McMaster University | Health Forum

Evidence Brief

Building capacity in Ontario's long-term care sector to safeguard residents' well-being during infectious disease outbreaks

17 & 18 November 2025

Context for the brief

Within Ontario's health system, the long-term care (LTC) sector is unique, given LTC homes serve as both residents' primary place of residence and a setting in which they receive care. LTC is also a broad and diverse sector, with close to 76,000 resident spaces spread across 609 licensed LTC homes in the province.(1) These homes are made up of a mix of publicly and privately owned organizations, the latter of which include both for-profit and not-for-profit organizations.

Residents of LTC homes are typically older and include people living with multiple health conditions who have complex physical, mental and social needs that are unique to the sector. Data from the Ontario Long Term Care Association indicate that three out of four residents entering LTC homes have three or more medical needs (such as arthritis, cardiovascular disease, dementia, diabetes and hypertension). The decline in immune response associated with ageing in general, coupled with the prevalence of comorbid conditions, makes LTC residents particularly vulnerable in the face of outbreaks of infectious diseases.(1) Despite this being an issue the sector has always faced, many Ontarians only became aware of it during the COVID-19 pandemic, when over 80% of COVID-19 deaths during the first pandemic wave occurred in LTC homes across Canada, with Ontario-specific estimates suggesting that among adults over the age of 69, those living in LTC homes experienced 13 times the number of deaths compared to those of the same age living in the community.(2; 3)

Box 1: Approach and supporting materials

This document was prepared to inform a stakeholder dialogue, which provides individuals – specifically those who will be involved in or affected by decisions about a topic – with an opportunity to deliberate about the problem and its causes, elements of an approach for addressing it, key implementation considerations, and next steps for different constituencies. A separate document contains eight appendices:

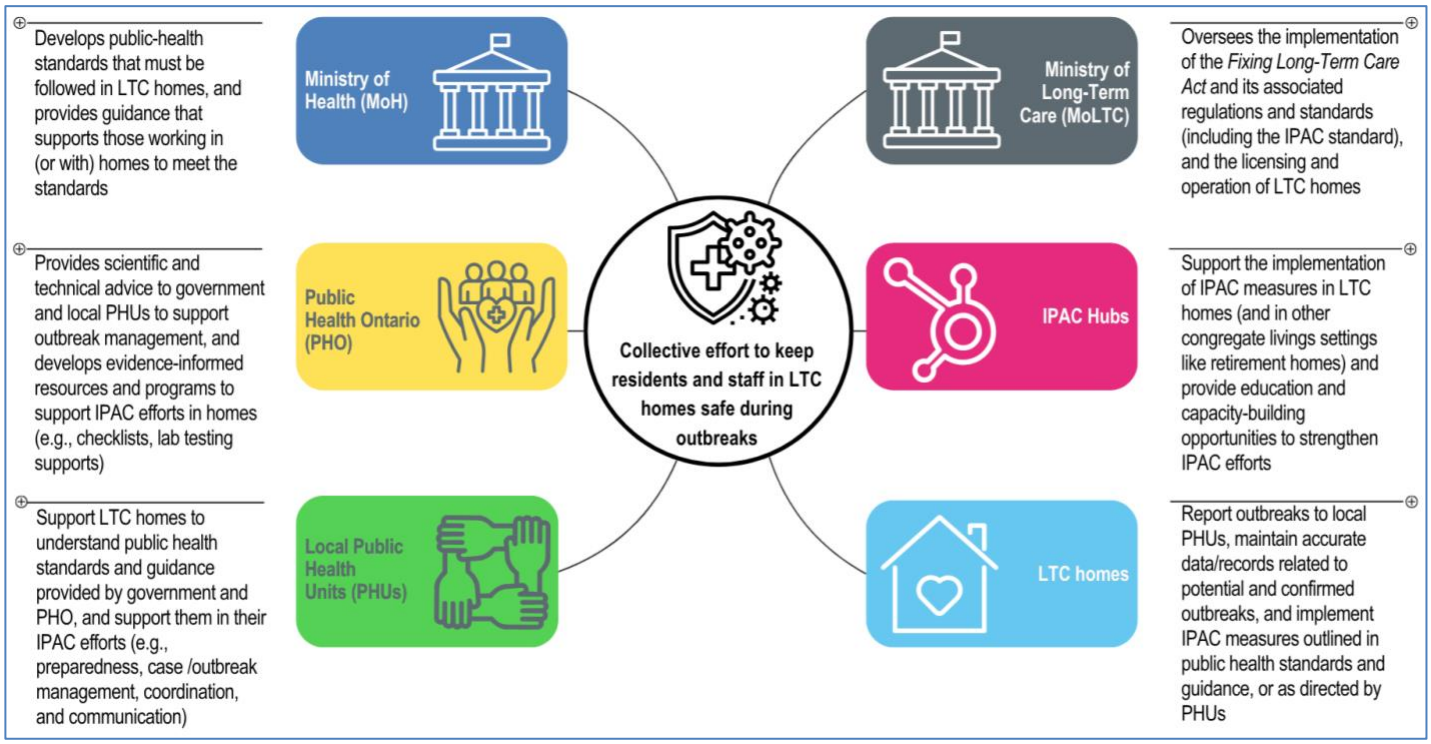
1. background to and methods used to prepare evidence brief
2. evidence syntheses relevant to building stronger implementation supports (element 1)
3. single studies relevant to building stronger implementation supports (element 1)
4. evidence syntheses relevant to co-developing context-specific responses to disease outbreaks (element 2)
5. single studies relevant to co-developing context-specific responses to disease outbreaks (element 2)
6. evidence syntheses relevant to strengthening capacity for evidence support (element 3)
7. single studies relevant to strengthening capacity for evidence support (element 3)
8. references.

