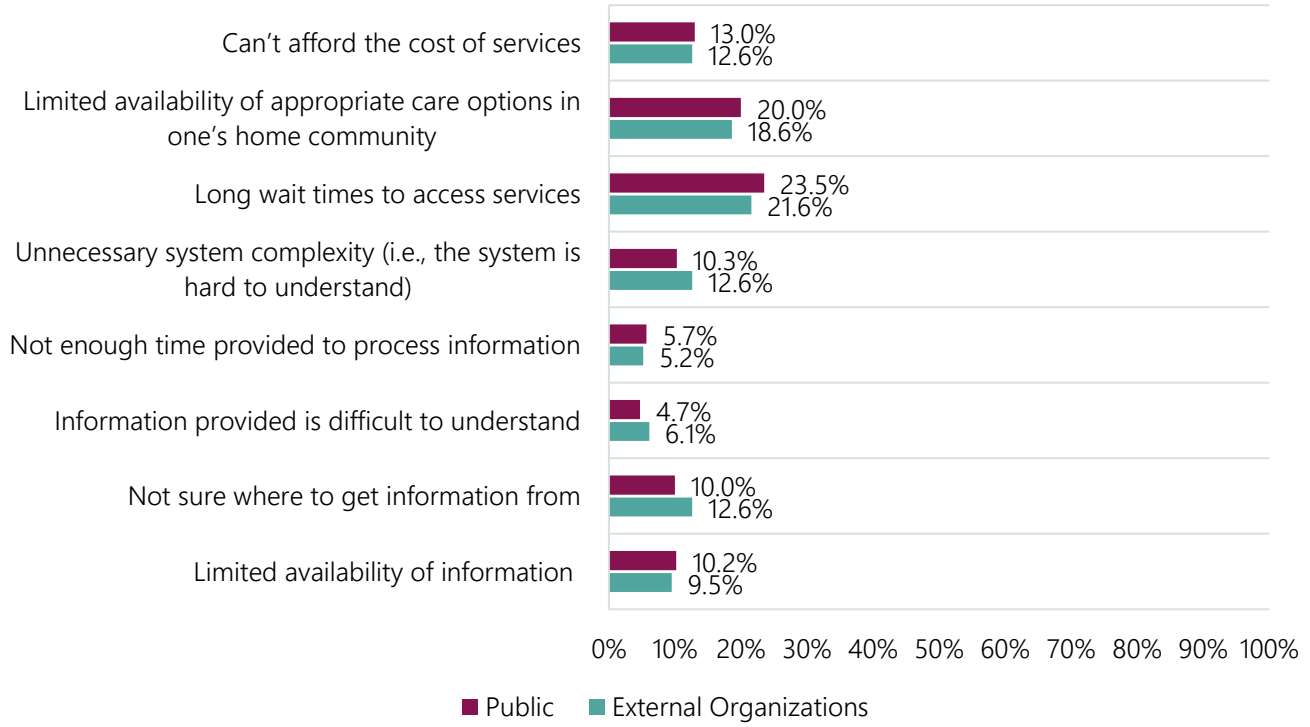
A total of 1,674 individuals responded to the public survey and 167 individuals responded to the external organization survey. Figure 45 shows that over half of external organization and public survey respondents indicated that residents, family, and ECPs have difficulty accessing LTC homes and PCHs when needed in NL with 60% of external organization respondents and 57% of public survey respondents answering yes.

Figure 45: Resident Difficulty with Accessing PCHs and LTC Homes when Needed



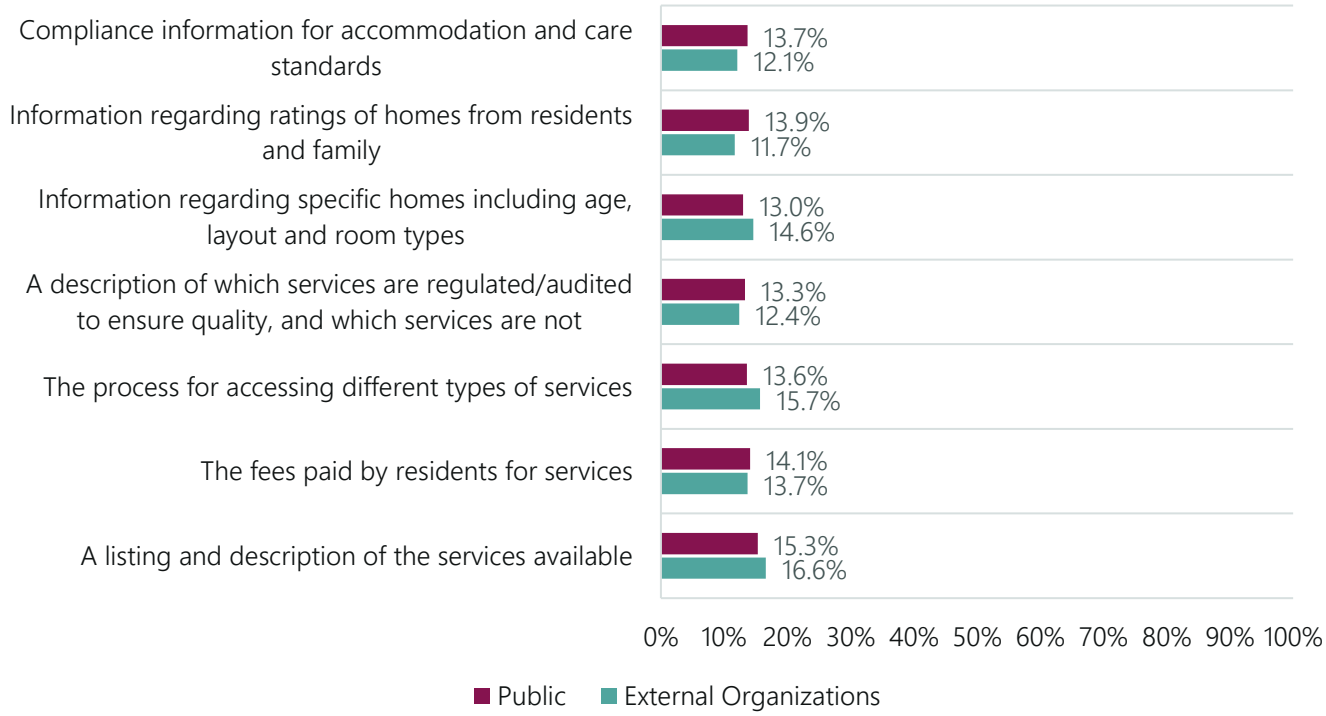
External organization and public survey respondents were also asked to select the different challenges that residents, families, and ECPs face when accessing LTC homes and PCHs. Figure 46 shows that the top challenges identified included long wait times to access services (selected by 23.5% of public respondents and 21.6% of external organization respondents) and limited availability of appropriate care options in one's home community (selected by 20% of public respondents and 18.6% of external organization respondents).

Figure 46: Types of Challenges Associated with Accessing LTC Homes and PCHs in NL



External Organizations and public survey respondents were then asked to select all the types of information that would be helpful in making decisions about accessing LTC home and PCH services. Figure 47 shows that external organization respondents identified a listing and description of the services available (16.6% of respondents) and the process for accessing different types of services (15.7% of respondents) as the most helpful information. Public survey respondents identified a listing and description of the services available (15.3% of respondents) and the fees paid by residents for services (14.1% of respondents) as the most helpful information.

Figure 47: Types of Information That Would be Helpful to Make Decisions about Accessing LTC and PCH Services



LTC Leadership, Staff, and Residents, Families and ECPs

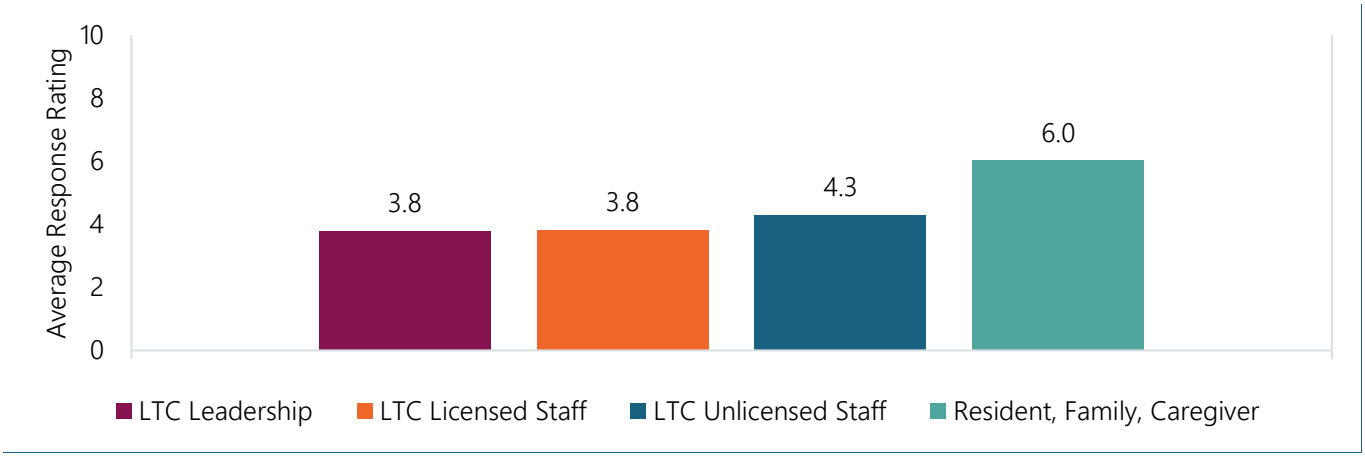
The following section summarizes the survey results related to LTC homes for four stakeholder groups including:

- LTC Leadership – 76 survey respondents
- LTC Licensed Staff – 286 survey respondents
- LTC Unlicensed Staff – 238 survey respondents
- LTC Residents, Family, and ECPs – 349 survey respondents

Stakeholders were asked to rate a residents' ability to access LTC homes and the supports they needed on a scale from 0 (difficult to access) to 10 (easy to access).

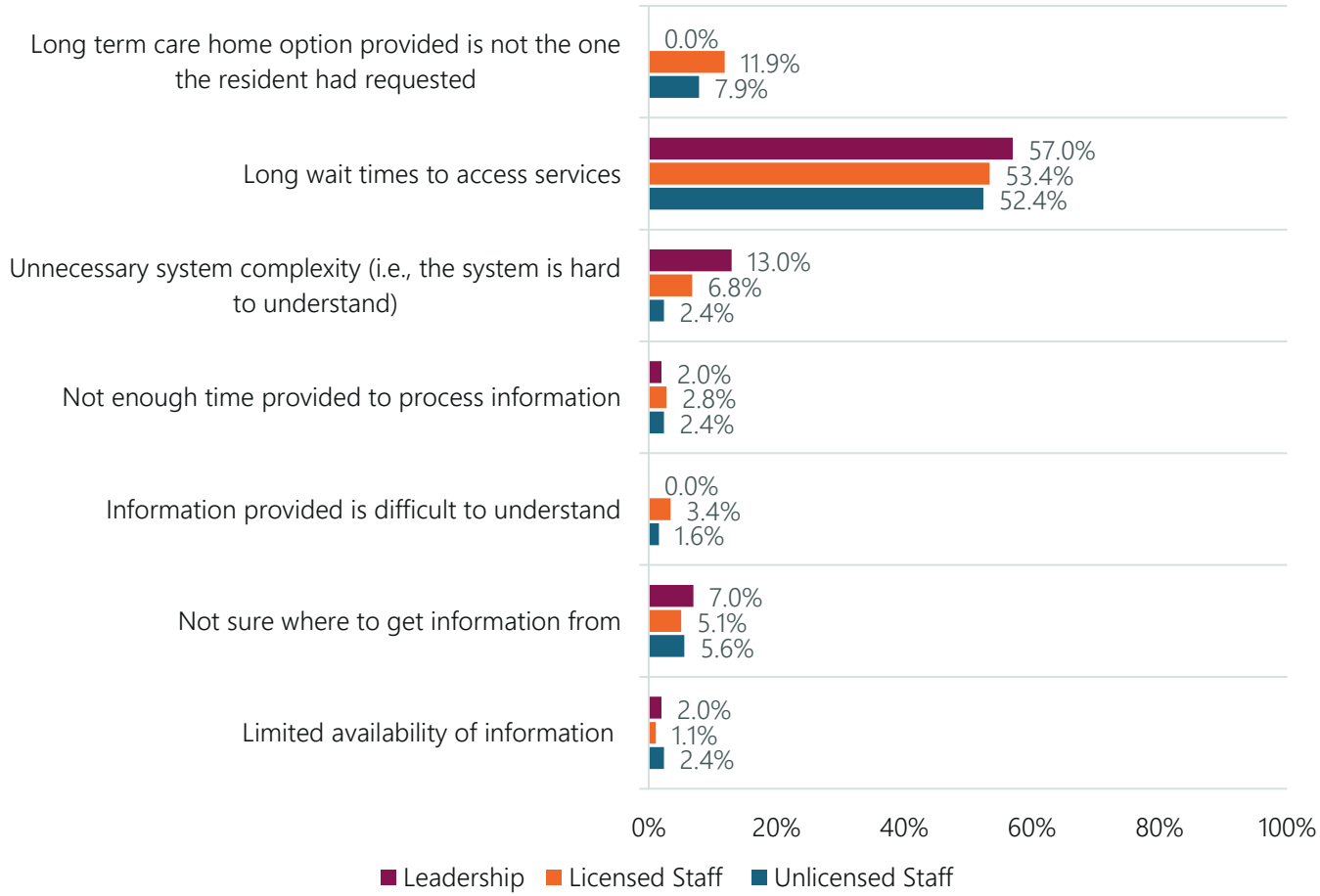
Figure 48 shows that LTC Residents, Family, and ECPs rated their ability to access LTC homes higher than LTC leadership and staff. The average rating for LTC Residents, Family and ECPs was 6.0 out of 10, compared to 3.8 out of 10 for LTC Leadership and LTC Licensed Staff and 4.3 out of 10 for LTC Unlicensed Staff.

