MINISTER'S EXPERT ADVISORY PANEL ON

LONG TERM CARE

RECOMMENDATIONS

DECEMBER 21, 2018

ACKNOWLEDGEMENTS & PURPOSE

We would like to acknowledge and thank all of the residents, their families, and stakeholders who passionately shared their stories and ideas that informed these recommendations.

The panel recognizes that while these recommendations are responsive to the numerous challenges facing the long term care (LTC) system, we were encouraged to hear and learn about so many positive experiences from residents, their families, staff, and various stakeholder groups. These recommendations are not intended to diminish the commitment and dedication of so many staff who work extremely hard every day to support residents and their families, but rather attempt to understand the challenges and recommend ways to overcome them.

PREFACE

The Expert Advisory Panel on Long Term Care, Dr. Janice Keefe, Dr. Cheryl A. Smith, and Dr. Greg Archibald, would like to begin by thanking the Minister of Health and Wellness for the tremendous opportunity to provide advice and recommendations to improve quality of care in long term care (LTC).

While the twelve-week timeline to complete our work was undoubtedly ambitious, it meant we had to immerse ourselves in the existing documentation and learn about initiatives under way to understand the current situation. The breadth of the mandate gave us the flexibility to take a whole-system view and explore ways to improve quality of care in LTC facilities; ensure appropriate staffing (complement and skill mix) of LTC facilities; and enable recruitment and retention of appropriate LTC staff.

Complexity	Culture	Fragmentation
Resident needs and the demand for specialized care is increasing without the resources and system adaptation to manage them.	The sector is not often seen as providing attractive and supportive workplaces and homelike facilities.	Accountability structures are disconnected, leaving a high degree of variability across the system.

Driven by a person-centred approach as the guiding principle, we engaged over 375 diverse stakeholders to more fully understand the challenges facing the LTC system. We met with residents and their families, staff and service delivery personnel (including unions and provincial organizations), sector organizations, health authorities, and representatives of the provincial government. We heard about the pressures on the system, including aging demographics, high rates of chronic disease and dementia, the responsive behaviours of some residents, and recruitment and retention of human resources, which are contributing to significant strain being placed on the LTC system. Throughout the engagements we consistently heard and learned about three systemic themes—complexity, culture, and fragmentation—that helped us understand the underlying causes and effects of the strained LTC system.

We want to acknowledge the residents, their families, and stakeholder organizations who came prepared and proposed recommendations for our consideration. These recommendations will be shared with the Department of Health and Wellness for further consideration.

The panel's recommendations are grounded in the perspectives and insights shared by residents, their families, and stakeholder organizations across the sector, as well as in existing research and documentation. It is our belief that the LTC sector has long reached a state of readiness for change, and what is needed now is the commitment of leadership to invest in and drive change across the sector. To guide this critical change agenda now and into the future, the panel recommends taking a whole-system view, with a focus on five key areas:

1. Invest in human resource capacity and enhance staffing mix to address staffing shortages and ensure enhanced and equitable access to a diverse complement of staff that will effectively address the complexity of resident needs.

2. Attract and grow a healthy workforce in which staff feel supported and see employment in the LTC sector as a viable career option.

3. Optimize capability and knowledge to increase skills of the care team and improve quality of care.

4. Improve transitions of care for residents and their families to and from LTC facilities to enhance coordination of services and improve health outcomes for residents.

5. Improve system performance and optimization by taking a holistic approach to lead and manage the system more effectively for the residents and the families they serve.

It has been a privilege being a part of this important work, and we, like so many of the residents, their families, and stakeholders we engaged, feel invested in these recommendations and desire to see them acted upon. Our hope is that these key areas of focus will serve as priorities to drive forward change that will begin a transformational agenda for the LTC system.

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WHAT WE HEARD

From information gathered while engaging with diverse stakeholders across the province, we deepened our understanding of the challenges and explored opportunities to examine ways to improve quality of care in the LTC system.

We gathered all of the information and synthesized our observations and learnings throughout the engagements. While it is understood that the individual needs of residents and their families are unique, it was striking to learn about commonalities across the sector perspectives. From these engagements we identified ten common and emerging themes that provide a holistic system perspective. These are kept top-of-mind as we work together to drive forward and realize system change.

ENGAGEMENT – WHO WE MET

20

Residents and Families from each of four NSHA zones

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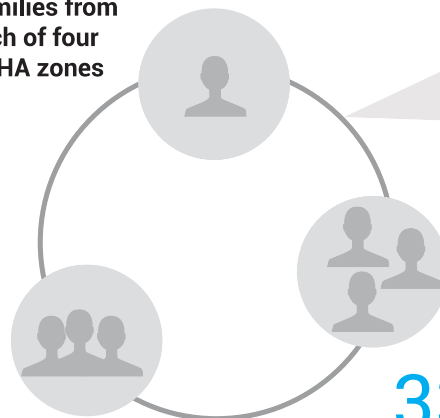

Over 375 people engaged in face-to-face meetings and contributed valuable perspectives and ideas that were foundational in shaping the recommendations.

