RESEARCH PAPER

Exemplars in Long-Term Care during COVID-19: The Importance of Leadership

Exemples en soins de longue durée pendant la COVID-19 : l'importance du leadership

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Abstract

Early in the pandemic, many long-term care (LTC) homes struggled to manage resources and care for vulnerable residents. Using an appreciative inquiry approach, we analyzed exemplar homes in Ontario that remained free of COVID-19 in wave one and interviewed executive

directors, directors of care and staff. Findings demonstrate the importance of leadership styles; clear, consistent communication; focusing on staff and resident safety; using a team-based approach; and adapting staff roles to meet care needs. The exemplar homes showed what works in practice. The decisions and approaches that they implemented could be used to develop standards to improve LTC and strengthen the sector.

Résumé

Au début de la pandémie, de nombreux foyers de soins de longue durée (SLD) ont eu du mal à gérer les ressources et à soigner les résidents vulnérables. À l'aide d'une approche d'enquête appréciative, nous avons analysé des foyers exemplaires en Ontario qui sont restés exempts de COVID-19 lors de la première vague. Nous avons interrogé les directeurs généraux, les directeurs des soins et le personnel. Les résultats démontrent l'importance des styles de leadership, d'une communication claire et cohérente, de se concentrer sur la sécurité du personnel et des résidents, d'utiliser une approche basée sur l'équipe et d'adapter les rôles du personnel pour répondre aux besoins en matière de soins. Les foyers exemplaires ont montré ce qui fonctionne dans la pratique. Les décisions et les approches qu'ils ont mises en œuvre pourraient être utilisées pour développer des normes visant à améliorer les SLD et à renforcer le secteur.

Background

The long-term care (LTC) crisis in Canada is well documented. In a sector known to have significant issues, including staffing, quality of care and accountability, the advent of COVID-19 created a perfect storm (Estabrooks et al. 2020). The first wave of COVID-19 in Canada spanned the beginning of March 2020 to the end of August 2020. During this period, LTC residents accounted for 64.5% of pandemic-related deaths in Ontario, 69% in Québec and 57% in British Columbia (CIHI 2021b). By May 2020, 82% of all recorded pandemic-related deaths nationwide were connected to LTC settings (MacCharles 2020).

Evidence demonstrates outcomes for LTC residents are impacted by type and age of facility and associated regulatory framework, ownership (public/private), location (urban/rural), room configuration (solo/shared) and resident characteristics (Stall et al. 2021). Differences in staff mix (regulated vs. unregulated), staffing numbers, conditions of employment and models of care lead to inconsistencies in quality and application of standards and regulations. Homes provide on-site personal and nursing care, 24-hour access to medical services and subsidized accommodation under a publicly funded system. Care is provided by a mix of personal support workers (PSWs), registered practical nurses (RPNs) and registered nurses (RNs). Boscart et al. (2018) found that PSWs provide the bulk of care (76.5%) in Ontario homes, followed by RPNs (17.3%) and RNs (5.9%). Additional services include nutrition, physiotherapy, recreation, food services, social work, administrative services and housekeeping/cleaning.

In Canada, LTC is a provincial responsibility. COVID-19 has laid bare the long-standing failure to protect the most vulnerable population, and the consequences can be described

as catastrophic (CIHI 2020; Ministry of Health and Long-Term Care 2017, 2018, 2019; Webster 2021). LTC homes are governed by legislation and regulations. Homes in Ontario are licensed by the Ministry of Long-Term Care (MLTC) and governed by the *Long-Term Care Homes Act, 2007*, while nursing and personal support services are governed by *O. Reg. 79/10* under the *Long-Term Care Homes Act, 2007* (Government of Ontario 2011; MLTC 2020).

As of June 10, 2021, there were 626 licensed LTC homes in Ontario with 77,257 long-stay beds (CIHI 2021a; Stall et al. 2021). Fifty-seven percent of the homes were privately owned, 27% were non-profit/charitable and 16% were municipally run (CIHI 2021a). According to data from CIHI (2020), 54.8% of LTC residents in Ontario were 85 years of age or older and the majority required support in activities of daily living. Data from 2019 showed that 90% of LTC residents in the province had some type of cognitive impairment (OLTCA 2019).