To keep residents, staff and, visitors in LTC homes as safe as possible during disease outbreaks (including during pandemics), infection prevention and control (IPAC) efforts are an important tool to help prevent and mitigate transmission. In Ontario, this was illustrated during the COVID-19 pandemic, when the IPAC efforts used in LTC homes –including mask wearing, testing and screening – were shown to reduce the spread of illness among residents and staff before the widespread roll out of vaccines.(2) Beyond the pandemic, IPAC measures continue to be important for a wide range of diseases of public health significance (DOPHS) and other infectious diseases that pose the greatest risk to residents in LTC, such as: respiratory infections (such as COVID-19 and influenza), gastroenteritis, Clostridioides difficile (often referred to as C. Diff), candida auris, and methicillin-resistant staphylococcus aureus (MRSA).

There are many interest holders with roles to play in helping to keep residents and staff safe in the face of disease outbreaks by developing and implementing IPAC measures (see **Figure 1**). This includes the Ministry of Health (MoH) and the Ministry of Long-Term Care (MoLTC), Crown agencies like Public Health Ontario (PHO), local Public Health Units

(PHUs), IPAC Hubs, LTC home operators and their staff, as well as residents, their caregivers, and their families. While it is a strength to have so many organizations and individuals with 'skin in the game' it can also create coordination and implementation challenges when collective efforts are required.