25

Sector Organizations
(e.g., NS Seniors Advisory Council, Unions, HANS, CGA, CCANS, Geriatric Psychiatry, Prov. Nurse and Physician groups, NSHA Quality Council, ACE)

330

Half-day Consultations (4) & Continuing Care Forums (4) across all NSHA Zones
(e.g., Facility Administration, Behavioural Health, PT, Dieticians, Family Council, NSHA Quality Council, Aware NS, Aboriginal Affairs)

KEY THEMES EMERGING FROM ENGAGEMENT

Dignity & Privacy of Residents	Well-being of Residents	Public-Family Expectations	Complexity & Individuality of Residents	Guilt & Shame
Need for personhood and confidentiality	Support for emotional, mental, and spiritual needs	Need for communication of what LTC facilities can and cannot provide	Individualize supports for unique needs of residents	LTC Staff identified a disconnect between personal values and LTC realities

Sector Stigma	Communication & Collaboration	Prevention	Accountability Across All	Safety
Inequity among health sectors that reinforce negativity within LTC	Need for modes of communicating and effectively working together	Proactive approach to avoid illness and injury, among residents, staff, and families	Need for trust built from consistency and transparency	Need for balancing and managing risk for residents in a compassionate way

RECOMMENDATION 1:
INVEST IN HUMAN RESOURCE CAPACITY AND ENHANCE STAFF MIX.

Quality of care of residents in LTC facilities is affected by the quality of work life for staff. Sufficient and appropriate staffing is necessary to meet the increasing care needs of residents. We heard over and over from residents and their families that staff do not have the time to provide appropriate care because they are “working short.” Shortages increase staff responsibilities, with more residents to provide care for, resulting in overstressed staff, high rates of injury and sickness, and many unfilled vacancies across the sector. It was most profound to hear from staff and many of the sector representatives about the guilt and shame they feel not being able to provide adequate care. These challenges highlight the urgency to invest in human resources to alleviate the unsustainable workload and untenable physical and mental fatigue of staff.

Increasing staff at the point of care is needed immediately to assist with activities of daily living. An introduction of more workers will provide necessary support in the short-term to address staffing shortages. Responding appropriately to the increasing complexity of resident needs not only requires an investment in more staff, but enhanced and equitable access to a diverse complement of human resources. Throughout our engagements we heard about the need for enhanced and equitable access to allied health supports. There was recognition of skills that allied healthcare providers bring to a person-centred approach by providing a holistic care plan that meets the unique needs of each resident.

The relationship of staffing mix to quality of care is inconsistent across studies[1] and various jurisdictions across Canada. We know that having more staff improves quality of care, but staff mix or ratio must be correlated to variables such as a resident's complexity of care, staff competency, and the physical layout of the facility[2]. While we heard the call for an increase in the staff ratio, at this time it is our belief that the implementation of the recommended investments in human resources is necessary before appropriate ratios can be determined. Ideally we would have better data to understand the current complex care levels and enable staff ratios to reflect this evidence of increasing complexity. The recent proposal to implement the *InterRAI LTCF* assessment to monitor outcomes of residents in facilities provides an important start. This implementation will provide data critical to future staffing ratio considerations.

It is recognized that the implementation of this recommendation will take time and careful consideration to understand the affects on residents and the LTC sector as a whole. Specifically, the panel has identified five actions to advance this recommendation in the short- and medium-term.

SHORT-TERM (February, 2019 – July 2019)

1.1 Hire temporary LTC Assistants to support the care team with residents' activities of daily living.

Staff are in need of immediate support to alleviate an overstressed workforce, enable workers to take vacations, and improve work conditions. These positions may act as an entry point to LTC and potentially support career progression of staff as a path to work toward a CCA position. The temporary positions are recommended in response to the current work conditions. It is advisable to reassess these temporary positions after one year and the implementation of Recommendation 2. We recommend these temporary workers be hired as soon as possible.

[1] *Kim, Harrington, & Greene (2009). Registered Nurse Staffing Mix and Quality of Care in Nursing Homes: A Longitudinal Analysis.* The Gerontologist*, 49(1), 81–90. http://doi.org/10.1093/geront/gnp014*

[2] *Kennedy, A. (2009). Evaluating Nursing Staff Mix in Long Term Care: A Comprehensive Framework for Decision-Makers.* Healthcare Quarterly*, 12(4).*

1.2 Assign one full-time LPN to Residential Care Facilities.

With the increase in complexity of care needs in all LTC Facilities, RCF's are being assigned additional duties, such as wound care. Regulatory personnel are needed to do clinical assessment and management. This will enable the resident to remain in the RCF with the appropriate clinical oversight.

1.3 Build sector pride by communicating the unique and diverse skills required to work in the LTC sector.

Residents currently admitted to LTC have multiple co-morbidities and complexities. Today, staff need unique and diverse skills to effectively work in LTC and care for this population. It is important to recognize the specialization of sector staff and celebrate the valuable work they do to ensure quality of life for residents. We recommend acknowledging the specialized and diverse skills of LTC workers. This process involves multiple areas, including but not limited to a public awareness campaign (Action 4.1), curriculum and training (Action 2.2 and 2.3), etc.

MEDIUM-TERM (August, 2019 – November 2020)

1.4 Expand access to Allied Health providers that is equitable across the sector and province.

The model for Occupational Therapist / Physiotherapist (OT/PT) and other allied health providers is inconsistent across the sector. The skills of these allied health providers will enhance the person-centred approach by providing a holistic care plan that meets the unique needs of each resident. For some facilities, this may require an alternative model of shared resources, as proposed in Action 5.3. We recommend the services of allied health providers be expanded and more equitably distributed across the sector.