On March 17, 2020, the Ontario government declared a state of emergency because of COVID-19 (Rodrigues 2020). On March 22, 2020, the Minister of Long-Term Care issued the first of many operational and policy directives under the *Long-Term Care Homes Act, 2007* (AdvantAge Ontario 2022). Intended to address the myriad issues related to the pandemic, these directives for LTC homes referred to procedures and precautions, infection prevention and control (IPAC) measures and restrictions on visitation. The directives had a profound impact on the LTC sector, residents and their families.

In contrast to LTC homes that struggled with COVID-19, some provided exemplary care and remained free of COVID-19 in the first wave of the pandemic. The purpose of this article is to (1) identify decisions and approaches that were effective in managing care and staff during the pandemic and (2) suggest strategies necessary for change in the LTC sector. Our study was conducted in Ontario. A similar study was conducted in Québec by Lavoie-Tremblay and colleagues in 2021, and their findings appear in this special issue (Lavoie-Tremblay et al. 2022). Ontario and Quebec are the two most populous provinces in Canada and were the hardest hit by COVID-19.

Methods

Design and participants

A case study design guided by appreciative inquiry was used (Bushe 2011; Cooperrider and Whitney 2001). This approach identifies organizational strengths and what works well in practice. Case study allows for an in-depth exploration of a select number of cases (Yin 2017). A purposeful convenience sample was selected based on the following criteria: no active cases of COVID-19 during the first wave, more than 100 beds and a variety of bed types. The research team e-mailed executive directors at four homes that met the criteria and invited them to participate in the study. Upon receiving their agreement, the research team

e-mailed directors of care (DoCs) at each home who then posted notices requesting staff participants for the study. Interested staff contacted the research team directly.

Semi-structured telephone interviews were completed between November 2020 and January 2021, with a convenience sample of managers and staff from each home. These interviews were conducted by a trained interviewer. Select members of the research team attended each interview. The interviews were 30 to 45 minutes long and were conducted until data saturation was reached. Questions focused on the decisions and strategies used to manage care during the pandemic, how facilities implemented and followed changing Ministry directives, how staffing was adapted to ensure a stable workforce and how daily roles changed to accommodate IPAC practices while caring for residents. To contextualize and interpret the study findings, the research team analyzed existing legislative and regulatory frameworks relevant to LTC as well as the MLTC directives that emerged during the pandemic (AdvantAge Ontario 2022).

Ethics

The research instruments underwent ethics review and received approval from the Hamilton Integrated Research Ethics Board (HiREB Project #11526) at McMaster University. Participants were informed of the study's purpose prior to the interviews. They were also advised that participation was voluntary and they had the option to withdraw from the study at any time without penalty. To maintain anonymity, data were aggregated and site names and identifiers were removed.

Data analysis

Interviews were recorded and transcribed verbatim and then coded into QSR NVivo 10.0 (QSR International Pty Ltd, Doncaster, Victoria, Australia). Texts were interpreted through thematic analysis (Boyatzis 1998). Preliminary coding was completed by three members of the research team who coded several texts independently and then shared their classifications. Themes were created based on a consensus process from the agreed upon codes, and findings were categorized under each thematic heading. Member checking was conducted and themes were refined over time.

Results

All the homes that were contacted agreed to participate. They were located in urban settings but varied in age (less than 20 to more than 40 years) and number of beds (less than 130 to more than 200). They also had a mix of basic, semi-private and private rooms. In total, 16 interviews were conducted. Participants included DoCs, nurses (RNs and RPNs), PSWs, dietitians, social workers and staff from physiotherapy, recreation, food services, housekeeping/cleaning and reception. The diversity in participants from various roles in the LTC sector provides a thorough understanding of exemplar LTC homes.

The majority of participants identified as female and were over the age of 30. Two-thirds were employed full time and most of the participants had been working at the homes for up to 10 years. The following themes emerged from the interviews: recognizing the rapidly changing situation; assuring stability in an evolving environment; anticipatory decision making and early detection; implementing a team-based approach; reinforcing resident-focused decision making; implementing effective staffing and supply strategies; enhancing ongoing communication and consistent messaging; and mobilizing strategic partnerships and resources. The themes were interpreted within the context of the pandemic.