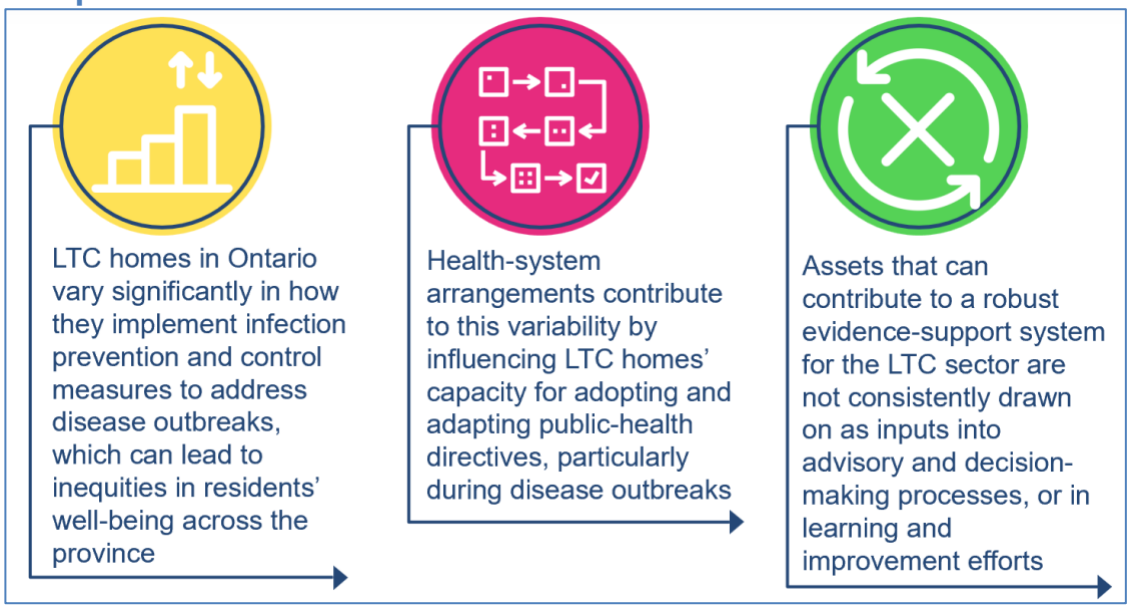
Figure 1: Roles of interest holders in Ontario in collective efforts to keep LTC residents and staff safe during outbreaks



This evidence brief was developed with the aim of informing a deliberative dialogue about building capacity in Ontario's long-term care sector to safeguard residents' well-being during infections disease outbreaks. It draws on the best-available research evidence and insights from key informants to clarify the key problems underpinning the issue, elements of a potentially comprehensive approach for addressing them, and implementation considerations. For each section, we also present insights from a citizen panel we convened on the same topic in advance of the dialogue. The brief builds on insights from studies showing that LTC homes in Ontario varied in their implementation of public health mandates during the COVID-19 pandemic,(4; 5) and was written while acknowledging two key issues:

1) many lessons were learned, and several positive steps were taken to improve LTC during the pandemic (e.g., legislation that mandates homes to adopt ethical frameworks and hire IPAC leads), but opportunities remain to do even better for residents and their families and caregivers, and staff
2) decision-making during emergencies such as the COVID-19 pandemic is different than 'normal times' (i.e., during a typical respiratory outbreak season), but there are structures and processes that represent common ground for improvements.

The problem



LTC homes in Ontario vary significantly in how they implement infection prevention and control measures to address disease outbreaks, which can lead to inequities in residents' well-being across the province

The 609 licensed LTC homes operating across the many unique communities that make up Ontario are diverse. Given this context, it is reasonable to expect differences in how homes operate across the province. However, when considering IPAC measures and outbreaks, certain best practices for preventing or stopping the spread of infections that place residents and staff at risk are well known, and ideally implemented similarly across settings as outlined in the Ontario Public Health Standards, and in checklists prepared by PHO.(6; 7)

Studies conducted during the COVID-19 pandemic have highlighted that this isn't the case: LTC homes can vary significantly in how public-health directives are implemented.(4; 5) For example, in Southeastern Ontario, homes differed in terms of:

- the rules dictating how residents visited with their families and caregivers, with inconsistencies in the types of visits allowed (e.g., in-person indoor visits vs. in-person outdoor visits vs. window visits vs. video visits vs. phone visits)
- the structure of resident activities, with inconsistencies across homes in terms of whether group activities were permitted (vs. only 1:1 activities allowed).

These same studies have also shown that residents' health and well-being (e.g., health instability, depression, cognitive impairment, social engagement, responsive behaviours, and antipsychotic use) varied across different phases of the pandemic, as different public-health directives were 'turned on or off.'

A recent analysis of administrative data from 201 of the 609 LTC homes in Ontario by the Institute for Clinical Evaluative Sciences (ICES)[i] suggests that the inconsistent operationalization of COVID physical distancing requirements (including rules about whether and how residents could participate in social activities, eat together and visit family and friends) across LTC homes is linked to differing levels of social isolation, which has an impact on residents' health outcomes. Specifically, the results of the analysis showed that residents with the highest levels of social connection:

- experienced a 26% reduction in the rate of death (and those with medium levels experiences a 32% reduction in the rate of death) compared to those with lower levels of social connection
- had significantly lower rates of hospitalization compared to residents with lower levels of social connection
- had lower rates of emergency department visits compared to residents with lower levels of social connection.