1.5 Increase the utilization of Nurse Practitioners (NPs) in LTC.

Many facilities have limited access to primary care services and no scheduled weekly provider visits. Facilities with NPs involved in providing primary care have fewer transfers to hospital[3]. The public supports the role of NPs, who score high on client satisfaction surveys[4].

Supporting more NPs to have LTC responsibilities would provide residents with greater access to a primary care provider in order to respond to acute health needs and responsive behaviours. By highlighting the specialized skills needed in LTC (see Action 2.2) more NPs might be attracted to this area. We recommend an increase in NP coverage in LTC to enhance weekly scheduled primary care services.

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[3] *Canadian Nurses Association (2013).* Nurse Practitioners in Long Term Care. *Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/fact_sheet_nurse_practitioners_2013_e.pdf*

[4] *Ploeg, Kaasalainen, McAiney, Martin-Misener, Donald, et al., (2013).* Resident and family perceptions of the nurse practitioner role in long term care settings: a qualitative descriptive study. BMC Nursing*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3849937/*

RECOMMENDATION 2:
ATTRACT AND GROW A HEALTHY WORKFORCE OF STAFF WHO FEEL SUPPORTED.

As described in Recommendation 1, having sufficient and appropriate staff to meet the increasing and complex care needs of residents is critical, and it is undeniable the sector must find better ways to recruit and retain staff. We heard from many LTC facility staff and management, as well as from union representatives, that the high vacancy rate is indicative of the overstressed workforce across the sector. Staff and administration told us about high rates of injury, sickness, and attrition among new employees.

This situation highlights the importance of taking a strategic approach to improve recruitment and retention for all LTC staff, but particularly CCAs, to ensure the sector is supported by a healthy workforce. While the recommendations to improve the working conditions of point-of-care staff will facilitate better retention patterns, CCA training programs need to ensure future workers have a sound understanding about the workload involved in the care. Recruitment into LTC must become a priority area for health human resources. Opportunities for employment in homecare and the acute care sectors have attracted many CCA graduates. Concerted effort is needed to attract workers and see employment in the LTC sector as a viable career option.

It is recognized that the implementation of this recommendation will take time and that careful consideration is required in order to understand the impacts to residents and the LTC sector as a whole. Specifically, the panel has identified four actions to advance this recommendation in the short- and medium-term.

SHORT-TERM (February, 2019 – July 2019)

2.1 Bring back the CCA bursary program to support CCA recruitment.

We believe the sector needs to invest in the recruitment of CCAs specific to LTC. An immediate approach is to financially support students in accessing training programs. In exchange for this support, students would have to be willing to work in the LTC sector for a committed period of time. One possible avenue might be the new temporary positions proposed in Action 1.1.

2.2 Recognize the unique skills needed to have a viable long term career in LTC.

An acknowledgement of the specialized skill set needed to work with residents who have multiple co-morbidities and varying levels of cognitive impairment is needed. We recommend language that emphasizes the specialization of LTC workers be included in communications and considered when developing policy.

MEDIUM-TERM (August, 2019 – November 2020)

2.3 Examine the methods of CCA education and curriculum, specifically with reference to LTC environments and hands-on experience.

There is a need for CCAs-in-training to have a better understanding of the workload of caring for LTC residents and the values and attitudes that are needed to provide the best care. Improvements to the LTC practicum rotation is needed to ensure prospective employees have the opportunity to see the benefits and challenges of working in the sector.

2.4 Develop a Provincial Recruitment and Retention Strategy for workers in this sector.

There are many vacant positions in LTC facilities, particularly for CCAs. A strategic plan is needed to address the health human resources (HHR) required to support the advanced healthcare needs of older people who need assistance. With an increased proportion of the population who will be aged 80 or older in the next decade (the first baby boomers turn 80 in 2026), coupled with the reduced availability of family caregivers (as baby boomers have had fewer children than their parents), the demand for care workers in home and long term care will continue to rise. In addition to recommending the strategy itself, these other factors need to be considered:

2.4.1 We recommend that this strategy develop a comprehensive plan to recruit the proposed LTC assistants into the CCA training program by providing incentives as outlined in Action 2.1.

2.4.2 To address the lack of data to appropriately forecast HHR needs and to ensure the qualifications of workers in the LTC sector, we recommend mandatory registration of CCAs.

2.4.3 We recommend that the regulatory challenges of hiring foreign workers to work in NS LTC facilities be examined with the goal of improving access to these workers.

RECOMMENDATION 3:
OPTIMIZE CARE-TEAM CAPACITY AND KNOWLEDGE BY INCREASING THEIR SKILLS AND IMPROVING RESIDENT QUALITY OF CARE.

The current landscape of LTC reveals that many organizations manage their workforce independently. Smaller organizations have less access to qualified health staff due to financial, geographical, or human-resource issues. When LTC facilities lack access to qualified health professionals (e.g., physicians, nurses, allied health providers), quality of care is affected. As a result, the workforce needed to support LTC residents is fragmented and often inequitable across the sector.

Optimizing capacity and knowledge is about harnessing and developing resources—human, organizational, and community—to increase the skills of the care team and improve the quality of care. The Nova Scotia Long Term Care Pressure Injury Prevention Strategy (2018) outlined critical steps to achieving this goal in the area of wound care. In addition, the strategy suggested that the concept of capacity building involves more than improving an individual worker's knowledge and skills; it also involves partnerships across multiple disciplines, supported by policy to ensure the sustainability of these skills.