Recognizing the rapidly changing situation

Managers had to make decisions in an uncertain environment to maintain continuity and consistency of care. Their role as leaders became increasingly vital for the daily operations of the homes and for staff guidance. Regarding the decisions that had to be made, one DoC commented, "We know what works and we know what we needed to do." Another manager cited their commitment "to continue with excellent practices and proactive surveillances, pandemic and preventative measures" to safeguard residents and staff. A PSW mentioned how their manager accentuated the importance of the team and that, COVID-19 notwithstanding, the site was still a "facility with 24/7 care … [and] everybody has a job to do."

During the first three months of the pandemic, managers had to respond to more than 25 directives issued to LTC homes. Participants reported the directives were frequently revoked, revised and replaced, and the new versions often lacked clarity and were increasingly restrictive. Among the first directives were those limiting visitors and resident mobility within congregate care settings. Participants indicated these restrictions caused a great deal of anxiety. A DoC observed:

> The staff were scared, families were extremely scared …. We do have some residents [who] are alert and they, too, were scared because they couldn't go out anymore.

Due to the fear and the changes precipitated by COVID-19, participants emphasized that care decisions had to be made using a humanistic rather than a solely rules-based approach. The managers fostered a stable, compassionate environment in which decisions continually focused on residents' needs. One PSW relayed, "I think it was always difficult working in long-term care, but when you take a pandemic or a situation like this … you just do [it] because you genuinely care." A DoC decided to make some accommodations in the home that allowed residents to go outside again:

> When we came down to May, and it was getting quite beautiful out and people wanted to get outside … the residents were [upset] because families weren't coming in, staff were all wearing masks, there were no happy smiling faces anymore. So I quickly got

> maintenance on board with me and we got Plexiglas out on the balconies to divide the units so now residents were having breakfast and lunch out on the balcony.

Assuring stability in an evolving environment

Managers were acutely aware of how the pandemic was affecting staff and residents and instituted novel practices to resolve issues and lessen the impact. For example, music therapy and iPads for family calls were used in an effort to combat residents' loneliness. A DoC described how their facility supported staff:

> We gave them a room on the units …. We brought up lounge [chairs], a refrigerator [and] extra microwaves. All these things were bought and put in to make the staff feel like they had a place to go for their breaks.

Managers also encouraged problem solving among staff. An RPN recounted the following situation involving resident care:

> At the beginning of COVID, there were two residents [who] would refuse to stay in their rooms and they would often try to walk the hallways …. So what I would do when I was giving medications [is] … have them walk with me … and I would just talk to them to keep them calm.

Managers and staff noted the need to be creative regarding resident mealtimes. Homes with large dining rooms were able to maintain centralized meals using social distancing, extra cleaning and by ensuring enough staff to provide support. In homes that did not have sufficient space in the dining room, alternate spaces for meals were created that allowed residents to practice safe distancing while still eating together rather than in isolation.

To address an important issue and assure stability, one DoC created a new role called *IPAC lead quality champion*. According to the DoC, the role was pivotal for "ordering swabs for COVID-19 and having much more rapid results … education and self-monitoring for staff and families [and] cohorting of the staff."

Anticipatory decision making and early detection

DoCs at the homes credited their extensive knowledge of and experience in the healthcare system, the LTC sector and IPAC for enabling them to anticipate and prepare. Most had healthcare backgrounds across different organizations. They drew on their expertise when devising mitigation strategies in advance of COVID-19 and they made the decision to initiate enhanced IPAC prior to the confirmed state of emergency.

The managers identified trends and threats before the pandemic was declared and made decisions that prepared their organizations. One DoC remarked, "In January [2020], we purchased PPE, gowns and gloves … and we stored them without knowing that it was going

to be that bad because nobody had said anything about it before." An RPN recalled that the "home took early action and put early interventions in place … I think we were really ahead of it." A manager described:

> From the beginning, it was a proactive approach and not reactive …. We did everything to try to prevent the pandemic coming to us. We did surveillance, passive screening. We did hand hygiene, we reminded [people] about social distancing …. We [made] a contingency plan and a pandemic plan even before the government gave direction[s] with respect to human resources. We identified the minimum staffing needs and prioritized critical services.

Participants acknowledged that increased cleaning and disinfection in a timely manner was a crucial intervention. This was viewed as a shared responsibility within and across sites, and managers expanded staff roles to make certain it was achieved. A receptionist explained how she assisted with cleaning:

> The director of care told us to wash the elevator buttons and everything that people were touching … We had to sanitize the pens that people were using.