The findings from this recent analysis align with past studies that showed pandemic restrictions having a negative impact on LTC residents in Ontario, as well as in other jurisdictions globally.(8-12)

Taken together, these insights indicate that the inconsistent implementation of IPAC measures across LTC homes have the potential to create different (and potentially unfair) living situations that can directly affect residents' health and well-being. On the one hand, residents living in homes with stringent adherence to mandates and guidance likely experience less risk of becoming ill from an infectious disease compared to those living in less adherent homes. On the other hand, if some of the IPAC measures introduced have the potential to negatively impact residents' mental health and well-being (e.g., by restriction social connections), these same residents may feel 'worse off' than their counterparts in homes that are less adherent, and ultimately be at a greater risk of death, hospitalization and visits to the emergency department.

At least **two categories of important contextual factors** may help to understand the observed variation across LTC homes in Ontario.

1) **Home operators are diverse,** operating under differing ownership models and profit status, and each serving a unique population across the many communities that make up Ontario. This can contribute to differences in:
   - risk profiles across communities (e.g., urban settings face different challenges at different points in an infectious disease outbreak than those in rural/urban settings) and across individual LTC homes (e.g., homes with a larger concentration of residents living with multiple chronic conditions)
   - capacity for interpreting and implementing public-health directives (which can be particularly challenging during a public-health emergency when information constantly changes), and for making decisions about when to 'turn on and off' different policy options, particularly when guidance allows room for flexibility at the local level.

   Studies from Ontario during the COVID-19 pandemic have helped to illustrate the impact that this contextual diversity can have on things like positivity rates (e.g., higher in Central Ontario compared to Northern Ontario, and in privately owned for-profit homes compared to municipally owned homes).(13)
2) **Home operators must balance reducing risk of transmission with other aspects of residents' overall health and well-being.** For example, removing personal items like family portraits from walls to make things easier to clean may do more harm than good (e.g., by failing to act in ways that respect the fact that these are residents' homes), particularly as risk profiles differ across resident populations and communities.

Health-system arrangements contribute to this variability by influencing LTC homes' capacity for adopting and adapting public-health directives, particularly during disease outbreaks

Contributors to the problem also include a range of health-system governance, financial, and delivery arrangements that shape the LTC sector.

Governance arrangements

There are **three key governance factors** that may be considered when trying to understand why LTC homes vary in how they apply IPAC measures during outbreaks of infectious disease.

1) **Legislative and regulatory frameworks can unintentionally make consistent IPAC implementation difficult** – especially when LTC homes operate in different settings, with different 'on-the-ground' realities.:
   - The *Reopening Ontario Act, 2020* (now repealed) limited staff to working in only one LTC home, which caused staffing shortages in some settings, and financial strain for workers who relied on multiple jobs to earn a living wage.
   - The *Fixing Long-Term Care Act, 2021* introduced stricter licensing rules for IPAC, which meant to improve adherence to standards, but can contribute to certain homes adopting a 'checklist' mindset, where homes focus on meeting targets (like 100% hand hygiene) rather than building flexible, context-specific IPAC strategies. This can be particularly problematic when mandates and guidance have been designed with flexibility in mind.
2) **Top-down directives from centralized decision-makers are not always clear.** Decision-making related to mandated IPAC measures for LTC homes is led by a few key organizations (i.e., MoH, MoLTC, PHUs), providing top-down directives that LTC homes may have found unclear or even conflicting. This is compounded by the fact that guidance and supportive technical documents come from PHO, while IPAC Hubs provide another layer of complementary

resources and information meant to help LTC homes adhere to directives. Insights from key informants added to this point by noting the following:

- LTC homes struggled to identify one clear source of truth, especially during the pandemic
- checklists included in the Ontario Public Health Standards guidance documents and the guidance provided by PHO were sometimes updated at different times, causing confusion
- coordination between MoH, MoLTC, and PHUs during outbreaks was often reactive, requiring new communication channels that led to mixed messages.