Figure 48: Average Rating of Residents' Ability to Access LTC Homes and Supports They Need



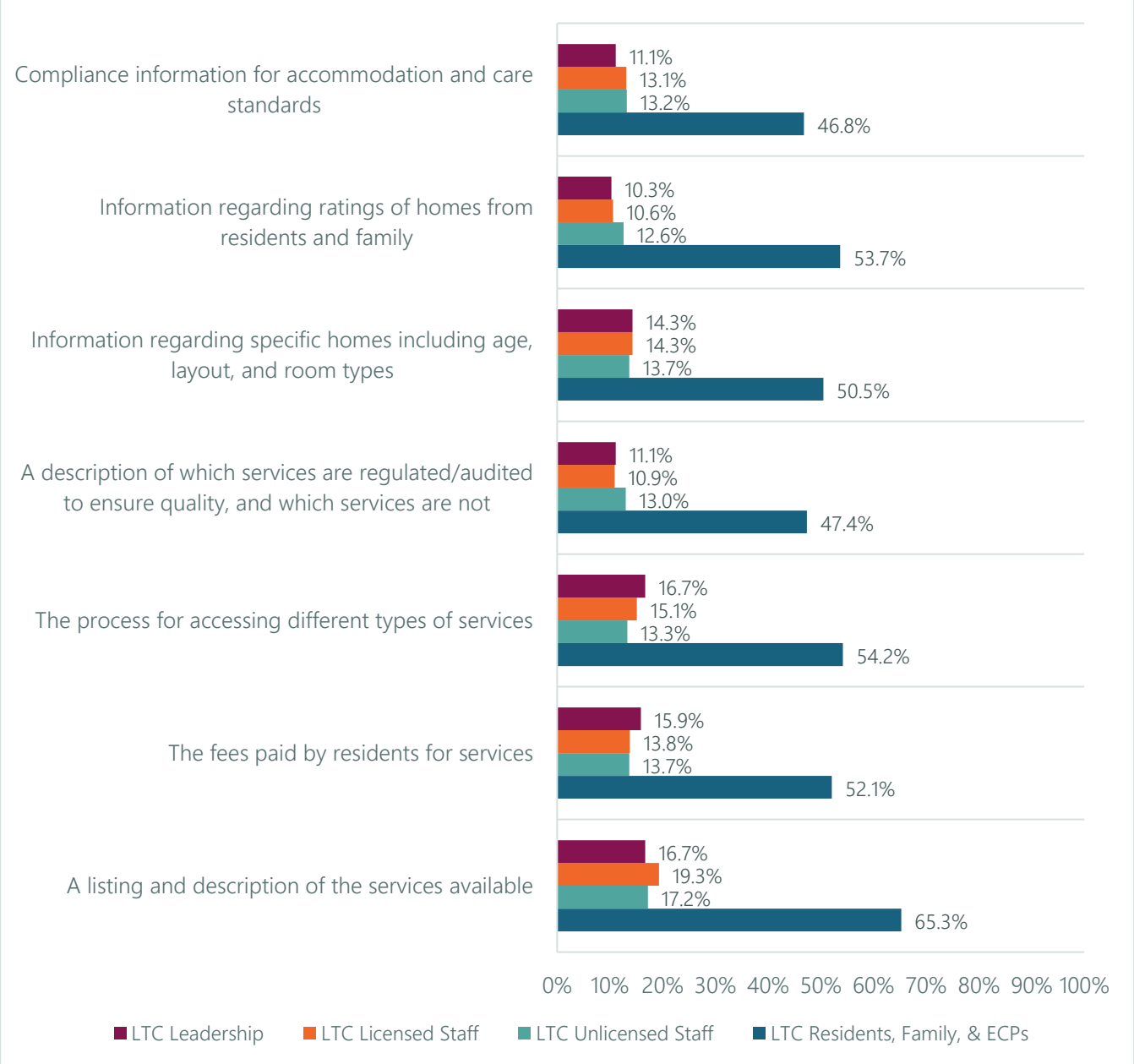
LTC leadership and staff were asked to select the different challenges experienced by LTC residents, families and ECPs when accessing LTC homes. Figure 49 shows that long wait times to access services was the highest selected challenge with 57% of LTC Leadership, 53.4% of LTC Licensed Staff, and 52.4% of LTC Unlicensed Staff selecting this option.

Figure 49: Challenges Experienced by Residents, Family, and ECPs When Accessing LTC Homes



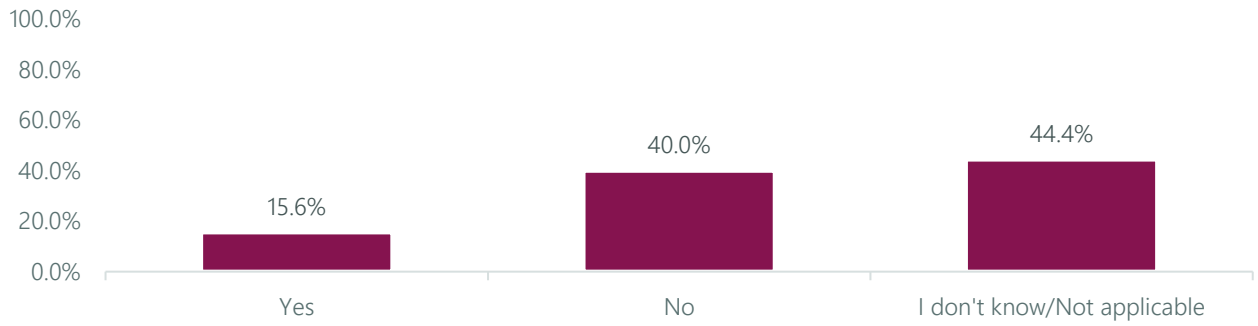
Stakeholders were also asked to select the different types of information that would be helpful for residents, family members and ECPs when accessing LTC services. Figure 50 shows that a listing and description of the services available, the process for accessing different types of services, information regarding ratings of homes, the fees paid by residents, and information regarding homes age, layout and room types were all selected by 50% or more of LTC Residents, Family and ECP respondents.

Figure 50: Types of Information That Would be Helpful to Make Informed Decisions When Accessing LTC Services



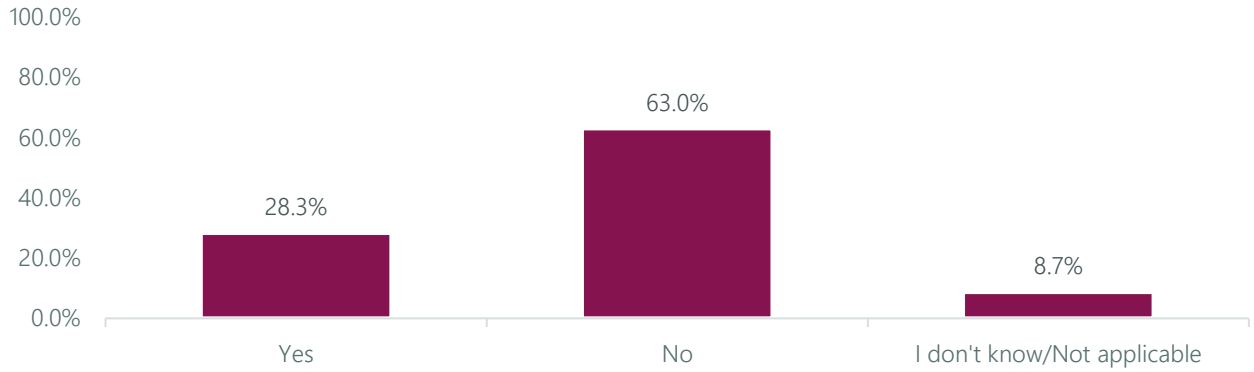
LTC home leaders were asked to share if they felt the current budget at their home was sufficient to provide appropriate care and services to residents. Figure 51 shows that only 15.6% of leaders answered yes while 40% answered no and 44.4% were unsure.

Figure 51: Leadership Responses to Sufficiency of Budget to Provide Appropriate Care to LTC Residents



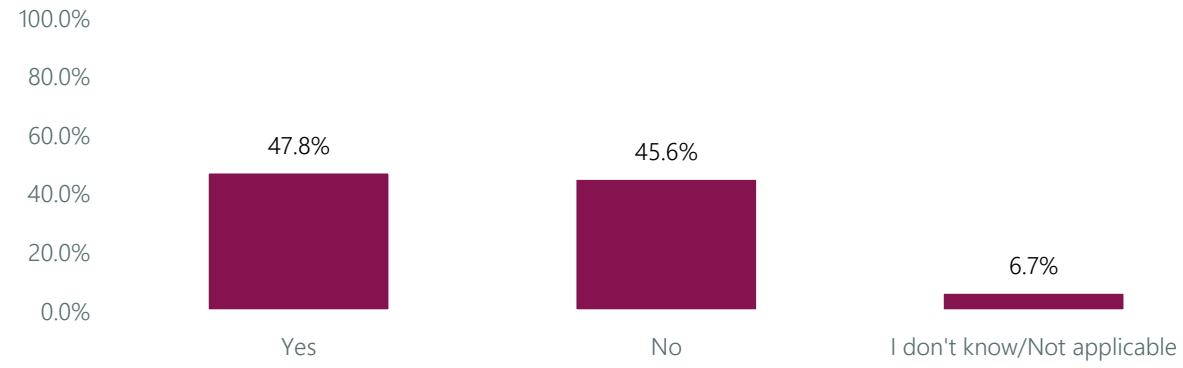
LTC Residents, Families and ECPs were asked to share if they had to leave their spouse when being admitted to a LTC home. Figure 52 shows that 63% of respondents answered no, while 28.3% responded that they did.

Figure 52: Percentage of Survey Respondents Who Had to Leave Spouse for Admission to LTC



LTC Residents, Family, and ECPs were also asked to indicate whether they were able to choose the LTC home they were admitted to. Figure 53 shows that 47.8% responded yes while 45.6% responded no.

Figure 53: Resident Ability to Choose the LTC Home They Were Admitted to



Opportunities for Improvement

Focus group and survey respondents were asked to provide suggestions for improving LTC home governance. The following themes were identified from surveys and focus group participants:

- Implement legislation, regulations, and operational standards for LTC homes.
    - Implement accountability measures and regular performance evaluations for LTC homes.
- Increase operational transparency through performance and monitoring dashboards available to the public.
- Increase the budget for LTC homes to improve resident quality of life and care.
    - Factor in cost-of-living increases and higher operational costs for northern/remote homes in updated budgets.
- Improve collaboration, knowledge sharing, and communication between LTC, primary care, acute care services.
    - Implement documentation and information sharing systems that coordinate throughout the system.
- Enhance coordination between LTC homes and communities in areas such as transportation, inclusion at local events, and involvement of local practitioners (massage therapy, chiropractic care, etc.).
- Improve access to information for families on LTC services and share more information on the first available bed policy to better prepare families and residents.
- Implement an independent process for residents and families to bring forward concerns without fear of repercussions.
- Reduce after hours transfers and provide appropriate notice of admission to residents and families to better prepare them for a move.
- Increase community supports and availability of social workers to support navigation, provide emotional support, and improve information sharing for residents and families.
- Reduce wait times by:
    - Reducing the medical assessment process to decrease administrative burden.
    - Creating metrics and standards regarding wait times and admission times (e.g. delay time between a bed becoming available and when someone is admitted).
    - Continuing to develop community-based options to support individuals in most appropriate setting.
    - Where appropriate, increase the number of LTC beds available.