The managers encouraged continuous monitoring, which included staff and supplies. When breaches occurred, they took immediate action such as just-in-time training on handwashing technique, wearing of masks and reverse isolation. One home engaged the Red Cross early to provide consistent and accurate IPAC guidance to all staff. This was completed over a four-week period in which agency personnel came in and established a plan of care for the home that included IPAC recommendations and advice on how to change and optimize staff roles.

Implementing a team-based approach

The managers discussed how all staff were respected and everyone was seen as integral team members. They leveraged the collective skills and abilities of their staff to support resident care, enabling them to take on new roles and providing them with the necessary training. A food services worker shared how the "PSW and the food service worker [offered to] work together … and the managers were listening and saying, 'That's a good idea.'" An RPN reported:

> We also had other departments crossing over and helping with the feeding. We had activation involved, management … everybody down to the PT [physiotherapist] and the physiotherapist assistant jump[ed] in and help[ed] out with the serving as well, so it was a team effort.

A PSW said, "We're very fortunate [that] our housekeeper helps feed. They don't have to but ever since COVID she has helped and continues to help because she knows we need the help."

To ensure that residents' needs were met, managers expanded staff responsibilities and redeployed staff from other departments, including personnel who previously had no direct role in care. A DoC highlighted the importance of reorganizing roles in the facility:

> Everybody is cleaning and everyone is taking ownership: the PSWs, nurses, kitchen [staff], all of them. I have a kitchen staff [who] on his break is going around and cleaning all the doorknobs. [The] knowledge [that] they have and the initiative [that] they take, you do not ask them to do any of that …. We are all working together to fight COVID.

Reinforcing resident-focused decision making

It was evident from the interviews that resident safety was the priority. A DoC observed, "We did rounds on a daily basis to make sure that the people are safe." As managers, they were required to make decisions. A DoC reported:

> [We] are dealing with frail residents in very close quarters who depend on people to do things for them. … Infection can spread very fast and easily. … We've got a lot of things that need to be done to prevent something like that.

A strategy used by the managers was increasing staff to ensure infection control measures were maintained. A nurse indicated, "Before, it used to be one housekeeping staff per floor, but now it's two housekeeping staff to each floor. We also have extra cleaners." An activity assistant stated:

> We make sure that when residents are gathered in a group, they are two metres apart. We clean their hands before and after the program and, of course, as staff we are always wearing masks throughout our shifts inside the building.

Throughout the pandemic, staff were encouraged to provide additional support to residents, especially during the time when all visitors were banned from entering the homes. One DoC described, "The nurses were not only focusing on the care but also keeping the residents entertained." A nurse recalled, "In the locked unit we can feel it that they are sad, they are very irritated. So we try to entertain them by playing music [and] we dance – the PSWs, the other nurses and me."

Implementing effective staffing and supply strategies

To reduce the transmission of COVID-19, the Ministry ordered that LTC staff could work

in only one facility. Consequently, agency personnel could no longer be used to fill staffing gaps. The managers described mobilizing existing staff early to ensure care for residents was not disrupted. They quickly converted existing part-time employees to full-time hours. A DoC remarked, "We increased hours because we needed more staff." Another DoC noted the change from 8- to 12-hour shifts resulted in less absenteeism because staff were working fewer days.

Recognizing the impact of COVID-19 and stress on both the professional and personal lives of their staff, the managers acknowledged their employees' performance and empowered them to act. They were also aware of the need to safeguard their staff. A nurse said, "They would give us a bag filled with masks and hand sanitizer to take home so that we were prepared." While some homes monitored PPE, staff did not indicate they had any challenges accessing it. A PSW commented, "We always have supplies, our DoC was really great for that … If we need 10 masks, we can have 10 masks." A DoC revealed, "We never had a shortage of PPE like … other long-term care facilities. … [This] is really important for staff morale because people are scared." In discussing staff who had to self-isolate, the DoC at one home emphasized: "They got paid."

Enhancing ongoing communication and consistent messaging

The managers developed a comprehensive communication plan to ensure up-to-date information was disseminated clearly, consistently and continuously. Some managers implemented a strategy similar to the daily huddles[1] used in acute care settings. These were brief daily meetings to discuss the latest pandemic metrics and data, review protocols and modify plans as necessary to reduce the risk of infection. One DoC recalled, "When we talked about COVID and isolation, we talked about where we are going to isolate the residents and the washrooms that are shared by four residents that would make it difficult for isolation."