Primary healthcare provides the right care, by the right person, in the right place[5]. Changes in health status cannot always be predicted; therefore, 24-hour oversight in LTC is required. For a younger population, travelling to the emergency room (ER) may be a viable option; however, changes in environment and travel are well known to have detrimental effects on the frail elderly. Providing consistent and equitable access to primary care in LTC will improve residents' quality of care and potentially reduce unnecessary ER transfers.

It is recognized that the implementation of this recommendation can build upon previous reports, such as the Nova Scotia Long Term Care Pressure Injury Prevention Strategy (2018), but some suggestions will take time and careful consideration. Specifically, the panel has identified three actions to advance this recommendation in the short- and medium-term.

SHORT-TERM (February, 2019 – July 2019)

3.1 Implement the recommendations from the Nova Scotia Long Term Care Pressure Injury Prevention Strategy (2018).

In the spring and summer of 2018, significant staff and consultant resources were invested in the development of a Wound Care Strategy for Nova Scotia. Two outcomes are expected from the implementation of the guidelines developed by the strategy: 1) the sector will build capacity and knowledge concerning pressure injury prevention and management to improve resident outcomes; 2) as a result of building on local knowledge, we will increase the sustainability of evidence-based practices. Such investments are not without challenges. We need to develop wound care specialists in each zone or region and enable a "train the trainer" model (Action 3.3) with the ability to expand the program to all point-of-care staff on local care teams. Moreover, such building of local knowledge bases (or hubs—see Action 5.2) will further increase the sustainability of evidence-based practices.

The NS DHW responded to the reports of increased pressure injuries in LTC. The Nova Scotia Long Term Care Pressure Injury Prevention Strategy (2018) Phase 1 was initiated, and staff requested additional training and resources to prevent and manage further wounds. The report offered several recommendations to improve outcomes. We fully endorse these recommendations and support their full implementation.

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[3] *Primary Health Care (2018). Retrieved from https://novascotia.ca/dhw/primaryhealthcare/)*

3.2 Develop a sector-wide strategy for LTC primary care coverage.

Currently, there is no 24/7 coverage in many RCFs and scattered provider coverage for nursing homes. The recent healthcare collective agreement enables NPs to offer on-call and after-hour services to facilities. This will increase the number of local providers able to provide LTC primary care. Care by Design is available in limited areas of the province. An organized approach to 24/7 coverage for LTC is required. Ideally, this involves local providers (physicians and NPs); however, the option of after-hours provincial on-call providers should be considered. Such a provincial after-hours provider could function similarly to EHS medical oversight.

This approach offers the potential for improving efficiencies in the system, such as in the reduction of healthcare costs for ER visits and ambulance transfer, because of rapid provider response to a health concern. In turn, this approach improves efficiencies by not involving travel time to an ER; reduces facility workload, as transfers to and from ERs increase workload; improves continuity of care, as important information can be lost during transitions; decreases transfers to the ER department for non–emergency visits; and decreases workload of overcrowded ER departments.

We acknowledge that challenges exist in the availability and capacity of local providers to give such coverage, and that the alternative of a non-local provider would result in significant cost. Therefore, we recommend that the DHW develop a model to support access to 24/7 primary care within LTC facilities that is feasible and sustainable.

MEDIUM-TERM (August, 2019 – November 2020)

3.3 Establish a "train the trainer" multidisciplinary bedside program (e.g., wound care) to ensure staff have the practical training needed to observe and respond to resident needs.

This "train the trainer" model can be useful for many LTC skills, such as wound care, use of mobility aids, management of lifts, responsive behaviours, and so on. For example, the increased complexity of care, the decreased mobility of LTC residents, and other factors have led to increased surveillance needed to prevent pressure ulcers and to identify and manage pressure ulcers early, when they are at stage 1. Having a wound specialist available to provide practical training at the bedside will facilitate knowledge transfer to point-of-care staff and increase sustainability. Similarly, a behaviour care specialist could demonstrate best practices when reacting to residents' responsive behaviours. Because not all facilities have access to specialist services, there will be a need to identify the key specialist needed and the services required. Implementation of this cluster of specialists in a community hub model (Action 5.2) will ensure the availability of expertise in each geographical area. We recommend this hands-on specialist training approach be considered for wound care management first and then expanded to other areas of need as determined by sector priorities.

RECOMMENDATION 4:
IMPROVE TRANSITIONS OF CARE FOR RESIDENTS AND THEIR FAMILIES.

Transition of care refers to the transfer of clients to or from various health facilities for the purpose of receiving care from health professionals[6]. Transitioning through the complexities of the healthcare system can be confusing and stressful for anyone. Being in a state of failing mental or physical health and needing to permanently change your address to that of a LTC facility can present one of the greatest difficulties in life. Even with the support of family, loved ones, or the Continuing Care system, this transition can seem insurmountable.

Transition of care can be viewed as the initial admission to a LTC facility (nursing home or residential care facility), whether it be from home or from an inpatient facility (acute care, alternate level of care, rehabilitation services). Transition can also be from one LTC facility to another, transfer for a scheduled appointment with a specialist or diagnostic testing, or transfer to an ER for assessment. Whenever a resident travels to receive care, a transition is taking place.