> ***"There are inconsistencies in policies/procedures across LTC that should be standardized."***

6.2 Personal Care Home Findings

The following section describes the current context and stakeholder engagement findings for governance of PCHs in NL, including the admission process.

6.2.1 Current Context

All PCHs in NL are privately owned and operators must abide by the Personal Care Home Regulations, 2001, and the Personal Care Home Operational Standards, 2007, which outline essential requirements for licensing, monitoring, and inspection activities. The Personal Care Home Operational Standards, 2007 define the governments expectations for PCHs to ensure consistency, establish benchmarks and guidelines for performance, and ensure tasks are carried out to a certain level of quality. The Standards include language to support resident quality of life in PCHs where homes empower a resident's independence, rights, dignity, privacy, and freedom of choice, through:

- Implementing a holistic approach and resident-centred care that promotes respect and dignity.
- Ensuring that care is provided in a respectful and caring way.
- Ensuring meals and snacks are served in compliance with national standards and considers a resident's personal food preferences.

The DHCS is currently in the process of drafting revised operational standards for PCHs.

NLHS and DGSNL share authority for licensing and monitoring PCHs compliance with the PCH regulations and standards. DGSNL completes environmental health, food safety and fire and safety inspections, with results available to the public on the government website. NLHS completes quarterly visits, announced or unannounced, and an annual review. The licensure status of each PCH is available on the government website.

Admission Process

Like the LTC admission process, PCH admission is through a single-entry system. A registered nurse, licensed practical nurse, or social worker completes a comprehensive clinical assessment using the RAI-HC to determine the appropriate care setting in accordance with the NL Level of Care Framework. Residents eligible for PCHs are assessed to require Level I, II or Enhanced Care, are medically stable and do not require continuous supervision or frequent intervention by professional nursing staff.

Cost of Personal Care Home Services

An income based financial assessment is completed by NLHS staff to determine the amount an individual is required to contribute toward the cost of PCH services and whether they are eligible for financial subsidy. The subsidy rate provided to the PCH is based on the individual's assessed level of care.

As of September 2023, the monthly rates for residents eligible for government subsidy within PCHs are:

- Level I: $2,837 per resident per month
- Level II: $2,972 per resident per month
- Enhanced Care: $4,157 per resident per month
- Level III: $4,465 per resident per month

An individual may choose to privately pay to live in a PCH if they do not meet clinical or financial eligibility, in which case the individual and PCH establish an agreed upon monthly rate. In addition, PCH operators may offer additional

amenities which are not included in the provincially set monthly subsidy, such as internet, TV, telephone service in rooms or private rooms. Residents may choose to privately purchase these services.

6.2.2 What We Heard

Focus group participants were asked to share their feedback on a variety of governance areas including:

- Access to PCHs.
- Monitoring and oversight of PCHs.
- Financial sustainability of PCHs.

Survey participants were also asked to share their input and rate several governance areas.

Focus Group Findings

Navigation Support

Focus group participants shared that the process for accessing PCHs can be complex for residents, families and ECPs and could be improved. Participants identified that more publicly available information on how to access PCHs would be welcomed. Additionally, navigation support would be beneficial for helping residents, families and ECPs navigate the system. PCH staff reported that they were supporting families and residents with the navigation process in some instances. Participants also identified that information and education for providers on the supports and services available in PCHs was a gap causing misleading information being provided to residents, families and ECPs.

Monitoring and Oversight

Focus group participants felt that there was a high frequency of audits, reporting, and monitoring processes in place for PCHs. Community health nurses and social workers were responsible for licensing and monitoring of PCHs and there were inconsistencies between staff with implementing monitoring standards. Further, the same staff responsible for conducting audits and monitoring were also responsible for providing clinical supports for PCHs which created a difficult balance between monitoring and maintaining a positive working relationship. Participants also shared that the monitoring and reporting process for PCHs requires high administration and manual reporting from PCH managers and NLHS managers.

Licensing Process & Transparency

Focus group participants shared that more transparency is needed regarding the rationale of the PCH licensing process. There was limited public knowledge regarding what non-compliant conditions result in a conditional license. It was felt that improved tools and a decision-making matrix should be used to determine non-compliant infractions for operators. Further, some participants noted that there was no appeals process for operators to challenge a conditional license or non-compliant rating. Participants also believed that licensing should be overseen by an independent third party and that the public should have insight into the process.

Communication and Collaboration

Focus group participants identified that communication and collaboration between PCHs and NLHS could be improved for training and education, licensing, and monitoring.

Operational Costs and Funding

Some focus group participants shared that PCH operators feel that funding is inadequate to support operational needs.

Legislation and Regulations

Focus group participants shared that a legislative framework was required to support the operational standards for PCHs. It was also shared that the current PCH operational standards are significantly outdated and require updating.

Focus group participants also identified that there were no policies related to rental limit increases for residents or ensuring adequate notice for rental increases.

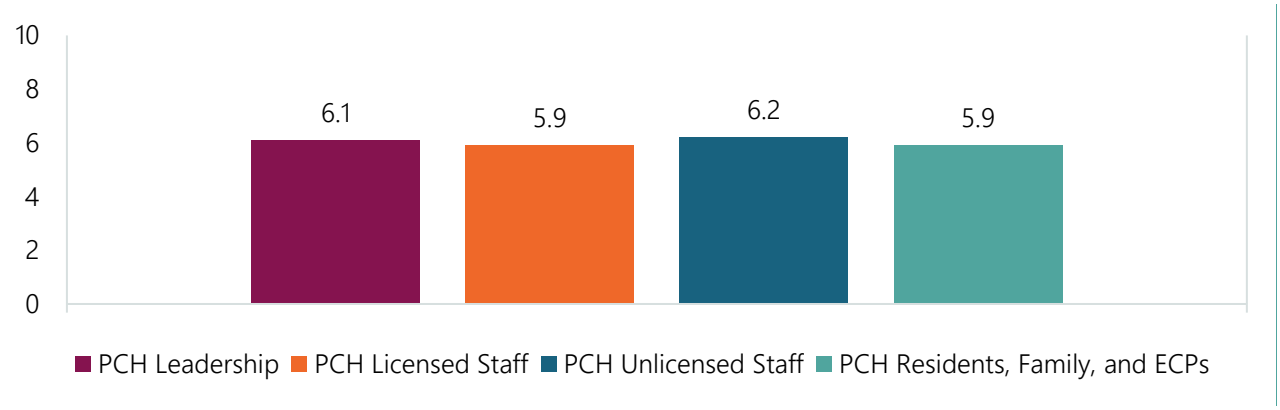
Survey Findings

The following section summarizes the survey results related to PCHs for four stakeholder groups including:

- PCH Leadership – 24 survey respondents
- PCH Licensed Staff – 24 survey respondents
- PCH Unlicensed Staff – 31 survey respondents
- PCH Residents, Family, and ECPs – 126 survey respondents

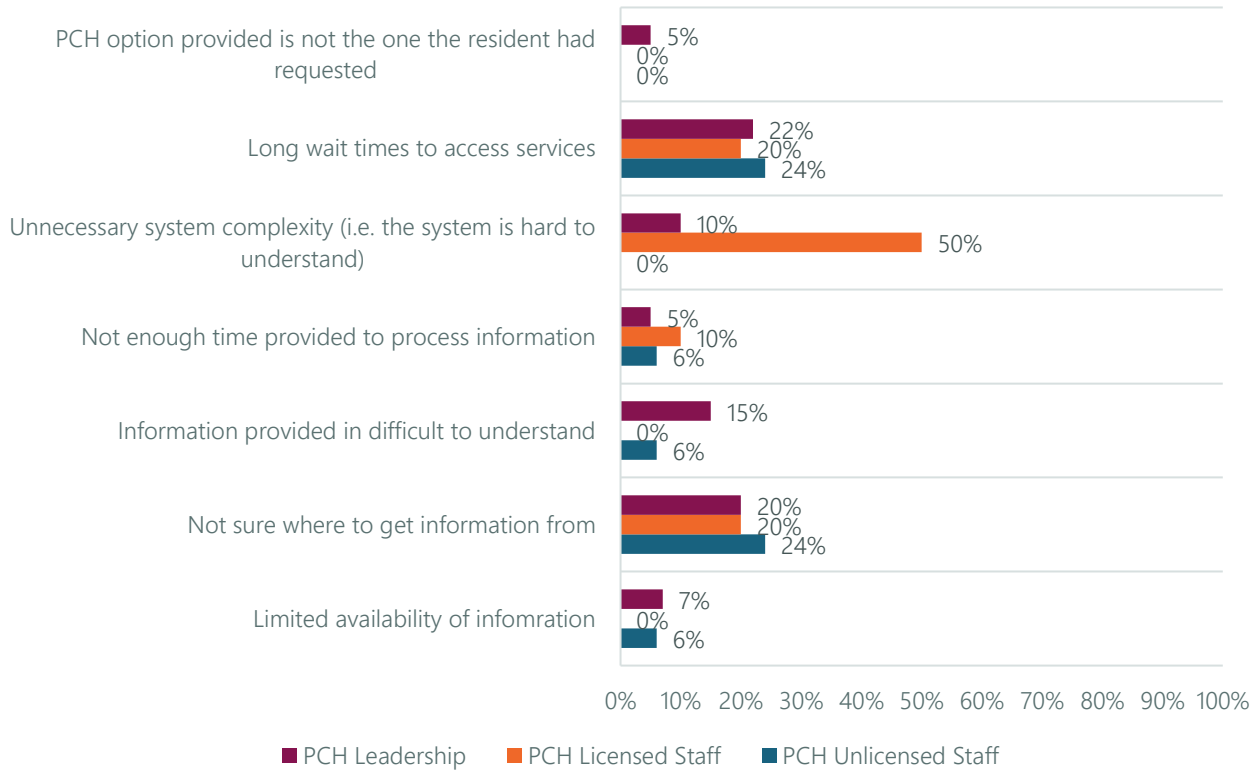
Survey participants were asked to rate a residents' ability to access PCHs and supports they needed on a scale from 0 (difficult to access) to 10 (easy to access). Figure 54 shows that PCH Residents, Family, and ECPs provided an average rating of 5.9 out of 10, compared to 6.1 out of 10 for PCH Leadership, 5.9 out of 10 for PCH Licensed Staff, and 6.2 out of 10 for PCH Unlicensed Staff.

Figure 54: Residents ability to access PCHs and Supports



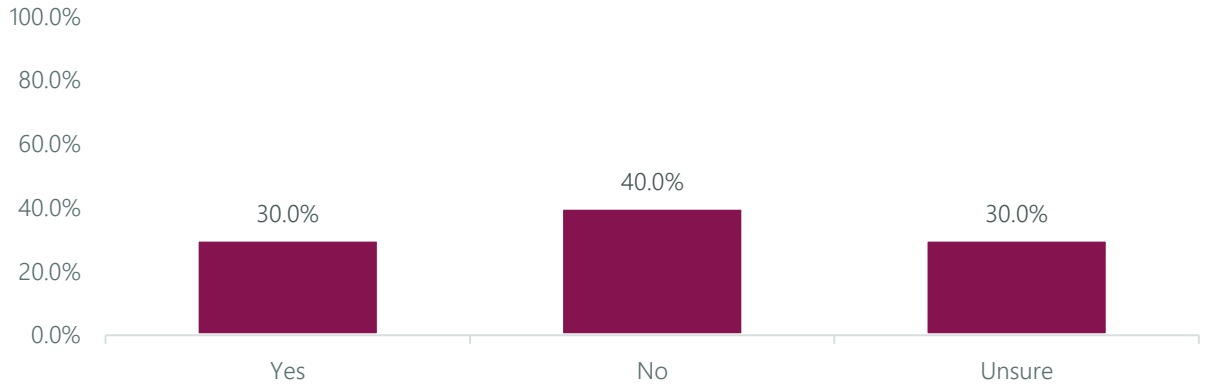
PCH leadership and staff were asked to select the challenges experienced by PCH residents, families and ECPs when accessing PCHs. Figure 55 shows that long wait times to access services (selected by 22% of PCH Leadership, 20% of PCH Licensed Staff and 24% of Unlicensed Staff respondents), not sure where to get information from (20% of PCH Leadership, 20% of PCH Licensed Staff, and 24% of PCH Unlicensed Staff respondents), and unnecessary system complexity (10% of PCH Leadership and 50% of PCH Licensed Staff respondents) were the challenges identified.