Staff commented that managers repeated messages to reinforce key information. An employee reported, "All the managers will send us the same message. So we always receive two e-mails on the same content and it's constant, and then we have [the] communication posted … so everyone can see it." A social worker identified an innovative strategy to reinforce the importance of communicating with and supporting staff:

> They've been working really hard for a long time and burnout could happen. So we did a positive communication workshop to just help touch base with the staff … [They] are at the core of everything that we do for residents and if they're not OK, then the home is not going to be OK.

Communication was also used to keep residents' families updated and lessen their fears. A DoC stressed, "It's very important to … be very transparent to them. Anything and everything we are reporting to them immediately." Another DoC added, "Communication

is the biggest thing you can do. The families need to know … People are scared, so build back trust with simple communication."

Participants agreed that technology was helpful for transmitting and receiving information. An RN mentioned that their DoC sent weekly updates regarding test results or changes to protocols and practices (e.g., having to wear a mask to work). One DoC sent staff weekly e-mails "congratulating them on their great work." A physiotherapist remarked:

> There's very good communication at different levels and exchange of ideas, suggestions and sharing experiences and how to manage the COVID-related issues because this is all new to everyone. I think that the strength is communication, and we appreciate the care and support.

Mobilizing strategic partnerships and resources

Managers agreed that their relationships with external organizations, such as local hospitals, non-governmental organizations and public health agencies, were crucial and provided additional resources and expertise. A DoC indicated, "We are learning collaboratively through each other's experiences." They underscored how vital the support that they received during the critical first months of the pandemic was and how it helped them navigate the rapidly evolving situation. One DoC noted, "During the pandemic it was very important to not send the residents to the hospital for routine treatments … so the specialist from the hospital would come to help."

One home was able to access additional PPE from a charitable organization in the community, while another teamed up with a local hospital to expedite testing for staff. When a potential outbreak threatened one of the homes, the DoC immediately brought in an external organization with expertise in crisis management to conduct a comprehensive assessment and provide recommendations. The organization suggested purchasing additional equipment, streamlining processes, making staffing changes and implementing user-friendly IPAC procedures. External organizations also provided auxiliary staff to stabilize the homes.

Discussion

This study is the first in Ontario to examine what LTC homes did well during COVID-19. None of the exemplar homes had an outbreak in the first wave of the pandemic. Findings demonstrate that it was important to mobilize the entire organization early to ensure residents were safe and protected. Leaders played a pivotal role in obtaining commitment from their staff. All cadres of workers, including regulated and unregulated staff, were involved in the provision of care.

An analysis of interviews with participants from the exemplar homes identified decisions and approaches that were effective in managing care and staff during the pandemic as well as strategies that can be implemented in the LTC sector. Leaders in the homes quickly realized the impact of changing Ministry directives on residents and staff. Their actions

were immediate and deliberate, and they recognized that additional training was required to enable staff to carry out their responsibilities. They enhanced collaboration and emphasized that the provision of care was a collective responsibility. Moreover, they monitored the situation on the floor rather than from their offices.

Although the pandemic created a rapidly changing situation, there was a clear and shared vision of safety for both staff and residents. Moving staff from different departments, expanding their roles and engaging everyone in the continuum of care demonstrated an organic rather than formalized approach to care. To this end, the homes did not isolate residents but reorganized dining spaces so that residents could eat together while maintaining social distancing as per IPAC and MLTC directives. In addition, residents' families were kept informed of the situation within the homes and the ensuing changes that were implemented to care for residents.

Managers struck a balance between mitigating risk and looking after their staff. To contain the spread of the virus, the homes followed isolation, cleaning and IPAC protocols. There was adherence to Ministry directives that included limiting the use of agency workers and mandating staff to work in only one facility. Exemplar homes converted part-time staff to full time to ensure a consistent, well-oriented workforce that could care for residents safely.

