RESEARCH PAPER

COVID-19 Issues in Long-Term Care in Ontario: A Document Analysis

Enjeux liés à la COVID-19 dans les soins de longue durée en Ontario : une analyse de documents

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Abstract

The COVID-19 crisis in long-term care in Canada has been characterized as a *crisis upon a crisis*. This study examines recent documents on the crisis in long-term care in Ontario, using document and thematic analysis to synthesize issues and recommendations from the perspectives of different groups and organizations. Thirty-three documents from 20 organizations were analysed and six thematic areas were identified: resident care; human resources; governance, leadership and management; financing; physical infrastructure and supplies; and training and preparation. The six common themes, as perceived by different perspectives, can inform policy makers on long-term care issues.

Résumé

La crise de la COVID-19 dans les soins de longue durée au Canada a été qualifiée de *crise de la crise*. Cette étude examine des documents récents sur la crise dans les soins de longue durée en Ontario, au moyen d'une analyse documentaire et thématique pour synthétiser les problèmes et les recommandations du point de vue de différents groupes et organisations. Trente-trois documents provenant de 20 organismes ont été analysés et six domaines thématiques ont été dégagés : soins aux résidents; ressources humaines; gouvernance, leadership et gestion; financement; infrastructures physiques et fournitures; et formation et préparation. Les six thèmes communs, tels que perçus selon divers points de vue, peuvent éclairer les décideurs sur les enjeux liés aux soins de longue durée.

Introduction

The Canadian healthcare system experienced a crisis in its long-term care (LTC) sector during the COVID-19 pandemic, with more than 26,000 resident cases and 6,080 deaths during the first wave (CIHI 2021: 6). Before the pandemic, LTC in Canada had already been experiencing significant issues for more than two decades, including staffing shortages, outdated infrastructure and increasingly complex residents (Berta et al. 2022; RSC 2020). Despite more than 50 previous reports, multiple public inquiries and evidence of these issues over the past decades, little action or observable shifts in policy have occurred. These challenges were exacerbated by the pandemic, resulting in a sector-wide crisis (Armstrong and Cohen 2020; Ontario Ministry of Long-Term Care 2020; RNAO 2020c). On March 27, 2020, the Ontario provincial government enacted emergency legislation to mitigate the COVID-19 crisis, including restricting LTC staff from working in more than one facility, restricting access of non-essential personnel into LTC homes and allowing redeployment of community and acute care health providers to the LTC sector (Government of Ontario 2020b). This was followed by requesting support from the Canadian Armed Forces (CAF) and the Canadian Red Cross Society and establishing a public inquiry: Ontario's Long-Term Care COVID-19 Commission (Government of Ontario 2020a).

Researchers in the US have reported on recommendations for improving LTC settings in the context of COVID-19, identifying recommendations related to resident quality of

care and healthcare (Vipperman et al. 2021). In the province of Quebec, public attention to the situation in LTC – similar to that in Ontario – has been described as a policy window (Béland and Marier 2020). The crisis in Ontario received significant attention. Many documents had been published from a variety of perspectives prior to COVID-19 on the state of LTC and play a key role in understanding the background and context of these issues. Since the pandemic, more documents have been published describing the situation in LTC as a *crisis upon a crisis*. Therefore, the question is this: How do documents from diverse perspectives describe the problems in LTC in Ontario and what are the recommendations they propose?

At the time of our review, no studies had been published analyzing public documents on the state of LTC in Ontario since the pandemic. This study examined recent documents from the perspectives of different stakeholder groups and organizations to synthesize issues and recommendations for addressing the crisis in LTC in Ontario.

Methods

Documents can shed light on how groups perceive certain issues. Coffey (2013) describes documents as being constructed from a specific viewpoint, and argues to "[pay] attention to the knowledge that documents 'contain' about a setting but also examining the role and place [of] settings" (Coffey 2013: 370). Authors have argued that documents give underlying meanings, patterns and processes (Altheide et al. 2008), as well as provide understanding of historical roots, issues and conditions of a phenomenon (Bowen 2009).

