

Timely Yet Long Overdue: Canadian Standards for Long-Term Care Homes

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<https://doi.org/10.5770/cgj.27.706>

ABSTRACT

The impact of the COVID-19 pandemic highlighted systemic problems in Canadian long-term care (LTC). While high mortality rates in LTC received significant attention, the pandemic also took an enormous toll on mental health of LTC residents, where mental health conditions, including cognitive disorders, are already much higher than in other community settings. The pandemic resulted in a renewed interest in improving quality of care in LTC and led to the recent development of several National Standards of Canada. The newly available Standards set ambitious targets, but many of the standards are practical and essential to moving beyond a focus on safety and physical needs in LTC and towards one that supports residents as whole persons. While the standards support good mental health indirectly, there is a need to recognize mental health in these settings as a fundamental human right and essential to quality of life, and for this to be reflected in ongoing and future standards development. Ensuring existing and forthcoming National Standards are meaningfully implemented, in whole or in part, will require extensive efforts at multiple levels. The guidance provided by Canadian Standards will shape this transformative process, necessitating aligned federal and provincial investments and policies, and stakeholder engagement to bring about the envisioned high-quality care.

Key words: mental health, mental health care, residential care, aging care, quality of care, quality of life, human rights

The COVID-19 pandemic highlighted systemic problems facing older adults in long-term care (LTC) and emphasized the need to recognize mental health in these settings as a

fundamental human right.⁽¹⁾ Reporting on COVID-19 in LTC was largely focused on mortality, while the impact on quality of care and mental health received relatively less attention.⁽²⁻⁴⁾ Amid an already high pre-pandemic risk of mental health conditions, LTC residents experienced social isolation, contributing to increases in depression and anxiety.^(2,3,5) Those with existing and new mental health conditions faced a worsening of already poor access to mental health services.⁽⁶⁾ Anecdotally, accelerated declines in cognition and function were observed among residents with dementia, though evidence on cognitive decline is mixed.^(4,7,8) However, few national and international recommendations on care in LTC during the pandemic addressed the critical aspects of mental health and psychosocial disability.⁽⁹⁾ Stigma and discrimination based on age (ageism), mental health conditions (mentalism), and disability (ableism) contributed to many of the broader issues in LTC exposed by the pandemic.⁽¹⁰⁻¹²⁾

Fortunately, there is renewed interest in improving care in LTC. In the wake of the pandemic, several National Standards have emerged or are under development; for example, Health Standards Organization (HSO) 21001 *Long-Term Care Services*,⁽¹³⁾ and Canadian Standards Association (CSA Group) Z8004 *Long-Term Care Home Operations and Infection Prevention and Control*⁽¹⁴⁾ were published in 2023 and 2022, respectively. CSA Z2004 *Mental Health and Well-Being in Long-Term Care and Assisted Living Settings* is in development, with anticipated publication in mid-2024.

Standards establish a level of expected performance consistent with best practices and are a foundation for public policy.⁽¹³⁾ HSO 21001 and CSA Z8004 are intended to be complementary and were developed by stakeholders with public input. HSO 21001 addresses care delivery, while

CSA Z8004 focuses on design and operations, encompassing aspects of care beyond infection control such as organizational culture and resident activities. Both use person-centred care as a core principle, and both emphasize that care in LTC should support quality of life, in addition to physical health and safety. They acknowledge the importance of the health of the workforce in the provision of high-quality, comprehensive care, and underscore the need for data collection for quality monitoring and improvement. The HSO LTC Services Standard additionally provides specific guidance for organizational leadership on incorporating equity, diversity, and inclusion practices and cultural awareness in LTC and on engaging care partners.

Mental Health in LTC

While several of the standards within HSO 21001 and CSA Z8004 support good mental health indirectly, they do not directly address care provision for the significant mental health needs in LTC. Mental health disorders are common among LTC residents, where approximately 40% of residents have a psychiatric need.^(6,15) The prevalence of major depression is 10%, while depressive symptoms are much more common, affecting nearly half (44%) of all residents.^(6,16,17) The prevalence of serious mental illness (SMI), including schizophrenia and bipolar disorder, already higher in LTC than among similarly aged populations in other community settings, is increasing, driven by accelerated cognitive, functional decline, and higher rates of medical comorbidity in SMI.⁽¹⁸⁾ (For example, middle aged individuals with schizophrenia are nearly four times more likely to be admitted to LTC).^(6,19) Despite the great need, mental health care in LTC is often inadequate or inequitable.^(6,19,20)

In LTC settings as elsewhere, mental health is not a binary state defined by the absence or presence of a mental health condition. Rather, mental health is fluid and exists along a continuum, ranging from optimal states of well-being to mental illness at each extreme, with diverse factors that may influence any individual's position on the continuum.^(21,22) Mental health care is thus care that addresses the spectrum of needs, including treatment for mental health conditions, but also the promotion of mental well-being and prevention of illness, and is fundamental for all LTC residents.⁽²¹⁾ To this end, the forthcoming *CSA Z2004 National Standard for Mental Health and Well-Being in Long-Term Care and Assisted Living Settings* will bridge the gap in existing Standards to guide high-quality care that supports resident mental health in LTC. Notably, CSA Z2004 will extend to Assisted Living (AL) settings (also known as retirement homes and supported living), where older adults increasingly reside and where rates of mental health conditions are less studied but likely similar or higher than in LTC.⁽²⁰⁾