Additionally, LTC homes may differ in what kind of guidance they prefer, which further complicates things: Some want clear, prescriptive rules – especially if they lack the capacity to interpret and plan – while others prefer flexibility to tailor IPAC measures to their specific context.

3) **Different ownership models may lead to varying levels of financial and technical ability** to implement IPAC measures.
   - Corporate-owned homes often have centralized IPAC support, which can provide technical help across all homes (although this can slow down local response compared to independently run homes).
   - Corporate governance structures add extra layers of decision-making, which can cause confusion or tension—especially with PHUs (who enforce government mandates) and IPAC Hubs (who support homes but lack legal authority).

Studies conducted during the pandemic showed how these complex differences can impact the health and well-being of residents during an outbreak, with for-profit homes experiencing a higher death-to-bed ratio, especially in regions where outbreaks where higher (such as Peel, Durham, Toronto, and Ottawa).(14)

Financial arrangements

Two key aspects of financial arrangements in the LTC sector contribute to challenges with the implementation of public health directives in Ontario.

1) **Staff remuneration is lower in LTC than in other sectors**, which can impact efforts to retain staff (both front-line and IPAC leads) despite the important role they play in implementing IPAC measures during outbreaks of infectious disease. Related to this, many staff work multiple jobs to make ends meet if they have a difficult time securing full-time hours, which can complicate the roll-out of certain IPAC measures (for example, only working in a single home to limit the spread from one care setting to another). This point is related to the human resources issued noted below.
2) **The LTC sector has historically received less funding than other sectors** in Ontario, which makes it difficult to develop and maintain similar capacity for IPAC in homes and across the sector more generally.

Delivery arrangements

Three aspects of delivery arrangements in the LTC sector are also contributors to the problem.

1) **LTC infrastructure can make it challenging to adopt certain IPAC measures**. In particular, some LTC homes – such as those operating in older buildings – are less able to pivot and accommodate proposed changes to IPAC measures when government directives or guidance are released. Examples of such changes that were challenging in certain homes during the COVID-19 pandemic include:
   - smaller homes with less open indoor space (e.g., large common rooms, dining halls, or atriums) had a harder time accommodating family and caregiver visits, mealtimes and recreational activities that require physical distancing, and those without large indoor facilities
   - homes at capacity that were designed to accommodate four residents per room were not able to move residents around to meet the suggested two residents per room.
2) **Health human resource planning is particularly hard in the LTC sector**. In particular, the sector is characterized by:
   - high turnover among staff
   - challenges filling open positions
   - burnout.(15)

These challenges were exacerbated by the pandemic. For example, the percentage of homes in Southeastern Ontario that were short 50% or more of the time increased between April 2020 and September/October 2021, and higher levels of burnout were found across this same time.(4; 5) Ultimately, the constant churn of staffing and an increasing reliance on 'agency staffing' to fill holes makes it difficult to 'build up' capacity (e.g., through upskilling staff) and create a culture that is commensurate with IPAC best practices in the LTC sector.

3) **Homes do not always have a dedicated IPAC lead with the knowledge and skills to interpret and implement IPAC measures**, and this is particularly challenging if/when they change during outbreaks. In particular:
   - IPAC leads in homes don't consistently have access to supports in the system that can assist them (e.g., some don't have consistent communication or strong relationships with IPAC Hubs)
   - LTC homes in Ontario vary significantly in terms of who they hire to fill the government mandated IPAC lead position – some homes may have a masters-prepared IPAC specialist with a keen interest in the field and with the knowledge and skills to leverage data and evidence to inform how they're adopting and implementing IPAC measures, whereas others may not even be able to consistently fill the position.

   As noted above, this variation exists across types of ownership models with stand-alone homes having less access to a centralized support lead to help navigate guidance compared to homes owned by a corporation.