Care transitions require increased coordination to avoid the loss of critical information needed to ensure resident safety. These transitions increase vulnerability and can negatively affect health outcomes[7]. Throughout the stakeholder engagements we heard from LTC facility staff and management that coordination of the transition process needs to be improved.

Improved transition to and from the LTC facility can improve health outcomes and staff satisfaction. Currently, residents are arriving for admission to the facility without all the necessary information or equipment needed to support their care. No formalized transition package is in place to ensure all required documentation follows the resident. The continuing care package is available; however, this does not include the most current clinical information.

The current system does not allow for specialized equipment to be ordered prior to admission to the facility. Residents arriving require assessment for this equipment, and the assessment may take a few weeks to complete, with another few weeks for the equipment to arrive. Clients can experience declining health while waiting for the equipment needed to provide quality care.

As the complexities of a resident's condition heighten, responsive behaviours can occur. Not all residents are able to transition to or stay in a LTC facility, due to such behaviours. The acute care system is burdened and not ideal for persons with dementia or responsive behaviours. The current landscape in Nova Scotia has limited specialized units for residents requiring unique

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[6] *World Health Organization. (2016).* Transitions of Care: Technical Series on Safer Primary Care. *Retrieved from http://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf;jsessionid=31C01391DC1146F043EF12E13F95922D?sequence=1*

[7] *World Health Organization. (2016).*

interventions. More specialized units for responsive behaviours would alleviate pressures in both acute and long term care settings, allowing the residents to obtain appropriate primary care services in controlled settings.

Transitions to and from LTC involve all three systemic themes that emerged during our engagements—specifically, the increased complexity of care, the cultural perception that LTC facilities are undesirable, and the fragmentation of the system. It is recognized that the implementation of this recommendation will take time and that careful consideration is required to understand the impacts to residents and the LTC sector, as well as to the broader health system and the wider community. Specifically, the panel has identified four actions to advance this recommendation in the short- and medium-term.

SHORT-TERM (February, 2019 – July 2019)

4.1 Develop and implement a communication campaign to raise public awareness about access to, and the important role of, long term care facilities.

LTC facilities are rarely accessed by the public until a relative or friend moves into one. Thus, people have limited understanding of the admission process, the transition period, the roles of staff, family, and others, and where to go for assistance. An orientation package for applicants and their families, explaining these roles and responsibilities, would greatly improve this transition period. Both DHW and NSHA have websites with up-to-date information; however, many waiting-list residents and their families would benefit from a pre-admission visit and an orientation package. We recommend a comprehensive orientation package and offer of a pre-admission visit become requirements across the LTC sector.

MEDIUM-TERM (August, 2019 – November 2020)

4.2 Plan appropriately for transition to and navigation in accessing LTC facilities.

Seamless transition into LTC will improve resident quality of care while decreasing staff workload. Assessments and resources need to be completed and plans developed to ensure the resident's care plan can be implemented upon LTC admission. Many in the sector called for a LTC navigator; however, we believe (and this has been verified through NSHA and DHW internal consultations) that this navigation role is best placed with the Continuing Care Coordinator for new residents entering the system, rather than introducing another person into an already fragmented process.

4.2.1 Enhance and improve the navigation role Continuing Care Coordinators play to enable a smooth transition of the individual's current care plan from community or discharge plan from hospital when it is a new admission to LTC. It is important facilities have the equipment, diagnostic information, and prescriptions required upon admission of new residents.

4.2.2 Better discharge planning needs to happen between hospitals and LTC facilities for residents once their hospital stay is completed. It is important facilities have the equipment, diagnostic information, and prescriptions required upon re-admission of existing residents.

4.2.3 Utilize the existing provincial transfer tool for residents transferring from a hospital or health centre to a LTC facility or between LTC facilities. It is important that facilities have the equipment, diagnostic information, and prescriptions required upon (re)admission of residents.

4.2.4 Implement a LTC Transition and Communication Package to improve the care of residents upon (re) entry to the LTC facility. This package should highlight all resources and services required to be put in place prior to transfer.

4.3 Establish behavioural management unit(s) in each zone to support residents experiencing responsive behaviours.

Having access to Behavioural Management Units is a major concern in all zones, and evidence of the need is identified in the *NSHRF Literature Review* and in the *NS Mental Health Strategy*. Following our deliberations and research of literature, we recommend having a minimum of one behavioural unit in each zone. Residents could be admitted to and become stabilized within the unit and then transition to the LTC facility. Having access to a specialized unit may encourage facilities to accept certain applicants, knowing that they will have access to professional specialized care if it is needed. We recommend that behavioural management unit(s) be developed and implemented in each zone to support residents experiencing responsive behaviours and LTC facilities to have greater access to specialized support when needed.

RECOMMENDATION 5:
IMPROVE SYSTEM PERFORMANCE AND OPTIMIZATION.

The LTC sector across Canada is viewed as the "poor cousin in healthcare." At the core of this negativity is ageism and an inherent devaluing of the people who live in LTC facilities and by extension their caregivers. This culture of negativity stems from populist attitudes of population aging as a burden, without a recognition of the contributions that older people have made

to our society. Similarly, the public and even professional groups and their representatives lack understanding of the special skills needed to support the complexities of individuals with multiple chronic diseases and living with varying levels of cognitive impairment and dementia in LTC.