Figure 55: Challenges with Accessing PCHs by Residents, Families and ECPs



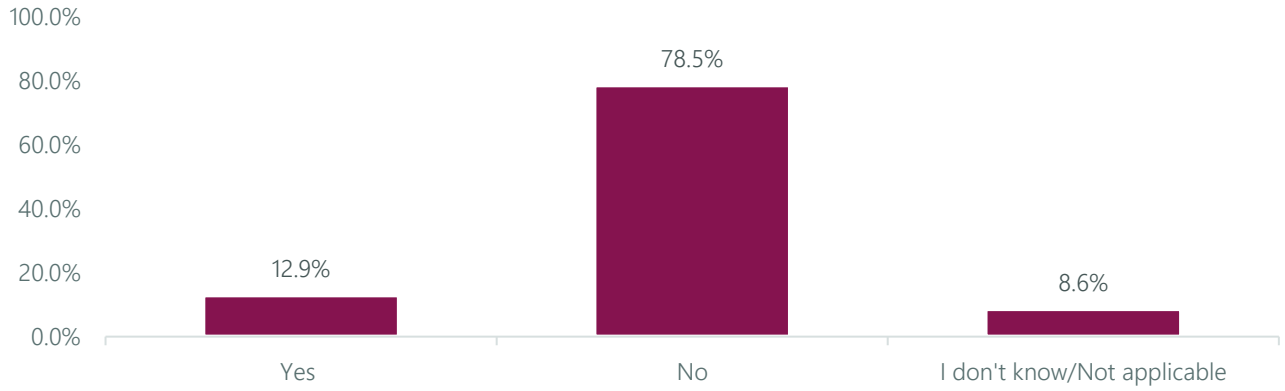
PCH leaders were asked to share if they felt the total revenue from all sources at the home was sufficient to provide appropriate care and services to residents. Figure 56 shows that 40% responded no while 30% responded yes, and 30% were unsure.

Figure 56: Leadership Responses to Sufficiency of Budget to Provide Appropriate Care to PCH Residents



PCH residents, families and ECPs were asked if they had to leave their spouse when admitted to a PCH. Figure 57 shows that 78.5% of answered no while 12.9% answered yes, and 8.6% were unsure.

Figure 57: Percentage of Survey Respondents Who Had to Leave Spouse for Admission to PCHs



Opportunities for Improvement

Focus group and survey respondents were asked to provide suggestions for improving PCH home governance. The following themes were identified from surveys and focus group participants:

- Increase navigation support and publicly available information to support residents, family members and ECPs through the admissions process.
- Enhance partnership and collaboration between NLHS and PCH operators.
- Implement tools and a decision-making matrix for licensing to standardize the process and improve public reporting.
- Implement an appeals process for PCH operators to review non-compliance or conditional licenses.
- Improve stakeholder education and information sharing on the types of supports and resources available in PCHs.
- Increase funding and government support for PCHs to improve resident quality of life.
- Implement a process for residents, families and ECPs to raise concerns and investigations to be conducted independently.

> ***"Implement an independent oversight agency to address issues on a timely basis without fear of retaliation."***

6.3 Leading Practices and Other Jurisdiction Research

The following section identifies emerging, leading, and best practices identified through literature review and interviews with representatives from other provinces to improve LTC and PCH governance, based on the opportunities for improvement identified from the findings in Sections 6.1 and 6.2 above.

6.3.1 Leading Practices

The HSO National LTC Standard recommends that the governing body of LTC homes ensures services cater to residents' diverse needs, prioritizing safety and health (criterion 1.1.2)[3]. The governing body ensures that services are provided 24-hours a day and 7-days a week, guided by resident feedback, health data, infection surveillance, practice audits, and inputs from various stakeholders, and that compliance with jurisdictional regulations is maintained. The HSO National LTC Standard also recommends that the governing body is responsible for ensuring accountability in the delivery of quality care and high-quality health services that are:

- "Resident-centred: responding to individual goals, needs, and preferences.
- Effective: providing evidence-informed health services to those who need them.
- Safe: avoiding harm to all people involved in care.
- Accessible: receiving care that is timely and equitable." (criterion 1.1.9)[3].

The HSO National LTC Standard recommends that executive leaders are held accountable to delivering high-quality LTC services (criterion 1.1.12), and that the governing body ensures LTC homes adhere to legal, regulatory, and contractual obligations (criterion 1.1.3). The governing body oversees compliance with laws, regulations, and contractual arrangements, adjusting services as needed to align with changes in the regulatory landscape.

Accreditation Canada is a nonprofit organization affiliated with HSO that provides assessment and accreditation services for healthcare organizations in Canada[79]. Their evidence-based process involves evaluating homes against established national standards to ensure quality care and safety for residents. LTC homes that achieve accreditation demonstrate a commitment to providing high-quality care and improving outcomes for residents. All LTC homes in NL are accredited through Accreditation Canada and will be measured against the HSO National LTC Standard.

6.3.2 Other Jurisdiction Research

Table 21 summarizes the legislation and standards governing LTC and PCH-like services in British Columbia, Alberta, Ontario, and Nova Scotia.

Table 21: Legislation and Standards Governing LTC and PCH Services in British Columbia, Alberta, Ontario, and Nova Scotia

Province	Types of Homes	Legislation	Standards/Regulations
British Columbia	LTC Homes	*Community Care and Assisted Living Act* (CCALA), and *Hospital Act*	Home and Community Policy Manual, and Residential Care Regulation
	Assisted Living	*Community Care and Assisted Living Act*	Assisted Living Regulation

Province	Types of Homes	Legislation	Standards/Regulations
Alberta	LTC Facilities Supportive Living	*Continuing Care Act*	Continuing Care Health Service Standards
Ontario	LTC Facilities	*Fixing Long Term Care Act*	Ontario Regulation 246/22
Nova Scotia	LTC Facilities	*Homes for Special Care Act*	LTC Program Requirements: Nursing Homes & Residential Care Facilities

British Columbia

Licensing and Monitoring

The licensing of LTC homes in BC is governed by two key pieces of legislation and regulations: *Community Care and Assisted Living Act* (CCALA) and *Hospital Act*[80]. The CCALA is the primary legislation that oversees the licensing of community care facilities, including LTC homes. It sets out the requirements for licensing, safety standards, and quality of care. Some older LTC homes may be licensed or designated under the Hospital Act. All types of licensed resident care homes must follow the Residential Care Regulation and Standard of practice which contain information regarding building standards, staffing and administration, recreational activities, documentation, health and cleanliness, dietary needs, and medication administration.

Under the CCALA, licensed facilities must adhere to minimum health and safety standards and undergo routine inspections by health authority licensing officers. A new Risk Assessment Tool, created collaboratively by the Ministry of Health and health authorities, assigns facilities a risk rating (low, medium, or high) to guide licensing officers in implementing necessary actions and preventative measures to safeguard residents[81].

Health authorities publish summary inspection reports on their websites, covering routine and follow-up inspections of licensed facilities. These reports contain details on substantiated complaints and inspection findings[82]. The Health Authorities have implemented support systems where operators have access to dedicated teams that work with facility operators to identify areas for improvement and provide guidance on best practices. NL could adopt a comparable strategy to British Columbia in disclosing the results of inspection reports for LTC homes and PCHs.

Assisted living services in BC are governed under the *Community Care and Assisted Living Act* and Assisted Living Regulation. To become registered as an assisted living residence, an operator must offer at least one assisted living service, such as private housing units, hospitality services including housekeeping services, laundry services, meal planning, support with daily activities, and assistance with medication.

Seniors Advocate

The Office of the Seniors Advocate (OSA) in British Columbia is an independent office of the provincial government dedicated to advocating for seniors and their ECPs. The OSA actively monitors and analyzes seniors' services across six critical areas:

- Health Care
- Housing
- Income Support

- Community Support
- Transportation
- Safety

The OSA publishes *The Monitoring Seniors Services* report[83] annually which examines key services within the Advocate's mandate, identifying areas where seniors' needs are addressed and where improvements are necessary.

The OSA also publishes the *Long-Term Care and Assisted Living Directory* annually which includes information about publicly subsidized LTC homes and registered publicly subsidized assisted living residences in BC. Information is compiled from multiple sources including LTC and assisted living facilities, the Ministry of Health, Health Authorities, CIHI, and the BC Centre for Disease Control. The report includes demographic data, wait time data, acuity levels, length of stay data, care hour funding, resident monthly rates, food costs, per diem funding rates, therapy service levels, medication use, restraint use, falls, pressure ulcer data, emergency room visits, inspection data, facility risk scores, complaint data, and incident data.

Organizational Structure and Governance

The regional health authorities typically oversee the administration and delivery of LTC and assisted living services within a specific geographic area. The leadership structure varies by regional health authority. Larger urban health authorities like Vancouver Coastal and Fraser Health typically feature a Vice President (VP) overseeing the LTC and assisted living sector. Reporting to the VP are Executive Directors for LTC and assisted living, potentially with separate Directors for owned/operated and contracted sites.

Interior Health organizes VPs by geographic region due to its geographic spread. Each VP has responsibility for acute care, community services, LTC and assisted living for their geographic region. The Executive Directors/Directors under each VP are responsible for home care, LTC and assisted living. Northern Health operates most LTC homes in the region and follows a geographic leadership model like Interior Health. Island Health also shares similarities with Interior Health and the leadership structure is organized according to geographical spread.

Private LTC operators commonly adopt organizational and leadership structures where the Chief Executive Officer (CEO) is accountable to a Board of Directors. The CEO oversees the organization in alignment with the standards and governance regulations dictated by the regional health authority in which the facility operates. Typically, the CEO is entrusted with monitoring the work plans of all departmental leaders, ensuring adherence to established protocols, and managing both operating and capital program budgets to maintain financial stability. The Director of Care supports the CEO by identifying care needs, establishing and upholding standards of care, and ensuring that staff have the skills and resources needed to provide resident care.

Resident Admission

The admission process for LTC in BC involves working with a centralized care coordinator to determine eligibility for LTC home admission. Individuals can contact the home and community care office in their health authority to request an assessment for LTC. The care coordinator helps identify appropriate LTC homes based on one's needs and preferences. They consider factors such as location, specialized services (e.g., dementia care), and availability of beds. The care coordinator collaborates with the resident and family until the resident is admitted to a facility.

A health authority makes every effort to place couples in a LTC home together when both spouses are eligible for LTC services. Alternatively, when only one spouse meets the eligibility criteria for LTC, and the spouses have requested to continue living together, health authorities will work with spouses and their families or ECPs to identify options that support the continuity of an ongoing spousal relationship.[84]

Resident Fees[85]

Individuals receiving publicly subsidized LTC services contribute up to 80% of their after-tax income towards secure housing and care, with a minimum and maximum monthly rate applied. The minimum monthly rate is adjusted annually based on changes to the Old Age Security/Guaranteed Income Supplement rate, with the 2024 minimum set at $1,417 per month. For couples sharing a room and both receiving the Guaranteed Income Supplement benefit, the minimum monthly rate per person is $1,001.69. The maximum client rate, adjusted annually based on the Consumer Price Index, is set at $3,974.10 per month for 2024. Those receiving support or shelter allowance under specific acts will pay a fixed monthly rate for LTC services.

Alberta

On April 1, 2024, the Alberta Government introduced the Continuing Care Act, regulations and updated standards which replace four different acts and four regulations with one streamlined legislative framework to regulate the full spectrum of continuing care services provided in continuing care homes, supportive living accommodations and home and community care.

The development of the new legislation was informed by extensive engagement with continuing care operators, home and community care providers, continuing care organizations and leaders, as well as input from residents, clients, families, and staff. This engagement resulted in legislation that meets the changing needs and expectations of Albertans, and addresses system gaps and inconsistencies. The Act also embraces the recommendations from the FBCC Review.

Admission Process

Access to designated supportive living and LTC in Alberta is determined by Alberta Health Services, requiring individuals to undergo an assessment by a health professional to ascertain their health needs before admission. Professional health care services and personal care assistance in these facilities are publicly funded, operated either by AHS directly or contracted care providers. The level and nature of care provided to residents depend on their assessed unmet care needs.

Resident Fees

LTC services in Alberta are publicly funded and managed either by Alberta Health Services or contracted care providers. The Alberta government sets the maximum accommodation charge that residents can pay for LTC and designated supportive living[86].

From July 1, 2023, to June 30, 2024, the maximum accommodation rates for LTC and designated supportive living increased by 3.6 percent, based on changes in the Alberta Consumer Price Index[87]. Table 22 summarizes the accommodation charges for subsidized and regulated room rates in Alberta.