Communication and transparency are crucial mechanisms for countering misinformation and panic, both of which were widespread during the onset of COVID-19 (Garneau and Zossou 2021). Regardless of whether the communication is electronic or in-person, it "must have meaning for the people involved" (Baumann and Hinohara 2017). The managers in our study tailored their communication to their audience and provided positive messaging along with updates as the situation evolved. The communication within the exemplar homes followed the three-Cs approach: clear, consistent and continuous. An important strategy was to filter communication to reduce information overload while repeating crucial directives. Another important strategy was calling external organizations in early to establish plans of care and create strategies to reduce the spread of the virus. Partnerships with hospitals and non-governmental organizations allowed homes to access additional supplies and auxiliary staff as needed.

Ontario's Long-Term Care COVID-19 Commission (Marrocco et al. 2021) cited neglect of the LTC sector by successive provincial governments, "lack of pandemic preparedness" and the failure of "policy makers and leaders … to take sufficient action, despite repeated calls for reform" (p. 2). A recent report urges a "comprehensive approach to improving the quality of care in nursing homes" (The National Academies of Sciences, Engineering, and Medicine 2022: 2). The exemplar homes in our study provide evidence for what works in practice and the decisions and approaches they implemented could be used to initiate change, strengthen leadership and provide guidance. Moving forward it is critical that governments and key stakeholders in the LTC sector, including executive directors and DoC, have integrated information that provides a foundation for rapid decision making and the development of comprehensive action plans for crises.

Conclusion

The results of our study have significant implications for LTC practice and policy. Throughout the study, the role and involvement of leadership were evident. The homes that did well focused on empowering, educating and supporting employees and used agile and innovative strategies for staffing. They also prioritized resident-focused care, built on existing partnerships, established new links with both community and health services and enabled staff and families to participate more fully in meeting the needs of a vulnerable population. The decisions and approaches implemented by the exemplar homes in our study provide evidence for what works in practice and, more importantly, in a crisis.

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Note

1. Daily huddle: A "brief, daily discussion focusing on the plan of action … [not] centered on workflow issues but instead promotes discussion among coworkers regarding patient safety and goals of care" (Di Vincenzo 2017: 59).

References

AdvantAge Ontario. 2022. Ministry Documents: List of Ministry Directives. Retrieved March 2, 2022. <https://www.advantageontario.ca/AAO/Content/Resources/Advantage_Ontario/COVID-19/Ministry_Documents.aspx>.

Baumann, A. and S. Hinohara. 2017. *Leadership in Challenging Times: 100 Years of Wisdom*. Fuzambo International.

Boscart, V.M., S. Sidani, J. Poss, M. Davey, J. d'Avernas, P. Brown et al. 2018. The Associations Between Staffing Hours and Quality of Care Indicators in Long-Term Care. *BMC Health Services Research* 18(1): 750. doi:10.1186/s12913-018-3552-5.

Boyatzis, R.E. 1998. *Transforming Qualitative Information: Thematic Analysis and Code Development*. Sage.

Bushe, G.R. 2011. Appreciative Inquiry: Theory and Critique. In D. Boje, B. Burnes and J. Hassard, eds., *The Routledge Companion to Organizational Change* (pp. 87–103). Routledge.

Canadian Institute for Health Information (CIHI). 2020, June. *Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare With Other Countries?* Retrieved May 20, 2021. <https://www.cihi.ca/sites/default/files/document/COVID-19-rapid-response-long-term-care-snapshot-en.pdf?emktg_lang=en&emktg_order=1>.

Canadian Institute for Health Information (CIHI). 2021a, June 10. Long-Term Care Homes in Canada: How Many and Who Owns Them? Retrieved June 13, 2021. <https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them>.

Canadian Institute for Health Information (CIHI). 2021b. *The Impact of COVID-19 on Long-Term Care in Canada: Focus on the First 6 Months*. Retrieved June 13, 2021. <https://www.cihi.ca/sites/default/files/document/impact-COVID-19-long-term-care-canada-first-6-months-report-en.pdf>.

Cooperrider, D.L. and D. Whitney. 2001. A Positive Revolution in Change. In D.L. Cooperrider, P.F. Sorenson, T.F. Yaeger and D. Whitney, eds., *Appreciative Inquiry: An Emerging Direction for Organization Development*. Stipes Publishing.

Di Vincenzo, P. 2017. Team Huddles: A Winning Strategy for Safety. *Nursing* 47(7): 59–60. doi:10.1097/01.NURSE.0000520522.84449.0e.