This societal attitude and perspective, coupled with the aforementioned increasing complexity of residents and fragmentation across the sector, has reached a tipping point that requires a holistic system approach to lead and manage the system more effectively for the residents and families it serves.

To improve system performance and optimization, access to data to measure performance outcomes is needed. We know our NS LTC system lags behind other provinces in collection of resident data to monitor clinical indicators but the recent announcement of the InterRAI LTCF assessment is a step forward.

The HFSC Act was last updated in 1989—now 3 decades ago. While government policies and regulations have continued to be improved, there is a need to "crack open the act" and update the language and vision to one that is person-centred and addresses the inconsistencies in access to services, such as those of Allied Health, and inequities in funding allocations. As we have heard over and over again, the health and physical and cognitive capacity of newly admitted residents differs significantly even from just 5-10 years ago. This complexity impacts many aspects of the LTC system and generates need for enhanced behavioural management, improved infrastructure to support electronic filing, advanced assistive devices and equipment to better support, monitor, and enhance residents' quality of life, better system performance measures, and targeted outcomes for facilities within the sector.

It is recognized that systems do not change overnight, that improvement of system performance and optimization will take time, and that careful consideration is required to understand the impacts to residents and the LTC sector as a whole. Specifically, the panel has identified seven actions to advance this recommendation in the short-, medium-, and long-term.

SHORT-TERM (February, 2019 – July 2019)

5.1 Establish a temporary arms-length committee to continue the dialogue concerning models and best practices to improve LTC and reduce fragmentation.

Given the negative media reports and the challenges regarding workforce physical and mental health, public confidence in the quality of care provided to LTC residents may be declining. The LTC system is complex, fragmented, and in need of a major shift. The NSHA is responsible for delivering the services, or the operational component, of LTC (e.g., assessment for eligibility, contracts with providers, and performance indicators), while the DHW is responsible for policy direction, funding, ensuring compliance with licencing, and investigating claims under the Protection of Persons in Care Act. LTC

providers expressed frustration when NSHA requires one course of action and a DHW branch or body, such as licencing, requires an opposing course of action. The sector also expressed frustration when NSHA and DHW fail to include organizations, such as CCANS/CGO and HANS Continuing Care Council (representing 95 per cent of facilities), in dialogue about the best practices in the sector. In order to improve accountability and enhance the public's confidence, we recommend that a model be considered as an arms-length entity from government to monitor the LTC system.

MEDIUM-TERM (August, 2019 – November 2020)

5.2 Consider establishing a "hub of community care" to optimize and mobilize resources from across the continuum of care within a region.

This hub of community care would house practitioners, such as social workers, mental health professionals, wound specialists, and allied health providers, to develop collaboration practices out-of-hospital and support optimal care within a geographical area. The physical location of the hub may be in one facility, but its goal would be to provide services to other LTC facilities in the geographical region, as well as to local clients of the homecare program. The collaborative practice would enable smaller LTC and RCF facilities to share resources, in effect collectively creating a full-time position in an allied health service, for example. Additionally, this hub builds on Action 3.3, providing opportunities for transfer of skills to the care team at the point of care. For example, a wound care management specialist would support care teams and also be available to homecare clients needing specialist support. This approach of pooling local experts in various disciplines would result in greater consistency and sustainability. We realize that this proposed recommendation will take a significant amount of needs assessment, human resource planning, and system planning prior to implementation. As we ponder the future needs of continuing care services, though, new thinking about how to share limited resources will be essential to meet the needs of residents in communities varying in size. We recommend that a model hub of community care be developed and piloted to evaluate the feasibility of this approach.

5.3 Investigate the use of RCF facilities by repurposing vacant licenced beds to provide convalescent and rehabilitation care.

Many people spoke about the need to reduce time spent in hospital awaiting a LTC bed and the need to invest in rehabilitation services to improve mobility. These needs accompany the reality that success of the homecare program has resulted in fewer people entering RCFs. These licenced vacant beds provide an opportunity to adapt the RCF environment in order to address the need to provide convalescent or rehabilitation

care in LTC and out-of-hospital settings. Having at least one unit of convalescent/rehabilitation care per NSHA zone would improve patient flow out of acute care facilities and increase resident satisfaction. Such actions are contingent on other proposed actions, such as establishing a minimum of one full-time LPN per RCF for clinical leadership (Action 1.2); increased utilization of allied health providers (Action 1.4 and 5.2); and increased utilization of primary care providers to assist with transitions (Action 3.2 and 4.2). In some cases facilities may need modest renovations to support the new type of resident. We recommend the development of a pilot project in partnership with an interested RCF to assess the utility and potential effectiveness of such an approach.

5.4 Dedicate space and specialized programming specifically for young adults.

There is an abundance of literature outlining the risks of housing young adults in the general LTC population. LTC facilities were not constructed for young adults focusing on maintaining their independence. Young adults with limited mobility may require a nursing home for nursing services; however, their physical, psychological, and educational needs differ from the majority of older residents, many of whom have dementia. We recommend revisiting the Continuing Care Strategy to implement dedicated space for young adults requiring long term care services.