Document analysis methodology is described as "[initially focused] on exploration, reading, looking, reflecting and taking notes […], followed by identification of key terms, images, themes, and associated frames" (Altheide et al. 2008: 135). Dalglish and colleagues' (2020) systematic READ approach (*ready* your materials, *extract* data, *analyse* data and *distil* your findings) in health policy was used. The search strategy began with a snowball approach, using a convenience sample of reports on LTC in Canada that were publicly accessible and published between January 2020 and February 2021. The search was expanded by a review of reference lists of reports; a manual search of government and organization websites; a Google search using terms such as "Long-Term Care," "LTC" and "Canada;" and by reviewing online news articles on "COVID-19 in long-term care." Inclusion criteria were documents tabled to the government for LTC reform or published by the government, describing the context in LTC just prior to and during the pandemic. Exclusion criteria were documents that provided limited detail or those that focused on a specific issue or intervention, including news articles, research studies and clinical guidelines. A title review was used to purposefully select public documents for inclusion that described generalizable issues and/or recommendations for the LTC context in Ontario.

Selected documents were uploaded to Atlas.ti qualitative software (ATLAS.ti Scientific Software Development, GmbH version 9, 2021). Coding of the documents followed an iterative approach, beginning with open and descriptive coding (Wood et al. 2020). This was followed by an inductive thematic analysis of coded excerpts to develop thematic areas

of related issues and recommendations within the documents (Braun and Clarke 2012). Organizations that published the documents were also grouped into perspective categories to examine similarities and differences in how different organizations defined the crisis in LTC.

Findings

Thirty-three documents were included in the study, published from the perspectives of 20 different groups and organizations. These were further organized into six categories (Table 1) to compare how they defined the crisis in LTC.

TABLE 1. Categories, perspective groups, organizations and number of documents

Categories (*n* =6)	Perspectives (*n* = 20)	Documents (*n* = 33)
Government/ department and commission public agencies	Canadian Armed Forces Canadian Institute of Health Information City of Toronto Ontario's COVID-19 Long-Term Care Commission Patient Ombudsman (Ontario) Province of Ontario (including the Ministry of Long-Term Care)	1 1 1 2 1 4
Academic	National Institute on Ageing – Toronto Metropolitan University Queen's University Working Group Royal Society of Canada 2020 Ontario COVID-19 Science Advisory Table	1 1 1 1
Professional/ labour association	Canadian Labour Congress Canadian Nurses Association Provincial Geriatrics Leadership Office Registered Nurses' Association of Ontario	1 1 1 3
Policy think-tank	C.D. Howe Institute Canadian Centre for Policy Alternatives	1 2
Other non-profit organization	AdvantAge Ontario Canadian Long-Term Care Association Council on Aging of Ottawa	5 3 1
For-profit	Revera Inc.	1

The documents had an average length of 27 pages, ranging from five to 92 pages. The selected documents included government and organizational reports, pre-budget submissions and policy and position papers. Focus and format varied, from detailed issues with research evidence to broad discussion of multiple issues with general recommendations. Some organizations published more than one document during the sample period. Inductive coding produced 1,001 coded excerpts that were grouped into six thematic areas and ordered based on emphasis of the themes in the documents.

Thematic areas

The thematic areas collate related issues and recommendations discussed in the documents. The following is a list of thematic areas, from greatest to least emphasis in the documents:

(1) resident care; (2) human resources; (3) governance, leadership and management; (4) financing; (5) physical infrastructure and supplies; and (6) training and preparation.

RESIDENT CARE

Resident acuity and complexity of residents, including high levels of cognitive impairment, co-morbidities and need for active monitoring, were all seen as significant factors affecting workload and a challenge to meeting residents' needs. There is variation among documents in the number of hours of care residents are currently said to receive, from 2.45 hours per day (NIA 2020: 23) to 3.73 hours per day (Ontario Ministry of Long-Term Care 2020: 15). However, a number of documents (AdvantAge 2020c; CALTC 2020; CLC 2020; Marrocco et al. 2020a; Ontario Ministry of Long-Term Care 2020; RNAO 2020a, 2020c) cited a study in the US that identified 4.1 hours as the minimum care required to meet resident physical care needs (Centres for Medicare and Medicaid Services 2001). Increased care hours were perceived to help alleviate some of the burden on staff, yet few of these documents discussed which providers or what type of care constituted these hours. Additionally, the documentation and reporting requirements were described as putting additional burden on care providers, reducing time for resident care needs by both personal support workers and nursing staff (AdvantAge Ontario 2020a; CALTC 2020; Council on Aging of Ottawa 2020; Ontario Ministry of Long-Term Care 2020; RSC 2020).