Estabrooks, C.A., S.E. Straus, C.M. Flood, J. Keefe, P. Armstrong, G.J. Donner et al. 2020. Restoring Trust: COVID-19 and the Future of Long-Term Care in Canada. *FACETS* 5(1): 651–91. doi:10.1139/facets-2020-0056.

Garneau, K. and C. Zossou. 2021. *StatCan COVID-19: Data to Insights for a Better Canada. Misinformation during the COVID-19 Pandemic*. Statistics Canada. Retrieved February 27, 2021. <https://www150.statcan.gc.ca/n1/pub/45-28-0001/2021001/article/00003-eng.htm>.

Government of Ontario. 2011. *A Guide to the* Long-Term Care Homes Act, 2007 *and Regulation 79/10*. Retrieved May 20, 2021. <https://health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf>.

Lavoie-Tremblay, M., G. Cyr, T. Aubé and G. Lavigne. 2022. Lessons from Long-Term Care Facilities without COVID-19 Outbreaks. *Healthcare Policy* 40–52. doi:10.12927/hcpol.2022.26855.

MacCharles, T. 2020, May 7. 82% of Canada's COVID-19 Deaths Have Been in Long-Term Care, New Data Reveals. *Toronto Star*. Retrieved May 18, 2021. <https://www.thestar.com/politics/federal/2020/05/07/82-of-canadas-COVID-19-deaths-have-been-in-long-term-care.html>.

Marrocco, F.N., A. Coke and J. Kitts. 2021, April 30. *Ontario's Long-Term Care COVID-19 Commission: Final Report*. Retrieved August 24, 2021. <https://www.ltccommission-commissionsld.ca/report/pdf/20210623_LTCC_AODA_EN.pdf>.

Ministry of Health and Long-Term Care. 2017, May 11. *Inspection Report Under the* Long-Term Care Homes Act, 2007. *Inspection No/No de l'inspection 2017_360111_0001 (A2)*. Retrieved May 18, 2021. <http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=17740&FacilityID=20100>.

Ministry of Health and Long-Term Care. 2018, December 3. *Inspection Report Under the* Long-Term Care Homes Act, 2007. *Inspection No/No de l'inspection 2018_643111_0023*. Retrieved May 18, 2021. <http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=20670&FacilityID=20100>.

Ministry of Health and Long-Term Care. 2019, December 6. *Inspection Report Under the* Long-Term Care Homes Act, 2007. *Inspection No/No de l'inspection 2019_655679_0029*. Retrieved May 18, 2021. <http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24063&FacilityID=20100>.

Ministry of Long-Term Care (MLTC). 2020, September. *Long-Term Care Home Licensing Framework*. Retrieved October 13, 2021. <https://wayback.archive-it.org/17275/20210810151235/http://www.ltccommission-commissionsld.ca/presentations/pdf/LTC_Licensing_Foundational.pdf>.

The National Academies of Sciences, Engineering, and Medicine. 2022, April. *Consensus Study Report Highlights. The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*. Retrieved April 19, 2022. <https://nap.nationalacademies.org/resource/26526/Nursing_Homes_Highlights.pdf>.

O. Reg. 79/10: GENERAL under *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8. Retrieved May 18, 2022. <https://www.ontario.ca/laws/regulation/100079>.

Ontario Long Term Care Association (OLTCA). 2019. *This is Long-Term Care 2019*. Retrieved August 24, 2021. <https://www.oltca.com/OLTCA/Documents/Reports/TILTC2019web.pdf>.

Rodrigues, G. 2020, March 17. Ontario Government Declares State of Emergency amid Coronavirus Pandemic. *Global News*. Retrieved October 13, 2021. <https://globalnews.ca/news/6688074/ontario-doug-ford-coronavirus-COVID-19-march-17/>.

Stall, N.M., K.A. Brown, A. Maltsev, A. Jones, A.P. Costa, V. Allen et al. 2021. COVID-19 and Ontario's Long-Term Care Homes. *Science Briefs of the Ontario COVID-19 Science Advisory Table* 2(7): 1–34. doi:10.47326/ocsat.2021.02.07.1.0.

Webster, P. 2021. COVID-19 Highlights Canada's Care Home Crisis. *The Lancet* 397(10270): 183. doi:10.1016/S0140-6736(21)00083-0.

Yin, R.K. 2017. *Case Study Research: Design and Methods (6th ed.)*. Sage.