5.5 Acquire better data and information to drive system action and decision making.

One of the pervasive and fundamental challenges facing our LTC system is having insufficient data to understand resident clinical-care needs and quality-of-care indicators, electronic records of medications, and healthcare utilization to support system planning and workforce planning. It is promising that the DHW has awarded an RFP to implement the InterRAI LTCF, an internationally recognized and validated assessment for LTC. This assessment involves quarterly assessments of residents to inform care planning, quality indicators, and resource utilization groupings (RUGS) that can be used for resource allocation. These data will be critical to understand complexities across LTC facilities and developing a funding model that is supported by an equitable model of resource allocation. Such an endeavour will take 24 months to implement.

While waiting for these LTCF data, the MDS–HC (an assessment tool to determine Resource Utilization Groups [RUGS] for homecare and eligibility for LTC) may offer a cursory assessment of changes in resource needs, cognitive and functional capacity, and level of complexities for newly admitted residents. We acknowledge there may be limitations to the acquired data; however, the MDS-HC would provide an indication of the changes over time and the preliminary evidence of the need for staff mix and staff ratios to change.

5.5.1 In the short term, we recommend increased use of existing data, such as that of the MDS-HC, to track the assessed care needs, behavioural challenges, and levels of complexity of new admissions to LTC, in order to obtain a better snapshot of residents who are entering LTC.

5.5.2 In the medium and longer term, a performance measurement of successful clinical outcomes for LTC should be developed, monitored, and reported publically to increase transparency and accountability across the sector. Such endeavours involve investing in capacity building within DHW and in university partnerships to train a cadre of analytical specialists in LTC.

5.5.3 In the long term the clinical outcomes will provide a better indication of the complexity of care and the evidence needed to support staff mix and potentially increase staffing ratios. We recommend monitoring these data to support decision making in resource allocation.

5.5.4 In the long term, we recommend that the InterRAI LTCF assessment data be analyzed to ensure LTC facilities are funded to support changes in resident care needs over time.

We acknowledge that data measuring resident clinical outcomes is one piece of the data puzzle. Long term strategic planning in the area of data management should also include resident electronic health records and an electronic medication administration system, as well as data from the proposed mandatory registry of CCAs to support system planning and workforce planning.

LONG TERM (Dec 2020 - onward)

5.6 Invest in equipment and technology to ensure safety and security for residents and staff.

Technological advancements are all around us and ever changing, making it difficult to make choices. What is known is that technological upgrades in computer databases will be necessary as part of the InterRAI LTCF assessment implementation and other data needs as outlined above (Action 5.5).

Two actions in the medium term have been identified: 1) the need for investment in technology and equipment that serves multiple populations (LTC residents), including homecare clients as part of the community hub model (Action 5.2); 2) addressing lag time in equipment refit during the transition from hospital to LTC (part of Action 4.2).

We also need to consider investing in technology and innovation to assist with better monitoring and responsiveness to residents' needs. For example, within wound care management, electronic sensors that assist in the monitoring of a resident's movements can be used to raise alarms about pending skin breakdown. Proactively responding to residents' needs will decrease negative health outcomes and decrease need for primary care services. Such technology should go hand in hand with investments of human resources, for otherwise the capacity to react to monitoring devices will be limited.

We recommend ongoing evaluation and assessment of new technology and its potential utility for improving resident quality of care and of life, supporting the workforce to provide the best care, and improving system accountability and reducing fragmentation in the sector.

5.7 Review and modernize legislation and "crack the act."

A long-range vision and strategy for continuing care that informs strategic planning should include modernizing legislation of the three-decade-old Homes for Special Care Act. A number of positive outcomes could be achieved by this approach: 1) the opportunity to create a vision for the future; 2) improved morale and pride among staff in the sector; 3) increased confidence in the transparency and accountability of the sector; 4) the opportunity to make LTC a specialty. Such an undertaking must involve in the dialogue for change the many people who contributed to these recommendations (residents and their families, staff and their representatives, and sector administrators, as well as representative organizations). This is a lofty recommendation and we realize it is unlikely to be achievable in the next two years. However, given the number of times that it was mentioned in our consultations we would be remiss not to recommend that the government consider this review and invest in significant modernization of the legislation.

KEY SUCCESS FACTORS

A number of factors are critical for successful implementation of these recommended actions, including the following:

DATA TO PROVIDE EVIDENCE OF CHANGE IS ESSENTIAL. Capacity to effectively utilize and analyze these data for decision-making purposes is equally important. All of these recommendations will require effective monitoring and data analysis to demonstrate improvements.

UNDERSTANDING THE CONTEXT OF LTC. In recent years, many of the continuing care policies and operations have focused on improving homecare services. The program's success in enabling people to remain in their homes has resulted in a ripple effect in other areas in the system. Examples include the increased complexity of care in recent admissions, the vacant number of beds in RCF facilities, greater opportunities for CCAs in homecare, and so on. We understand the challenges that people in the community face when they eventually need homecare, and we agree in principle with the proposed changes to the placement policy, which prioritizes the needs of the client, including client health status, level of dementia, and caregiver availability, as well as length of time on the waiting list. We want to reiterate that the recommendations and investments in LTC are critical to the success of the sector. Putting higher-need residents into LTC without such investments in human resources in the system will be untenable.

A PERSON-CENTRED OR RELATION-CENTRED APPROACH MATTERS. The philosophy of person-centred care is foundational to a resident's quality of life in LTC. We know that a resident's quality of life is interwoven with the staff's quality of work life. Indeed, LTC's greatest asset is its people. Consequently, investment in the workforce is needed to support the capacity of the system to continue to provide person-centred care for residents.