Informal providers – such as family, friends and privately paid companions – provide significant psychosocial support as well as physical care needs to individuals (Berta et al. 2022; Ontario Ministry of Long-Term Care 2020). The Ontario government's decision to restrict informal providers from entering LTC facilities to prevent exposure of residents to possible infections from outside visitors added to staff burden and impacted quality of life of residents (City of Toronto 2020; PGLO 2020; Revera 2020). Documents described that care providers had difficulty meeting resident care needs before the pandemic, an issue that worsened dramatically during the pandemic. The addition of infection control protocols and the absence of informal providers added to workload and subsequently affected the care of residents.

HUMAN RESOURCES

Documents demonstrated that human resource issues, including staff-to-resident ratios, employment status (i.e., full-time, part-time, casual, and agency staff) and compensation, were major issues prior to the pandemic. Homes frequently operated short-staffed, while poor staff job satisfaction, burnout and inadequate time to provide care were described as significant issues related to retention (AdvantAge Ontario 2020c; CNA 2020; Ontario Ministry of Long-Term Care 2020; RNAO 2020c; RSC 2020):

> [We] have heard repeatedly and consistently about critical staffing shortages pre-COVID and the reasons for long-standing recruitment and retention challenges

> in long-term care homes. The staffing challenges have been well documented with numerous reports on the subject. COVID-19 exposed these challenges in stark terms." (Marrocco et al. 2020a: 2)

Issues during the pandemic led to further crisis. Provincial legislation to prevent transmission limited care providers to working at one facility and inadvertently restricted access to part-time and casual staff, as LTC personnel often worked across multiple homes. Furthermore, fear of contracting COVID-19 and the increased care burden of caring for children at home led to fewer workers available (CAF JTFC 2020; Ontario Ministry of Long-Term Care 2020; Revera 2020). Documents recommended improved compensation and sick-leave benefits as well as increasing full-time positions as strategies to manage the crisis (City of Toronto 2020; C. D. Howe Institute 2020; Marrocco et al. 2020a; Ontario Ministry of Long-Term Care 2020; Revera 2020; RNAO 2020c; RSC 2020; Stall et al. 2021). The need to increase nursing staff (CNA 2020; Ontario Ministry of Long-Term Care 2020; RNAO 2020a, 2020c; RSC 2020), improve appropriate staff mix (Marrocco et al. 2020a) and engage allied health personnel were identified in several documents (Ontario Ministry of Long-Term Care 2020), concluding that these would improve quality of life and reduce risks such as resident falls and aggressive behaviour. Longer term recommendations suggested a comprehensive human resources strategy and improvement of public perception of LTC to attract and retain personnel (Ontario Ministry of Long-Term Care 2020; RNAO 2020c).

GOVERNANCE, LEADERSHIP AND MANAGEMENT

Provincial legislation – namely the *Long-Term Care Homes Act, 2007,* and its regulation (*O. Reg. 79/10*) – relating to the delivery of LTC in the province was described as strict and compliance-focused, with a punitive inspection model (AdvantAge Ontario 2020a; Ontario Ministry of Long-Term Care 2020). The Commission's Second Interim Report recommended moving back to the annual inspection model (Marrocco et al. 2020b: 5). Many reports noted the lack of federal and provincial standards. In addition, concepts such as accountability and transparency were discussed as well as the need for standardized public reporting on inspections, resident outcomes, hours and quality of care and staffing (Armstrong and Cohen 2020; CALTC 2021; Marrocco et al. 2020b; RNAO 2020c). Documents affirmed there was a lack of capacity and resources to manage COVID-19. There were recommendations to improve collaboration and integration with the acute care system, including infection control capacity (Armstrong et al. 2020; Marrocco et al. 2020b; Revera 2020; RNAO 2020b):