Table 22: Alberta's Accommodation charges for subsidized and regulated room rates

Room Type	Subsidized Accommodation Charges (As of October 1, 2023)		Full Regulated Rates (As of October 1, 2023)	
	Daily	Average Monthly	Daily	Average Monthly
Private room	$74.95	$2,286	$76.60	$2,336
Semi-private room (double occupancy)	$64.85	$1,974	$66.30	$2,022
Standard room (waiting in hospital)	$61.65	$1,880	$63.00	$1,922

Residents in designated supportive living and LTC homes may have their accommodation charges fully or partly covered if they qualify for the Alberta Seniors Benefit or the Assured Income for the Severely Handicapped (AISH) program. As of January 2024, eligible residents under these programs will retain $357 per month for personal expenses like hygiene items, telephone, and television.

Ontario

All LTC homes in Ontario must be licensed or approved by the Ministry of Long Term Care to operate LTC beds. The licensing process ensures that homes meet specific standards and regulations. The Ministry is responsible for:[88]

- Supporting the building of new homes and upgrading existing ones.
- Setting legislation, regulations, and policies that all homes must follow.
- Developing programs to attract and retain workers.
- Inspecting homes to ensure standards are met.

The *Fixing Long Term Care Act, 2021* in Ontario outlines the provisions regarding the appointment, duties, and powers of inspectors for LTC homes. The Minister may appoint inspectors who are responsible for ensuring compliance with the Act through inspections, including conducting annual inspections. Inspections are typically unannounced, and inspectors may meet with Residents' or Family Councils during inspections if requested. After inspections, inspectors must provide reports to licensees and relevant councils, documenting any non-compliant issues found. Reports are posted publicly on the Ministry of Long Term Care website, including all visits completed in the last five years[89].

When facilities are found non-compliant with the Act, inspectors have several options, including issuing written notifications, making orders, issuing administrative penalties, or referring the matter to the Director of Care for further action.

Health Quality Ontario (HQO) plays a crucial role in assessing and reporting on the performance of LTC homes including wait times for admission, quality of resident care, and other relevant measures to identify areas for improvement[90]. HQO reports this information to the public through its public reporting website and the Quality Monitor, an annual report on Ontario's health system[91].

Resident Admission[92]

The LTC placement process in Ontario involves Home and Community Care Support Services. A care coordinator assesses the care needs and develops a care plan if an individual is eligible for LTC services.

Resident Fees[93]

All LTC residents in Ontario are required to contribute toward the cost of accommodation and meals. The amount of the co-payment fee depends on the type of accommodation:

- Basic Accommodation: $65.32 per day or $1,986.82 per month.
- Semi-private Accommodation: $78.75 per day or $2,395.32 per month.
- Private Accommodation: $93.32 per day or $2,838.49 per month.
- Short-stay: $42.28 per day (short-stay residents do not have a monthly rate).

These maximum co-payment fees are standardized across all LTC homes in the province. If a resident cannot afford the basic co-payment fee, they may be eligible for financial assistance through the LTC Rate Reduction Program. This program helps cover the co-payment fee for eligible residents living in basic accommodation. Spouses or partners who live together in a two-bed semi-private room that has been redesignated as basic accommodation may also qualify. The program considers multiple factors in calculating a resident's rate reduction, including income and dependents. While individual circumstances vary, a person with an income of $25,629 or less (based on the basic accommodation rate effective July 1, 2023) would likely qualify for a rate reduction.

Nova Scotia

The Department of Health and Wellness is responsible for licensing nursing homes and residential care facilities under the *Homes for Special Care Act*. The Department issues annual licenses and in rare occasions issues three-month licenses for non-compliant facilities. Facilities must comply with approximately 400 requirements outlined in the Act, Regulations, and the Long Term Care Program Requirements[94]. Licensing inspections are unannounced and occur at least twice annually for nursing homes and once annually for residential care facilities[95]. Inspection reports are publicly available online and outline only the areas requiring actions. Non-compliance with licensing requirements may lead to more frequent inspections. In rare occasions, facilities are fined $100 per day for non-compliance.

LTC Advisors are government employees that support LTC operators to ensure compliance with regulations and standards. These advisors assist operators with addressing gaps and errors in care and also identify recurring themes and patterns across the province to identify areas for improvement.

The Nova Scotia Department of Seniors and Long Term Care (DSLTC) focuses on promoting the social and economic well-being of older adults in the province[96]. The department oversees LTC homes and homecare agencies across the province and provides leadership and policy coordination to enhance the quality of care for seniors. Their responsibilities include setting policy direction, and funding and overseeing LTC homes and government-funded homecare agencies to ensure they have adequate support and staffing. The department also focuses on protecting older adults from mistreatment, conducting research to address future needs, and collaborating with healthcare partners to share best practices for improving older adults' health.

The *Protected Persons in Care Act* aims to safeguard vulnerable individuals 16 years of age and older who are receiving care from Nova Scotia hospitals, residential care facilities, nursing homes, and homes for the aged; or disabled persons under the *Homes for Special Care Act*; or group homes or residential centres under *the Children and*

Family Services Act[97]. The act establishes guidelines for reporting and addressing abuse, neglect, or mistreatment of residents. The DSLTC publicly reports on its investigations.

Resident Admission

A centralized placement approach is used in Nova Scotia where individuals are assigned to a case coordinator from their health authority to assess care needs and guide potential residents through the process. The admissions process takes into consideration if an individual is receiving care in a hospital or in the community. A placement coordinator assists residents with the transition into LTC by working with DSLTC staff, LTC home staff, and hospital staff[98].

Resident Fees[99]

LTC costs in Nova Scotia are shared between the resident and the provincial government. The Department of Health and Wellness covers health care costs, while residents pay for accommodation costs and personal expenses.

Standard accommodation charges are set annually by the government. These charges do not exceed:

- 85% of the resident's income (for single residents).
- 60% of the combined income (for residents in a partnership).

DSLTC guarantees that LTC residents retain a portion of their income for personal expenses. They will keep at least 15% of their annual income, ensuring they have a minimum annual income of $4,143.

6.4 Governance Conclusions

The following conclusions have been drawn for LTC and PCH governance based on the findings in the preceding sections.

6.4.1 Long Term Care Home Conclusions

1. Stakeholders reported challenges with the assessment, placement, and admission process for LTC homes. Concerns were raised about inaccurate assessments affecting resident placement and continuity of care, long wait times and delays in LTC placement, and late-night admissions impacting resident quality of care. Stakeholders identified a need for a more holistic assessment model that incorporates trauma informed care and input from multi-disciplinary team members as necessary.
2. The Provincial Long Term Care Operational Standards were developed in 2005 and are in the process of being revised and updated to reflect and prioritize resident quality of life and resident-centred care.
3. Stakeholders reported a need to create an independent body to monitor and enforce standards and publicly report on LTC home inspection outcomes.
4. Currently, there is no legislative framework in place in NL for LTC to underpin and support the Long Term Care Operational Standards. Stakeholder feedback and leading practices suggest a need to develop legislation to better support operational standards and improve accountability for LTC homes in the province.
5. Focus group participants identified a need to improve system navigation, coordination and information sharing between primary care, acute care, and LTC and to improve access to community resources to enhance supports available for residents, families and ECPs.
6. Focus group participants suggested enhancing collaboration between Indigenous Governments and NLHS and access to culturally safe and equitable care in LTC.

6.4.2 Personal Care Home Conclusions

1. The Provincial Personal Care Home Operational Standards were developed in 2007 and are in the process of being revised and updated to reflect and prioritize resident quality of life and resident-centred care.
2. The PCH regulations are dated and require updating through development of continuing care legislation to underpin and support the operational standards. Stakeholder feedback and leading practices suggest a need to develop legislation to better support operational standards and improve accountability for PCHs in the province.
3. Stakeholders reported a need to create an independent body to conduct PCH licensing and monitoring of standards, and publicly report on PCH inspection outcomes to ensure a consistent approach to monitoring.
4. Focus group participants highlighted the complexity of accessing PCHs for residents, families, and ECPs suggesting a need for more publicly available information and navigation support.

6.5 Governance Recommendations

The findings from Section 6.1 to Section 6.4 above identified several opportunities to improve LTC and PCH governance in NL. A total of four recommendations for improvement were developed. Each recommendation includes:

- A description of the recommendation.
- The key actions required to implement the recommendation.
- The expected benefits of implementing the recommendation.
- Implementation roadmap for the recommendation.
- The financial considerations of the recommendation.

Recommendation #19: Enhance collaboration and ongoing engagement with Indigenous Partners to better understand the systemic gaps experienced by Indigenous Peoples.

Sections 6.1.2 and 6.2.2 show that Indigenous Peoples experience challenges accessing LTC home and PCH services, including accessing services near their home community.

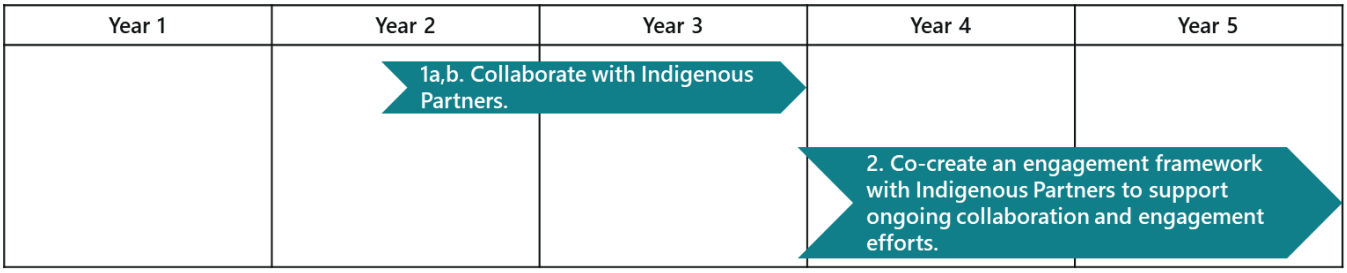
Key Actions Required:

1. Collaborate with Indigenous Partners to better understand:
    a. Challenges with integration between First Nations and Inuit Health Branch (FNHIB) and LTC and PCHs.
    b. Challenges with accessing LTC and PCHs.
2. Co-create an engagement framework with Indigenous Partners to support ongoing collaboration and engagement efforts for LTC and PCH initiatives.

Expected Benefits:

The implementation of this recommendation is anticipated to increase understanding of systemic gaps in LTC and PCHs for Indigenous Peoples and improve collaboration to identify solutions and improve access for Indigenous Peoples.

Implementation Roadmap



Financial Considerations

Financial considerations for this recommendation include existing staff time to support engagement and collaboration.

Recommendation #20: Improve navigation and decision-making support for residents, families, and ECPs.

Sections 6.1.2 and 6.2.2 indicate that residents, families, and ECPs experience challenges navigating the admissions process for LTC and PCHs and have challenges accessing information to assist with decision making. Leading practices and literature (Section 6.3) also support implementing the improvements identified in the key actions below.

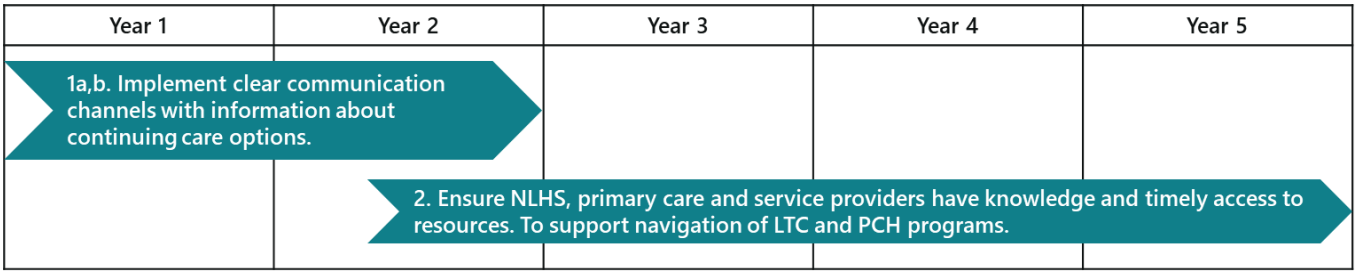
Key Actions Required

1. Implement clear communication channels through which families, residents, and ECPs can access information about continuing care options.
    a. Ensure that communication materials are available to the public in a variety of locations in the community and online platforms.
    b. Ensure there is a mechanism for residents and families to provide feedback on the navigation process.
2. Ensure that NLHS staff, primary care and service providers have knowledge and timely access to resources to support navigation of the LTC and PCH programs.