The Canadian Academy of Geriatric Psychiatry (CAGP) and the Canadian Coalition for Seniors' Mental Health (CCSMH) previously called for mental health care in LTC to be an essential service in the context of pandemic restrictions, and outlined eight key considerations to optimize the mental

health of LTC residents and workers during the pandemic.⁽⁹⁾ Considering the current and growing mental health needs in this population, we reiterate and extend our call-to-action, post-pandemic. Mental health symptoms or conditions are the rule and not the exception among LTC residents—good mental health and mental health care must become priorities in aging care settings.⁽¹⁵⁾

Adopting and Sustaining National LTC Standards

The development of standards is a new opportunity to focus improvement efforts on high quality care, including mental health care, in LTC. The available Standards set ambitious targets but many of the standards within them are practical, basic, and essential to moving beyond a focus on safety and physical needs in LTC and AL, and towards one that supports residents as whole persons. Ensuring existing and forthcoming Standards are meaningfully implemented, in whole or in part, will require support and uptake at multiple levels: stakeholder, including LTC leadership, workforce and health-care providers; consumers (the public, LTC residents and care partners); and, government and jurisdictional authorities.⁽¹³⁾

Federal and provincial government initiatives and public funding models must enable high quality care. One-time investments and dedicated budget funding in 2021⁽²³⁾ are welcome and signal that improving LTC is a national priority. However, legislative change to enable federal government funding for residential care within the Canada Health Act (LTC is not currently an insured health-care service under the Act), or distinct federal legislation, such as the proposed Safe LTC Act,⁽²³⁾ would support consistent investment and oversight necessary to standardize high quality of care across the country.⁽²⁴⁾ This is particularly important in the context of a shift towards for-profit aging care in Canada, and widely varying home ownership (i.e., public vs. private) across provinces.⁽²⁵⁾ Consistent funding is also necessary to ensure equitable access to LTC. Out-of-pocket expenses to residents also differ considerably from province to province,^(24,26) and are at odds with the Canada Health Act's primary objective to facilitate access to health-care services without financial or other barriers.⁽²⁷⁾ Provinces cannot rely on federal funding alone and must also invest improving aging care. Funding and accreditation can then be tied to national benchmarks based on available Standards and be used to promote consistency across settings.

Funding will support the necessary resources, especially staffing,⁽²⁸⁾ to promote high quality care in LTC, but must be paired with consistent minimum staffing levels (including time for both direct and indirect care) across provinces.⁽²⁶⁾ An adequate and skilled workforce depends both on recruitment of well-trained workers and retention via satisfactory working conditions. Many recommendations have already been outlined on how to achieve this.⁽²⁹⁻³¹⁾ Given the prevalence of mental health needs in LTC, there may also be a need in the future for dedicated LTC mental health staff, and basic staff education and training in mental health is essential for all LTC workers. The concept of the Teaching Nursing Home,

adopted in countries such as Norway and the Netherlands and more recently in Ontario, can enhance education and capacity building in LTC.⁽³²⁾ Innovative approaches that leverage limited specialized resources across homes (e.g., Behavioural Supports Ontario), remotely delivered care⁽³³⁾ and shared care models, will likely be required to ensure access to mental health resources for residents who need them.

Transparent data collection and reporting of quality of care in LTC is essential to monitoring efforts to implement National Standards. Necessary data collection will involve increasing the currently limited performance measures tracked and reported in LTC to encompass those that generally support high quality care (e.g., staffing indicators such as staffing mix and staff to resident ratio),⁽²⁹⁾ as well as developing measurable quality indicators that align with key standards. The latter includes developing processes for measuring and monitoring mental health and quality of life in the same way as physical health. Expanding measurement and reporting of quality of care in LTC, for both physical and mental health care, will enable mechanisms to support compliance and oversight with key standards, and provide accountability to residents, care partners, and the public. Broadening quality monitoring to other aging care settings, such as AL, is also needed, as they increasingly provide care for older residents with complex needs.

Geriatric health care providers share responsibility for adopting and maintaining the Standards in LTC. Organizations (such as the CAGP, CCSMH, and the Canadian Geriatrics Society) can play an important role in dissemination of the Standards, advocating for implementation, and providing educational opportunities that support capacity enhancement and training needs (e.g., via the ECHO and Brain Exchange networks). Organizational change that supports a culture where adoption of the Standards is possible, and change that prioritizes the whole person in the tangible ways outlined in these Standards will fall to LTC leadership and its workforce.

Finally, inherent to all of the above are two fundamental paradigm shifts: first, increasing the value placed on aging care in Canada; and two, shaping aging care and settings to support quality of life, including both physical health and mental health.⁽²¹⁾ Ongoing commitment at the federal and provincial levels contribute to both by communicating the significance of these issues to Canadians and providing the necessary regulatory framework that will support standardization of high-quality care.

While Canadian Standards for high-quality, person-centred care mark an encouraging initial step towards addressing pandemic-exposed deficiencies in LTC, mental health must be integrated into the person-centred roadmap for LTC and AL to ensure the protection of human rights of older individuals living in these settings.⁽¹²⁾ Ongoing development of National Standards must incorporate mental health and well-being. Achieving meaningful improvements in care necessitates extensive efforts at stakeholder and health system levels to ensure the adoption and effective implementation of existing and forthcoming Standards. The guidance provided

by Canadian National Standards for LTC and AL will shape this transformative process, requiring aligned investments, policies, and engagement to bring about the envisioned high-quality care.

ACKNOWLEDGEMENTS

Not applicable.

CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal's* policy on conflicts of interest disclosure and declare the following interests: JK is the Chair of CSA Z2004 Mental Health and Well-Being in Long-Term Care and Assisted Living Technical Subcommittee. Other authors declare that they have no conflicts of interest to declare.

FUNDING

This research did not receive external funding.

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