NO WAITING FOR PERFECTION. We know that the sector needs more evidence, more data, and more investments, but we cannot wait until we have all the details before action is taken. In our ambitious time frame, our expert panel has not addressed many of the important details that we heard during our consultations, such as the unique needs of aboriginal peoples in LTC; the increasing need for respite for highly complex children; the importance of cultural sensitivity concerning food, care delivery, and activities for residents; the many facets of food and nutritional care; and the importance of oral health—to name just a few. We believe we have provided some guidance on ways to get the LTC sector on an improved trajectory, and we hope that these recommendations are given serious consideration.

CLOSING STATEMENT

In closing, we sincerely thank all of the residents, their families, and the stakeholders who took the time to passionately share their stories and ideas over the past few months. Your valued perspectives and insights have been foundational in helping us understand more deeply the challenges facing the sector.

While these recommendations do not outline a blueprint for change, our hope is that they provide a framework and starting place to build momentum that will drive forward system-wide change necessary to transform the LTC sector.

We, like so many of the stakeholders we engaged, feel invested in this cause and desire to see these recommendations acted upon. Again, thank you for the opportunity to contribute to this important work. It is our hope that the recommendations outlined here, many of which have been previously suggested in other LTC reports, will provide important first steps to improving conditions in LTC to the benefit of both residents and workers.

APPENDIX A

GLOSSARY OF TERMS

Allied Health includes physiotherapy, occupational therapy, physiotherapy and occupational therapy assistants, behavioural therapy, music therapy, therapeutic recreation or assistance, etc.

The **interRAI Long Term Care Facilities Assessment System** (interRAI LTCF) enables comprehensive, standardized evaluation of the needs, strengths, and preferences of persons living in chronic care and nursing home institutional settings. Retrieved from http://www.interrai.org/long term-care-facilities.html

Long Term Care (LTC) facilities are publicly-funded, licenced care facilities and include Residential Care Facilities (RCFs) and Nursing Homes (NH). The expert panel also considered the impact of Alternative Level of Care units on LTC facilities in their review.

MDS-HC – Minimum Data Set for Home Care is an assessment tool from the interRAI suites of tools that informs and guides comprehensive care and service planning. In Nova Scotia it is used to assess clients' level of service needs for the Provincial Home Care Program and eligibility for admission to a LTC facility.

Person-centred care is derived from the idea of a resident's right to self-determination and choice; it entails that the resident be the centre of all arrangements, including care and decision-making, and it has been viewed as a solution to overly medicalized approaches to care (Rockwell, 2012).

Primary healthcare refers to a patient's first point of contact with the healthcare system. For many people, that first contact is with a family doctor, but there are other ways to access that care. By increasing access to teams of healthcare providers, which could include doctors, nurses, social workers, mental health professionals and others, patients will be able to see the right health professionals at the right time. A more collaborative approach is better for doctors, who will have more support and balance. It is better for nurses and other healthcare professionals, who can work to their full scope of practice. And it is better for Nova Scotians. Retrieved from https://novascotia.ca/dhw/primaryhealthcare/

Quality of care means providing care to residents at the right time, in the right place, and by the right provider in a safe and affordable manner. Such care encompasses clinical, social, psychological, and spiritual needs and is influenced by quality of working conditions, quality of life, and quality of end-of-life.

RCFs, or residential care facilities, provide people with personal care, supervision, and accommodation in a safe and supportive environment. (People living in residential care facilities must be able to evacuate the facilities independently in the event of an emergency.)

Staff refers to individuals employed or contracted to provide a core set of care services to LTC residents.

Staffing mix refers to the proportion of different categories (RN, LPN, CCA) of healthcare personnel involved in the provision of direct care to residents of LTC facilities.

Stakeholders include residents and their families, LTC staff and service delivery personnel (including members of unions, training personnel, and those of provincial organizations), LTC sector organizations and representatives, and NSHA and NS government representatives. Stakeholder acronyms used in this report include:

ACE — Advocacy for Care of the Elderly
CCANS — Community Care Association of Nova Scotia
CGO — Community Governed Organization in Long Term Care
DHW — Department of Health and Wellness
HANS — Health Association of Nova Scotia
NSHA — Nova Scotia Health Authority
NSHRF – Nova Scotia Health Research Foundation

APPENDIX B

INPUTS AND SOURCE DOCUMENTS

We would like to acknowledge the diversity of sources received, including written documents from many stakeholders—unions, staff, residents and their family members, and advocacy organizations. These included poignant experiences and practical suggestions from many personal and unsolicited documents and emails from family members and care providers.

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We also acknowledge and have used submissions from the following stakeholders:

Advocacy Care for the Elderly
Continuing Care Branch NSHA and DHW (internal documents)
Canadian Union of Public Employees
Families for Quality Eldercare
HANS, CGO and CCANS, (joint presentation)
Geriatric Psychiatry
IWK Health Centre- Children's Medical Critical and Rehabilitation
Nova Scotia Dietitians Continuing Care Action Group
Nova Scotia Nurses Union
Nova Scotia Union of Public Employees
Recreation Association of NS
Quality Council NSHA Advisory Committee
Shannex Incorporated
UNIFOR