Expected Benefits

The expected benefits of this recommendation include improved communication and access to information on LTC and PCH services to support decision making.

Implementation Roadmap



Financial Considerations

The financial considerations for this recommendation include existing staff time to support implementation and develop supporting communication materials.

Recommendation #21: Improve the placement and admissions process for residents.

Sections 6.1.2 and 6.2.2 shows that there are challenges related to admissions and placement into LTC and PCHs. Leading practices and literature (Section 6.3) also support implementing the improvements identified in the key actions below.

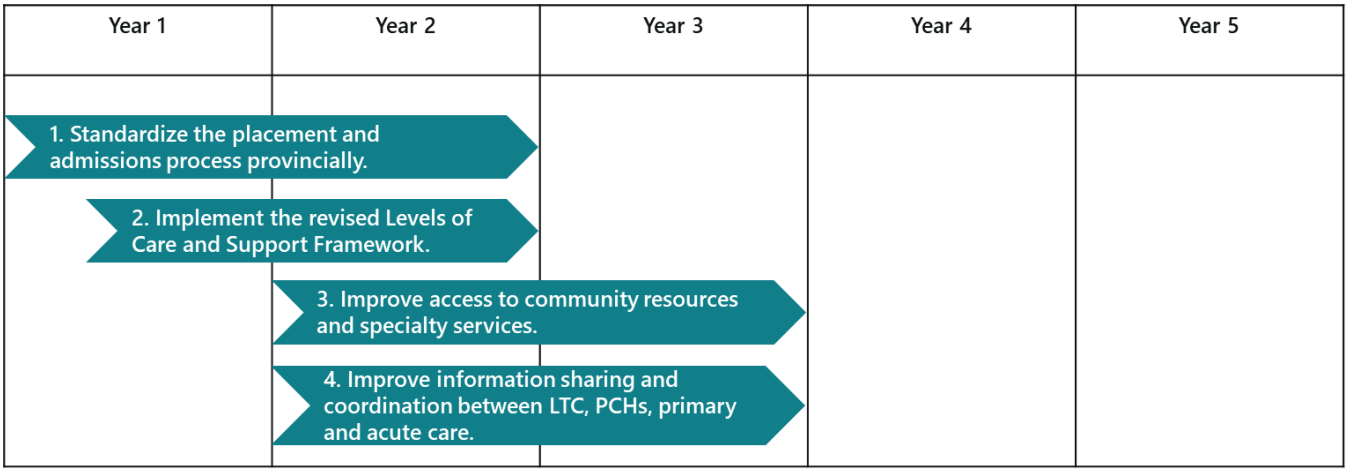
Key Actions Required

1. Standardize the placement and admissions process provincially to ensure a consistent and transparent process.
2. Implement the revised Levels of Care and Support Framework to ensure residents are assessed to receive care in the most appropriate setting.
3. Improve access to community resources and speciality services to support residents with complex needs.
4. Improve information sharing and coordination between LTC, PCHs, community, primary and acute care.

Expected Benefits

The expected benefits of this recommendation include improved coordination and information sharing regarding resident placements, reduced wait time for LTC and PCH beds, more appropriate placements for residents, and improved information sharing with families, residents and ECPs.

Implementation Roadmap



Financial Considerations

Financial considerations for this recommendation include existing staff time to develop supporting information and communication materials to support navigation and information sharing.

Recommendation #22: Create or update legislation, regulations, and operational standards to improve monitoring and accountability.

Sections 6.1, 6.2 and 6.3 indicate that legislation and updated operational standards are required to improve resident quality of life and care.

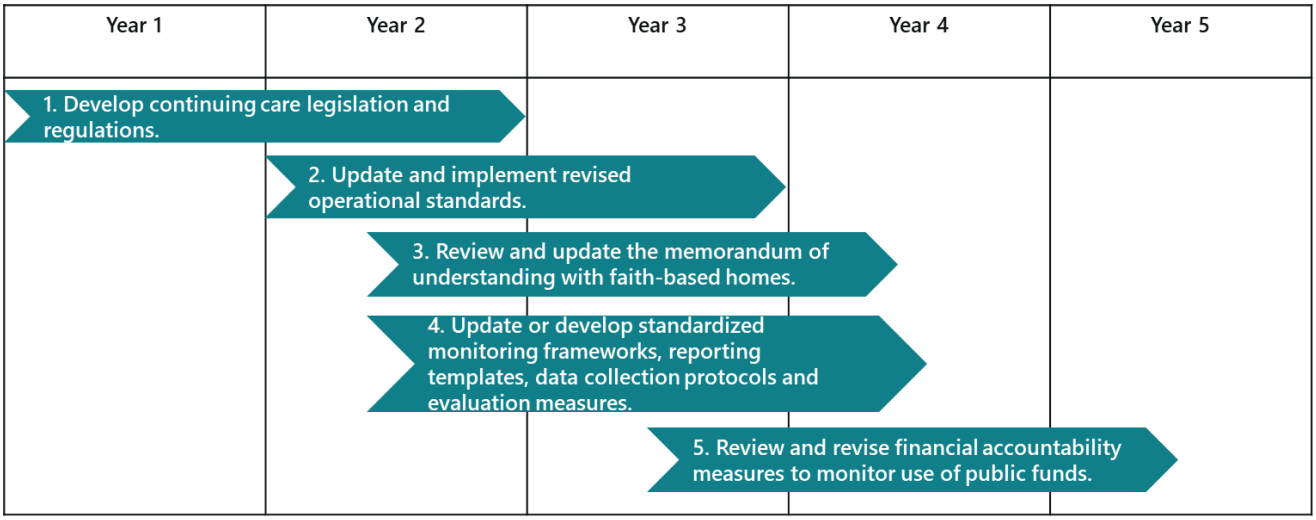
Key Actions Required

1. Develop continuing care legislation and regulations that reflect best practices and resident-centered principles.
2. Update and implement revised operational standards and ensure alignment with HSO National LTC Standards and CSA LTC Home Operations and Infection Prevention and Control Standards.
3. Review and update the memorandum of understanding with faith-based homes.
4. Update or develop standardized monitoring frameworks, reporting templates, data collection protocols and evaluation measures.
5. Review and revise, if necessary, financial accountability measures to monitor the use of public funds.

Expected Benefits

The expected benefits of this recommendation include improved accountability and transparency for LTC and PCH residents.

Implementation Roadmap



Financial Considerations

Financial considerations for this recommendation include existing staff time to develop continuing care legislation and regulations.

Recommendation #23: Create or identify an independent monitoring and licensing body.

Sections 6.1, 6.2 and 6.3 indicate that the establishment of an independent monitoring and licensing body could improve resident quality of life and care.

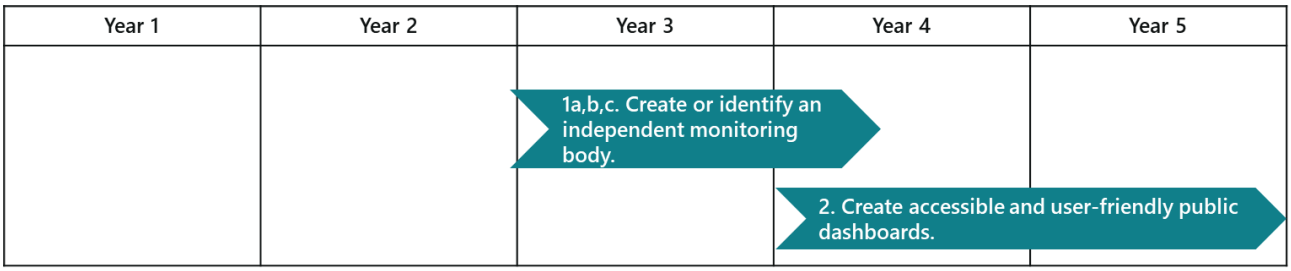
Key Actions Required

1. Create or identify an independent monitoring and licensing body which has authority over both LTC and PCHs to conduct inspections, investigate complaints, enforce standards, and impose sanctions for non-compliance.
    a. Ensure the regulatory body is transparent, accountable, and adequately resourced.
    b. Implement an appeal process to challenge conditional licensing or non-compliant infractions.
    c. Explore use of technology to improve efficiency for monitoring and licensing.
2. Create accessible and user-friendly public dashboards to share reporting metrics, such as inspection reports, quality ratings, resident satisfaction surveys, and complaint resolution processes.

Expected Benefits

The expected benefits of this recommendation include improved monitoring, accountability and transparency for LTC homes and PCHs.

Implementation Roadmap



Financial Considerations

The estimated startup costs for an independent monitoring and licensing body are $405,000. The estimated annual operating cost for the body is approximately $1.1 million. Detailed assumptions are provided in Appendix 2.

SECTION 7

SUMMARY AND NEXT STEPS

7 Summary and Next Steps

The Long Term Care and Personal Care Home Review identified several opportunities for improvement related to quality of life, quality of care, the workforce, and governance based on an analysis of quantitative data sets, stakeholder feedback collected through focus groups and surveys, and leading practices identified through literature reviews and jurisdictional research. A total of 23 recommendations for improvement (see Figure 58 for a summary) have been provided to improve the quality of care provided in LTC homes and PCHs, and the overall quality of life of LTC and PCH residents in NL. Further details regarding each recommendation including key actions, expected benefits, implementation roadmaps, and financial considerations can be found in Sections 3.5, 4.5, 5.5 and 6.5 above.

Figure 58: Summary of Recommendations

Quality of Life	**Recommendation #1:** Establish quality of life as the number one priority.
	Recommendation #2: Improve the quality, choice, and flexibility of meals.
	Recommendation #3: Improve access to meaningful activities and recreational programs.
	Recommendation #4: Enhance and support the role of volunteers.
	Recommendation #5: Enhance opportunities and support residents to maintain connections in the community.
	Recommendation #6: Ensure the upkeep and maintenance of existing infrastructure, and renovations (where practical) as well as new construction align with leading practice design standards.
	Recommendation #7: Support couples to remain living together if they choose.
Quality of Care	**Recommendation #8:** Establish quality of care as a main priority of continuing care.
	Recommendation #9: Improve assessment and support/care planning for residents.
	Recommendation #10: Improve access to medical, therapeutic, and other health related services.
	Recommendation #11: Improve access to mental health and addictions supports and resources.
	Recommendation #12: In LTC, increase the direct hours of care for residents and adjust the skill mix and staffing model to ensure staff are working to full scope.
	Recommendation #13: In PCHs, ensure residents are supported to safely age in place.

Workforce	**Recommendation #14:** Implement a workforce strategy to improve the recruitment and retention of staff.
	Recommendation #15: Develop an engagement strategy to improve workplace morale, workforce culture, workplace safety and flexibility for staff.
	Recommendation #16: Implement an Equity, Diversity, and Inclusion (EDI) strategy to ensure that staff, residents, and family work and live in an environment free from ageism, racism, sexism, and discrimination.
	Recommendation #17: Enhance staff training and education.
	Recommendation #18: In LTC, support leaders to effectively lead and manage.
Governance	**Recommendation #19:** Enhance collaboration and ongoing engagement with Indigenous Partners to better understand the systemic gaps experienced by Indigenous Peoples.
	Recommendation #20: Improve navigation and decision-making support for residents, families, and ECPs.
	Recommendation #21: Improve the placement and admissions process for residents.
	Recommendation #22: Create or update legislation, regulations, and operational standards to improve monitoring and accountability.
	Recommendation #23: Create or identify an independent monitoring and licensing body.

The implementation of these 23 recommendations is expected to be staggered over a 5-year period (except Recommendation #6 which will be implemented over a longer period of time), based on the preliminary implementation roadmaps provided with each recommendation.

The total estimated costs to support and implement these 23 recommendations include annual investments of $19.4 million in year 1 and $30.9 million in year 2 and onward to increase staffing and management capacity to improve the delivery of LTC and PCH programs, training investments of $13.7 million to enhance resident-centred care, technology investments of $3.6 million, investments of $405,000 to establish an independent monitoring and licensing body and $1.1 million annually to operate that body, annual investments of $366,000 for project management supports to implement recommendations, annual investments of $40,000 for marketing and promotion of volunteer opportunities and LTC and PCH careers, and infrastructure investments ranging from $573 million to $954 million to improve resident quality of life (Table 23).

The recommended investments in staffing capacity will increase the direct hours of care provided by nursing staff from 3.4 hours per resident day to 4.0 hours per resident (over 2 years), and the hours of care provided by allied health staff from 0.37 hours per resident day to 0.48 hours per resident day. This is aligned with recent changes made in Ontario and Nova Scotia.