> Every long-term care home should have a partner organization to provide support for management, infection prevention and control, and staffing to prevent and respond to any COVID-19 outbreaks. This could be a municipality, a hospital or other organization that can provide resources. (Patient Ombudsman 2020: 7)

A select number of documents questioned the role of profit in LTC (Armstrong et al. 2020; CLC 2020), compared quality among different ownership types (AdvantAge Ontario 2020b; C.D. Howe Institute 2020; CALTC 2020; Stall et al. 2021) and suggested that reliance on casual and agency staff by private homes exacerbated the staffing crisis (CLC 2020).

FINANCING

There were several topics outlined that had financial implications. They included recommendations such as increased staffing, changes to compensation and benefits and the development and re-development of infrastructure. Additionally, the provincial funding model was described as inflexible and strict, preventing homes from meeting local needs and disincentivizing quality of care improvements:

> When [interventions] are implemented […] resident complications are prevented or resolved, resident acuity decreases. While this is good for residents, the home's [Case Mix Index] falls and funding in future years is decreased. […] This penalty acts as a disincentive to improve patient outcomes. (RNAO 2020c: 32)

It was recommended "that the Ministry provides greater discretion to the licensees in their use of public funds in recognition of the unique needs of different operators and resident groups" (AdvantAge 2020a: 10).

PHYSICAL INFRASTRUCTURE AND SUPPLIES

Lack of basic supplies and physical infrastructure were perceived as major issues in managing the spread of COVID-19 (CAF JTFC 2020; Ontario's Long-Term Care COVID-19 Commission 2020a; Patient Ombudsman 2020). Infrastructure was described as impractical for social distancing and isolation, with 40% of existing infrastructure not meeting current standards (Drummond et al. 2020; NIA 2020: 7). The public inquiry's final report also addressed this issue, proposing a new model in which private capital and investment be used for development and management of LTC infrastructure, while not-for-profit or public " mission-driven" organizations manage care delivery for residents (Marrocco et al. 2021).

TRAINING AND PREPARATION

Documents written during the pandemic identified significant issues related to infection control training, including lack of specially trained infection prevention and control personnel, the need for improved infection control training (CALTC 2020; City of Toronto 2020) and training essential visitors and informal providers entering LTC facilities (Armstrong et al. 2020; PGLO 2020). Also, orientation and training of agency and new staff was recognized as a significant issue before – and worsened during – the pandemic (CAF JTFC 2020; City of Toronto 2020; Marrocco et al. 2020b; Revera 2020; RSC 2020).

Discussion

LTC is a highly complex system. It comprises a blend of private for-profit, not-for-profit and public operators; a mixed funding structure of public money and individual resident contributions; a role for families as care providers and decision makers; and diverse needs of the resident populations. The documents reviewed for this study demonstrated that there were many common issues identified in LTC, including resident care, human resources and governance, leadership and management. These topics represented different perspectives, including those of academic researchers, advocacy groups, provincial government, public agencies and numerous professional and labour associations. Documents indicated a concern about burnout and retention of LTC providers and many recommendations were made for increased staffing. While issues of infrastructure and training were observed, they lacked emphasis among the documents.

Ontario's Long-Term Care COVID-19 Commission published its final report in April 2021, echoing many of the themes of our analysis: "[many] of the challenges that had festered in the long-term care sector for decades – chronic underfunding, severe staffing shortages, outdated infrastructure and poor oversight – contributed to deadly consequences for Ontario's most vulnerable citizens during the pandemic" (Marrocco et al. 2021: 11). It is important to emphasize that these issues were not unique to one province, as they were raised in reports from other provinces across Canada (Béland and Marier 2020; CLC 2020; Drummond et al. 2020; RSC 2020).