Table 23: Summary of Recommendation Costs

Staffing and Management Capacity Investments	Estimated Annual Cost
Direct Hours of Care Increase (Year 2 and Onward)	$23,074,309
Allied Health Enhancements	$3,443,247
Recreational Therapy Enhancements	$2,264,808
Add LPN Clinical Oversight Capacity to PCHs	$609,623
Enhance LTC Leadership Presence	$1,536,600
Total Annual Investment to Enhance Staffing and Leadership	**$30,928,588**
Training Investments	**Estimated Total Cost**
LTC and PCH Dementia Training (5 years)	$708,450
Other LTC Training (3 years)	$4,996,800
PCH Training Program (4 years)	$8,000,000
Total Investment in Training	**$13,705,250**
Innovation and Technology Investments	**Estimated Total Cost**
Innovation and Technology Strategy (2.5 years)	**$3,600,000**
Independent Monitoring and Licensing Body Investments	**Estimated Annual Cost**
Monitoring/Licensing Body Annual Operating Costs	**$1,075,320**
Project Management Investments	**Estimated Annual Cost**
Annual Project Management Costs	**$366,000**
Marketing Investments	**Estimated Annual Costs**
Annual Marketing Costs	**$40,000**
Infrastructure Investments	**Estimated Total Cost**
LTC Capital Enhancement/Replacement Costs (range based on replacement by renovation versus new construction)	$572,429,666 to $954,049,016
Monitoring and Licensing Body Startup Costs	$405,000
Total Estimated Infrastructure Investments	**$572,834,666 to $954,454,016**

7.1 Next Steps

To keep the momentum established by the Review, the next important activity for the GNL will be to review and decide which recommendations to accept in this report and develop detailed action plans for the recommendations that have been accepted. The detailed action plans should include:

- An articulation of the level of system change required, including change management requirements.
- A prioritization of timing for implementing recommendations.
- A more detailed listing of the key steps and activities needed to implement recommendations, including opportunities to leverage existing projects/initiatives.
- Detailed resource requirements (human and financial resources) to implement recommendations.
- Revised timeframes for implementing recommendations, including key milestones.
- Accountabilities and responsibilities for implementing recommendations.
- The interdependencies associated with implementing recommendations.

APPENDICES

Appendix 1 – Definitions

The following table defines key terms and concepts discussed throughout the report. These definitions are curated from government websites, advocacy groups like Seniors Groups, comparisons with other jurisdictions, and adherence to established standards.

Term	Definition
Activities of Daily Living (ADL)	The activities of daily living (ADLs) is a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. The activities of daily living are classified into basic ADLs and Instrumental Activities of Daily Living. Basic ADLs are those skills required to manage one's basic physical needs, including personal hygiene or grooming, dressing, toileting, transferring or ambulating, and eating. The Instrumental Activities of Daily Living include more complex activities related to the ability to live independently in the community such as managing finances and medications, food preparation, housekeeping, and laundry[100].
Clinical Oversight	Systematic supervision, monitoring, and management of healthcare services including services accessed by LTC and PCH residents.
Community Services	Range of coordinated and integrated services provided in various community settings, including, but not limited to primary care services such as routine check-ups, vaccinations, and screenings; rehabilitation services such as physical therapy, chiropractor, and emotional recovery; and other services such as eye exams, dental services, and hearing exams.
Community Supports	Services for seniors, adults, and children with disabilities, as well as individuals requiring professional assistance while at home or following hospitalization. These services encompass a range of offerings designed to enhance independence and improve quality of life[101].
Essential Care Partners (ECPs)	A person or persons chosen by a resident, or if incapable, their substitute decision maker, to participate in the resident's ongoing care. An ECP can be a family member, close friend, private care provider, or other caregiver. A resident has the right to include or not include an ECP in any aspect of the resident's care. Depending on the jurisdiction, an ECP may be referred to by other terms, such as designated support person or essential family caregiver[4].
External Organizations	Entities that operate independently and exist outside the boundaries of Newfoundland and Labrador government, long term care homes, and personal care homes. They often serve a specific purpose such as advocacy, research, or education.
Family	Encompass various relationships and support networks that play a role in the care and well-being of individuals. The definition of family in this context goes beyond the traditional nuclear family structure and recognizes the importance of chosen family, friends, partners, and other significant individuals in an individual's life.

Term	Definition
Full-Time Equivalent (FTE)	A Full-Time Equivalent (FTE) refers to a standardized measure that quantifies an employee's productive capacity. An FTE of 1.0 corresponds to the hours worked in a day for a full-time employee. For example, if a Registered Nurse works full-time, which is 40 hours per week, their FTE would be 1.0. Part time employees would have an FTE less than 1.0, proportional to their weekly worked hours. In this report, an FTE is used as a standard measure of hours worked by a position.
Home-Like Environment	An environment that aims to provide residents with comfort, familiarity, and a sense of belonging. The physical environment plays a significant role, with comfortable furnishings, personal belongings, natural lights, homelike décor, and respectful treatment from staff.
Leadership	Involves guiding and influencing the team to achieve common goals while addressing the challenges faced in the home. Some common leadership roles include Executive Director, Director of Nursing, Clinical Nurse Manager, Residential Care Manager, Food Service Director, and Human Resources Manager.
Licensed Staff	Various professionals who are governed by a regulatory body including physicians, registered nurses, licensed practical nurses, and allied health professionals such as physiotherapists and occupational therapists. It involves adhering to professional standards, laws, and ethical guidelines while continuously improving practice and maintaining personal and professional accountability.
Long Term Care Home (LTC)	A premise, place, or residence in which 24-hour nursing care is provided to residents who need moderate to total assistance with daily living. Residents in long term care homes typically require on-site health and nursing services.
Personal Care Home (PCH)	Private (for-profit and not-for-profit) accommodations primarily for seniors and other adults requiring assistance with activities of daily living and instrumental activities of daily living.
Resident-Centred Care	"An approach based on the philosophy of people-centred care that ensures that the resident is a partner and active participant in their care. The resident's goals, needs, and preferences drive decision-making for care"[3].
Unlicensed Staff	Individuals who are not regulated by legislation and have a variance in educational preparation. Provide support licensed staff in providing care to residents, including but not limited to assisting with meals and activities of daily living, providing emotional support and companionship, and participating in recreational activities.
Volunteers	Individuals who bring skills, experiences, and perspectives to enrich a resident's life. Volunteers support residents with recreational activities, companionship, emotional support, and support with daily activities such as meal assistance, and accompanying residents to appointments or community events.

Appendix 2 – Recommendation Costing Assumptions

Staffing and Management Capacity Investments

Recreational Therapy Staff Enhancements (Recommendation 3)

The estimated annual costs to hire additional staff to expand access to recreation and meaningful activities is $2.26 million annually. It is assumed that Recreational Specialist and Recreational Therapy Worker staffing complements will be increased to create additional capacity for recreational and meaningful activities. Further capacity will be created by considering alternative shift scheduling as well. Detailed assumptions are provided in Table 24.

Table 24: Estimated Annual Cost to Increase Recreational Therapy Staffing Complements in LTC

Variable	Assumption
Current Number of Recreation Specialist (RS) FTEs	29.0 FTE
Increase RS FTE by 20%	5.8 FTE
Average Salary per RS FTE	$70,590
Estimated Additional Annual Salaries - RS	$409,422
Current Number of Recreation Therapy Worker (RTW) FTEs	64.2 FTE
Increase RTW FTE	26.0 FTE
Average Salary per RTW FTE	$55,653
Estimated Additional Annual Salaries - RTW	$1,446,978
Total Additional Annual Salaries – RS and RTW	$1,856,400
Total Additional Annual Salaries + Benefits – RS and RTW	$2,264,808

Notes:

1. The current number of RS and RTW FTEs were provided by the DHCS.
2. The average salary per FTE for RSs is based on Step 2 of CG-36 in CUPE collective agreement.
3. The average salary per FTE for RTWs is based on Step 2 of CG-29 in CUPE collective agreement.
4. Benefits were estimated at 22% based on data provided by DHCS.

Allied Health Staff Enhancements (Recommendations 10 and 11)

The estimated annual costs to increase access to allied health services by increasing the number of physiotherapists, occupational therapists, behavioural management specialists, and dieticians; as well as adding physiotherapy support workers, occupational therapist assistants, and social work assistants to enable professionals to work to their full scope of practice is $3.4 million. Detailed assumptions are provided in Table 25.

Table 25: Estimated Annual Cost to Implement Allied Health Enhancements in LTC

Variable	Assumption
Physiotherapy	
Current Number of PT FTEs	11.9 FTE
Increase PT FTE by 20%	2.4 FTE
Average Salary per PT FTE	$90,675
Estimated Additional Annual Salaries - PT	$215,807
Current Number of PT Support Worker FTEs	28.7 FTE
Increase PT Support Worker FTE by 20%	5.7 FTE
Average Salary per PT Support Worker FTE	$36,407
Estimated Additional Annual Salaries – PT Support Worker	$208,973
Total Additional Annual Salaries – PT and PT Support Worker	$424,780
Total Additional Annual Salaries + Benefits – PT and PT Support Worker	$518,231
Occupational Therapy	
Current Number of OT FTEs	11.7 FTE
Increase OT FTE by 20%	2.3 FTE
Average Salary per OT FTE	$85,430
Estimated Additional Annual Salaries - OT	$199,905
Current Number of OT Assistant FTEs	0.0 FTE
Add OT Assistant FTE to create 1 to 1 ratio with OTs	14.0 FTE
Average Salary per OT Assistant FTE	$48,750

Variable	Assumption
Estimated Additional Annual Salaries – OT Assistant	$684,450
Total Additional Annual Salaries – OT and OT Assistant	$884,355
Total Additional Annual Salaries + Benefits – OT and OT Assistant	$1,078,913
Social Work	
Current Number of SWA FTEs	2.5 FTE
Add SWA FTEs to create 0.5 to 1 ratio with SWs	14.45 FTE
Average Salary per SWA FTE	$62,537
Estimated Additional Annual Salaries - SWA	$903,660
Estimated Additional Annual Salaries + Benefits - SWA	$1,102,465
Behavioural Management Specialists	
Increase BMS FTE	5.0 FTE
Average Salary and Benefits per BMS FTE	$98,000
Estimated Additional Annual Salaries + Benefits - BMS	$490,000
Dieticians	
Current Number of Dietician FTEs	13.2 FTE
Increase Dietician FTE by 20%	2.6 FTE
Average Salary per Dietician FTE	$68,750
Estimated Additional Annual Salaries - Dieticians	$207,900
Estimated Additional Annual Salaries + Benefits - Dieticians	$253,638
Total Estimated Additional Salaries + Benefits for Allied Health Enhancements	$3,443,247

Notes:

1. The current number of FTEs for each position were provided by DHCS.
    a. The PT Support Worker complement does not include information for LTC homes attached to health centres.

2. The average increase in FTEs for assistant positions were estimated as follows:
    a. The FTE increase for PT Support Workers was based on maintaining the existing ratio of 2.4:1 for PT Support Workers to PTs.
    b. The FTE increase for OT Assistants was based on achieving a ratio of 1 OT Assistant to 1 OT. There are currently no OT Assistants for LTC homes.
    c. The FTE increase for SWAs was based on achieving a ratio of 0.5 SWAs to 1 SW, because there is already a higher complement of SW staff in LTC homes compared to PTs and OTs.
    d. Staffing complements for PTs, OTs and dieticians were increased by 20% to increase the average hours of care per resident day for allied health services to be more consistent with provinces like Ontario.
    e. Staffing complements increase for BMS was based on information provided by DHCS,
3. The average salary per FTE for PT Support Workers, SWAs and BMS were provided by DHCS.
4. The average salary per FTE for all other positions were based on internet research at indeed.ca and Glassdoor.ca.
5. Benefits were estimated at 22% based on data provided by DHCS.

Direct Hours of Care Increase (Recommendation 12)

The estimated annual cost to increase the average direct care hours for nursing care (i.e., PCAs, LPNs, and RNs) in LTC from 3.4 hours per resident day to 4.0 hours per resident day by year 2 is $23.1 million (Table 26). The increase in direct care hours will be achieved by increasing the average PCA hours per resident day from 1.59 to 2.19 by year 2. The increase in PCA direct care hours shifts the staff mix ratio from 14%RN/39%LPN/47%PCA to 12%RN/33%LPN/55%PCA by year 2. The increase in PCA direct care hours will require the addition of 492.8 FTE PCA staff members across the province by year 2. Over the next five years, the skill mix ratio for nursing staff will move towards 70% PCAs and 30% RNs/LPNs through attrition of RNs/LPNs (mostly LPNs) and replacing those positions with PCAs. This transition is expected to result in potential cost savings to the system.

Table 26: Estimated Annual Cost to Increase Direct Care Hours

Position	Staff Mix in 2022/23	Care Hours per Resident Day 2022/23	New Proposed Care Hours by Year 1	New Proposed Care Hours by Year 2	New Staff Mix by Year 2	Additional FTE Required by Year 1	Additional FTE Required by Year 2	Cost per FTE	Projected Additional Cost by Year 1	Projected Additional Cost by Year 2
RN	13.8%	0.47	0.47	0.47	11.7%	0.00	0.00	$93,131	$0	$0
LPN	39.4%	1.34	1.34	1.34	33.5%	0.00	0.00	$55,653	$0	$0
PCA	46.8%	1.59	1.89	2.19	54.8%	246.42	492.83	$46,820	$11,537,155	$23,074,309
Total	**100%**	**3.40**	**3.70**	**4.00**	**100%**	**246.42**	**492.83**		**$11,537,155**	**$23,074,309**

Notes:

1. The FTE for 2022/23 is based on analysis in Figure 29.
2. Additional FTE requirements include worked FTEs and benefits FTEs.
3. Direct care hours for PCAs will increase from 1.59 to 1.89 hours per resident day in year 1, and from 1.89 to 2.19 hours per resident day by year 2.

4. The average salary per FTE is based on current collective agreements as follows:
    a. RNs – Average of Step 4 for NS-30 and NS-31 in RNUNL collective agreement
    b. LPNs – Step 2 of CG-29 in CUPE collective agreement
    c. PCAs – Step 2 of CG-24 in CUPE collective agreement

Add LPN Clinic Oversight Capacity for PCHs (Recommendation 13)

The estimated annual cost associated with providing additional LPN staff to NLHS to provide clinical leadership to PCHs is $609,623. Detailed assumptions are provided in Table 27. Additional capacity for clinical oversight might be created through the implementation of Recommendation #23, which could reduce the estimated annual costs in Table 27.

Table 27: Estimated Annual Costs to Add LPN Clinical Oversight in PCHs

Variable	Assumption
Current Number of PCH Beds in NL	5,477
Increase LPN FTE to provide additional coverage of 610 beds/LPN	9.0 FTE
Average Salary per LPN FTE	$55,653
Estimated Additional Annual Salaries – LPN Clinical Oversight	$499,691
Estimated Additional Annual Salaries + Benefits – LPN Clinical Oversight	$609,623

Notes:

1. The 9 FTE is intended to create some additional capacity for PCH oversight. The current complement of staff at NLHS to provide clinical oversight and complete inspections is currently unknown. It is assumed that additional capacity for PCH clinical oversight will also be created by the establishment of the independent monitoring and licensing body.
2. The average salary per LPN FTE is based on Step 2 of CG-29 in CUPE collective agreement.
3. Benefits are estimated at 22% based on data provided by DHCS.

Enhance LTC Leadership Presence (Recommendation 18)

The estimated annual cost of increasing management capacity by 20% in LTC homes to ensure leadership presence on evenings and weekends is $1.5 million. Further capacity will be created by modifying schedules as appropriate to ensure there is sufficient leadership presence during evenings and weekends. Detailed assumptions are provided in Table 28.

Table 28: Estimated Annual Costs to Add LTC Leadership Presence

Variable	Assumption
Current Number of Resident Care Manager (RCM) FTEs	59.1 FTE
Increase RCM FTE by 20%	11.8 FTE
Average Salary and Benefits per RCM FTE	$130,000
Estimated Additional Annual Salaries + Benefits - RCM	$1,536,600

Notes:

1. The current RCM FTE is based on data provided by the DHCS.
2. Increase in RCM FTE based on discussions with DHCS.
3. The average salary and benefits per FTE RCM were provided by DHCS.

Training Investments

Dementia Training for LTC and PCH Staff (Recommendation 1)

The estimated costs of providing dementia training to LTC and PCH staff are estimated to be $708,450, or $141,690 per year over 5 years. This assumes that LTC and LCH staff can utilize the Dementia Passport Training modules from the Alzheimer Society of Newfoundland and Labrador. Detailed costing assumptions are provided in Table 29.

Table 29: Estimated Costs for Providing Dementia Training to LTC and PCH Staff

Variable	Assumption
Number of LTC Staff and Managers Requiring Training	3,123
Number of PCH Staff Requiring Training	1,600
Training cost per person	$150
Total Estimated Cost to Provide Dementia Training	$708,450
Estimated Annual Cost (Over 5 Years)	$141,690

Notes:

1. Number of LTC and PCH staff based on information provided by DHCS.
2. Training costs based on information provided at https://dementiapassport.ca/learning-modules.

Other LTC Training Costs and PCH Training Costs (Recommendations 16, 17 and 18)

The estimated investments to support other training programs for LTC and PCHs is $5 million over 3 years to provide EDI, leadership, palliative end of life care, and other resident-centred care topic training for LTC staff and

management; and $8 million over 4 years to provide provincially mandatory training to PCH staff. Detailed assumptions are provided in Table 30.

Table 30: Estimated Costs for LTC and PCH Programs

Variable	Assumption
Other LTC Training (Provided Over 3 Years)	
Number of LTC Staff and Managers Requiring Training	3,123
Average Hours of Training per LTC Staff/Manager	80 hours
Average Hourly Cost to Provide Training	$20
Estimated Total Cost to Provide Other LTC Training over 3 Years	$4,996,800
Average Training Cost per Year	$1,665,600
PCH Training Program Costs	
Number of PCH Staff to be Trained	1,600
Average Cost per Course	$5,000
Estimated Total Cost to Provide PCH Training over 4 Years	$8,000,000
Average Training Cost per Year	$2,000,000
Total Estimated Cost for Other LTC and PCH Training	$12,996,800

Notes:

1. LTC staff and managers includes RNs, LPNs, PSWs, AH, RCMs, CNEs, CNSs and Care Facilitators
2. Number of LTC and PCH staff is based on data provided by DHCS.
3. Average LTC training cost per hour is based on https://trainingmag.com/2023-training-industry-report/.
4. Average cost for a 16-week PCH training course is based on costs of providing similar training in Alberta.

Technology and Innovation Investments (Recommendation 6)

The total estimated cost to develop a technology and innovation strategy is $3.6 million over 2.5 years through providing grants to researchers and continuing care sector experts. The estimated costs are based on similar approaches being considered in Alberta.

Independent Monitoring and Licensing Body Investments (Recommendation 23)

Detailed assumptions for the staffing requirements for an independent monitoring and licensing body are provided in Table 31.

Table 31: Staffing Requirements to Operate Independent Monitoring and Licensing Body

Variable	Assumption
LTC Inspector Requirements	
Number of LTC Homes	43
Number of Unannounced Visits per year	1
Number of Announced Visits per year	1
Time Required per Unannounced Visit	8 hours
Time Required per Announced Visit	16 hours
Average Travel Time to and from LTC Homes	10 hours
Time required to complete LTC visits	1,032 hours
Follow up time required	1,032 hours
Travel time	860 hours
Time spent on planning /administrative tasks	1,106 hours
Total Hours Requirements for LTC	4,030 hours
Hours per Inspector FTE	2,015 hours
LTC Inspector FTE Requirements	2.0 FTE
PCH Inspector Requirements	
Number of PCHs	87
Number of Unannounced Visits per year	1
More Unannounced Visits per year	3
Time Required per Unannounced Visit	4 hours
Time Required per Announced Visit	8 hours

Variable	Assumption
Average Travel Time to and from PCHs	4 hours
Time required to complete PCH visits	2,436 hours
Follow up time required	2,436 hours
Travel time	1,392 hours
Time spent on planning /administrative tasks	1,796 hours
Total Hours Requirements for PCH	8,060 hours
Hours per Inspector FTE	2,015 hours
PCH Inspector FTE Requirements (LPNs)	4.0 FTE
Other Staff Needs	
Executive Director FTE	1.0 FTE
Administrative Assistant FTE	2.0 FTE
Total Staffing Requirements	9.0 FTE

The estimated startup costs for an independent monitoring and licensing body are $405,000 (Table 32).

Table 32: Estimated Start-Up Costs for Independent Monitoring and Licensing Body

Variable	Assumption
Number of Body Staff	9.0 FTE
Space Requirements per FTE	250 square feet
Total Space Required	2,250 square feet
Leasehold Improvement Costs per Square Foot	$170
Estimated Leasehold Improvement Costs	$382,500
Furnishings and Fixtures Cost per Square Foot	$10
Estimated Furnishings and Fixtures Cost	$22,500
Total Estimated Body Start-Up Cost	$405,000

Notes:

1. Space requirements include space for offices, common spaces, and hallway/corridor spaces.
2. Leasehold improvement costs based on 2023 Altus Cost Guide for NL.
3. Furnishings and fixtures costs include desk furniture and computer costs.

The total annual operating costs for the monitoring and licensing body are estimated to be $1.1 million. Detailed staff costing assumptions are provided in Table 33 and a summary of the total cost requirements are provided in Table 34.

Table 33: Estimated Annual Staffing Cost Requirements for Independent Monitoring and Licensing Body

Position	Total FTE	Salary/FTE	Annual Estimated Salary
Executive Director	1.0	$140,000	$140,000
Administrative Assistants	2.0	$45,000	$45,000
LTC Inspectors (RN Equivalent)	2.0	$93,131	$186,262
PCH Inspectors (LPN Equivalent)	4.0	$55,653	$222,612
Total Estimated Annual Salaries	9.0		$638,875
Total Estimated Annual Salary + Benefits	**9.0**		**$779,427**

Notes:

1. The average salary per FTE is based on the following:
    a. Executive Director - based on mid range ADM level in GNL salary disclosure
    b. Administrative Assistants – based on Clerk 4 in GNL salary disclosure
    c. RNs – Average of Step 4 for NS-30 and NS-31 in RNUNL collective agreement
    d. LPNs – Step 2 of CG-29 in CUPE collective agreement

Table 34: Summary of Total Estimated Annual Operating Cost for Independent Monitoring and Licensing Body

Variable	Assumption
Salaries and Benefits	$779,427
Rent	$78,750
Travel Costs	$130,200
Office Supplies	$15,000
Promotional	$15,000
Internet/Phone	$10,000

Variable	Assumption
Staff training	$31,944
Accounting/Legal	$15,000
Total Estimated Body Annual Operating Cost	$1,075,321

Notes:

1. Rent costs based on a gross lease rate of $35 per square foot and 2,250 square feet of leasable space. Lease rate based on based on https://www.cbre.ca/properties/commercial-space/details/CA-Plus-348895/35-blackmarsh-road-st-johns-newfoundland-a1e-1s4.
2. Travel costs estimated at $300 per visit.
3. Staff training costs estimated at 5% of salary costs.
4. All other costs estimated based on recent costing to establish a health ombudsman office in Saskatchewan.

Project Management Investments

The annual estimated cost to provide project management support to implement recommendations is $366,000 (Table 35).

Table 35: Estimated Annual Cost for Project Management Support

Variable	Assumption
Number of FTE Project Managers	3.0 FTE
Average Salary per FTE	$100,000
Estimated Additional Annual Salaries – Project Management	$300,000
Estimated Additional Annual Salaries + Benefits – Project Management	$366,000

Notes:

1. Average salary per FTE Project Manager based on research from Indeed.ca.
2. Benefits estimated at 22% based on data provided by DHCS.

Infrastructure Investments (Recommendation 6)

There are currently 18 LTC homes in NL with 1,282 LTC beds in NL with FCI scores of 30% or higher. The total estimated costs (in 2024 $) for replacing or enhancing these 18 LTC homes through renovation or new development ranges from $572 million to $954 million (Table 36).

Table 36: Total Estimated Costs for LTC Infrastructure Enhancements/Replacement

Variable	Assumption
Number LTC Beds at LTC Homes with FCI Rating > 30%	1,282 beds
Cost per LTC Bed for New Construction in 2024	$744,188
Cost per LTC Bed for Renovation in 2024	$446,513
Estimated Cost of Bed Replacement Through New Construction	$954,049,016
Estimated Cost of Bed Replacement Through Renovation	$572,429,666

Notes:

1. FCI data provided by DHCS.
2. New construction costs based on recent quotes to develop a new LTC facility in Northwestern Ontario.
3. Renovation costs estimated to be 60% of new construction costs, based on discussions with Colliers.

Annual Marketing Costs (Recommendations 4 and 14)

The total estimated annual costs for developing marketing materials and conducting marketing activities for promoting volunteers (Recommendation 4) as well as LTC and PCH careers (Recommendation 14) is $40,000.

Appendix 3 - Leading Practice and Literature Reference List

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