Within Canada, LTC is primarily regulated by provincial legislation and policies. This is where reform begins but also where the challenge lies as recommendations may not directly translate into changes in policy. As well, perceived problems and proposed changes can conflict among diverse stakeholders' perspectives. One example is the province's announced increase of care hours residents receive in provincially regulated homes. Existing legislation identifies the minimum care residents are to receive (e.g., two showers a week, daily changes, grooming), not minimum time or staffing (*Long-Term Care Homes Act, 2007*; *O. Reg 79/10*). Mandating four hours of daily care may require clear policy and legislative changes articulating what type of care or interventions constitute the four hours and how it is calculated; presently, the only staffing requirements for care is that one registered nurse be present in the facility at all times (*Long-Term Care Homes Act, 2007*). However, *O. Reg 79/10* made under the *Long-Term Care Homes Act, 2007*, provides a calculation of minimum nutritional staffing hours per week in LTC; therefore, there is precedent in the existing legislation for similar detail for care staff. The caveat is that such detailed legislation may have the consequence of further restricting LTC operators' flexibility to use funds to address local needs.

Another example of where issues and recommendations were seen to conflict is with respect to reporting requirements and accountability. Documentation and reporting requirements in LTC were described as a burden for care providers, taking away from time to

address resident needs. Existing legalisation identifies mandatory documentation for resident assessments and care plans, as well as reporting to the ministry and law enforcement for specific incidents. However, the responsibility for daily documentation remains implicit to demonstrate the achievement of the fundamental principle of *Long-Term Care Homes Act, 2007*, that each home is to provide a comfortable, safe and secure place to live and where residents' "physical, psychological, social, spiritual and cultural needs [are] met" (*Long-Term Care Homes Act*, 2007). Reducing requirements for documentation and reporting could make it more difficult to prove that homes are meeting this mandate and also conflicts with the recommendation for increased accountability. Alternatives could be to increase staffing levels or employ technology platforms to reduce the burden of documentation; however, this could have significant financial implications.

There are other examples of system-wide changes implemented since the pandemic, such as British Columbia temporarily classifying all LTC staff as public employees to guarantee wages and sick benefits (Hager and Woo 2020). While the Ontario government has commenced formulating policy actions to address the challenges experienced by LTC homes, staff and residents, these reforms may fall short of achieving their goal, given the complex considerations needed to implement effective change in the sector. New models of LTC, such as a mix of private investment for LTC infrastructure and management by "mission driven" organizations, suggested by the Ontario commission's final report (Marrocco et al. 2021) and development of federal standards for LTC (HSO 2021) also align with recommendations from the documents. However, it is yet to be seen if and how they will be implemented and what impact they may have.

Limitations

Limitations of this study relate to the variation of the documents, including size, focus and the period and context in which they were written. Documents analyzed provided perspectives from January 2020 – three months before the province of Ontario declared a state-of-emergency over COVID-19 – to the end of the second wave in February 2021. Although this time had been the most devastating in LTC in terms of COVID-19 cases, outbreaks and deaths, the situation continues to evolve and more data, research and reports continue to be released. Therefore, results of this document analysis should be considered from the perspectives and context from which they were written and how this may have affected the emphasis on certain issues in LTC.

Conclusion

The pandemic's disproportionate impact on LTC has garnered intense focus among leaders and policy makers at multiple levels, as well as the public. This study helps contribute to our understanding of the crisis in LTC from the perspective of diverse stakeholders and identifies six key areas of concern: (1) resident care; (2) human resources; (3) governance, leadership

and management; (4) financing; (5) infastructure and supplies; and (6) training and preparation. These provide a roadmap for policy reform. However, as the study demonstrates, the issues that emerged as prominent during the COVID-19 pandemic are not new issues faced by this sector. Furthermore, although the documents detailed many issues in LTC, what was seen as key issues in these areas and the recommendations the groups made to address them varied and presented some conflict. Many of the trade-offs for proposed policy reform have significant financial implications and long-term policy commitment. The mix of government, for-profit and public operators, care providers, residents and families in the financing and delivery of care represents a complex system of stakeholders with varying power and priorities. With leaders and policy makers at all levels promising change for LTC, moving forward with any of the proposed recommendations will require a model of care, regulation and standards that address the many concerns described by multiple documents.

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