Assets that can contribute to a robust evidence-support system for the LTC sector are not consistently drawn on as inputs into advisory and decision-making processes, or in learning and improvement efforts

It is important to enable government policymakers, system and organizational leaders (including LTC home operators), professionals (including LTC staff), as well as residents to use the best-available data and research evidence when making decisions about IPAC measures, particularly when they're given flexibility in how they are implemented. This vision of timely, demand-driven evidence-support is difficult to establish in any sector and particularly so in LTC, in part due to the following reasons:

- decision-makers at all levels in LTC are always moving rapidly from one priority (or crisis) to the next, without adequate time or resources to focus on long-term goals such as establishing structures and processes to support learning and improvement
- evidence about IPAC most often comes from hospital settings and there are too few direct supports available to help decision-makers interpret and adapt evidence for their own settings
- relative to other sectors like acute care, LTC often lacks capacity for evidence-informed decision-making and doesn't have a strong culture that emphasizes the importance of evidence support.

While there are many 'assets' in Ontario that are well-positioned to support a robust evidence-support system – including PHO provincially, local PHUs and IPAC Hubs at the community level, and IPAC leads within homes – they are not consistently 'linked up' to help coordinate flows of timely, demand-driven evidence. The establishment of the Science Table and its corresponding outputs during the pandemic provide one example of how such coordination might work in Ontario; however, this approach did not always align with the needs of LTC home operators staff or residents (or those supporting them to adhere to mandates and implement best practices), and would need to be tailored.

Key insights from citizen panels about the problem

Themes about the problem identified by panel participants	Insights and examples from citizens
Lack of accountability	• Participants discussed a lack of accountability for IPAC in the LTC sector, which they framed in relation to several factors:

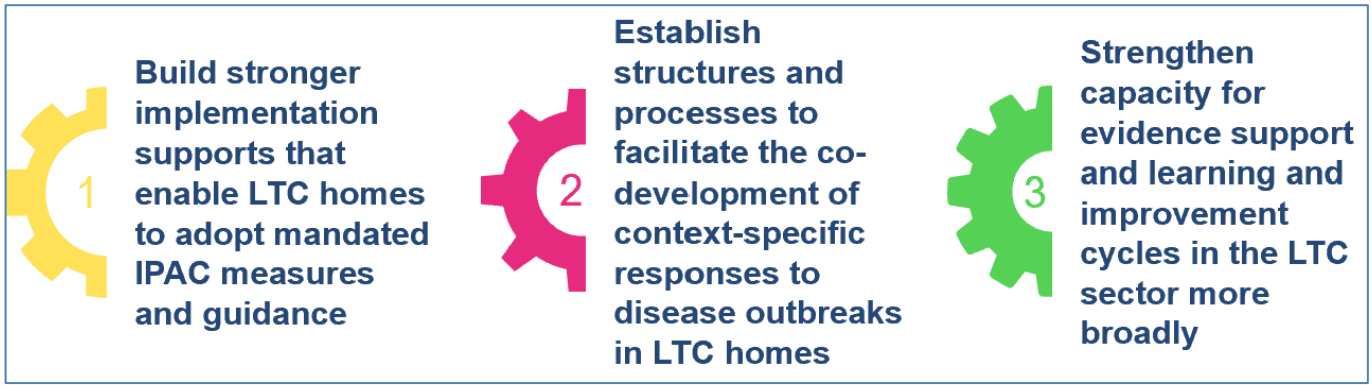
Themes about the problem identified by panel participants	Insights and examples from citizens
across the LTC sector	○ too many decision-making authorities with overlapping or unclear roles (particularly from the perspective of residents, their families, and caregivers) ○ poor coordination between levels of government (e.g., provincial and municipal), and overly complex government decision-making processes that could discourage broader participation by residents (and their families and caregivers) and staff given they were perceived to be primarily 'top down' ○ inconsistent enforcement of the rules within and across LTC homes (which some participants linked to problems with the transparency of the inspections process), and a lack of engagement of residents and staff in how they are developed and implemented
Lack of accountability in LTC homes	• Participants raised several issues that they framed as contributors to a lack of accountability in homes for adhering to mandated IPAC measures, such as: ○ irregular and inconsistent inspections that are narrowly focused on compliance, with several participants indicating that they felt that this contributed to variations in quality of care ○ few opportunities for residents, their families and caregivers, and staff to provide feedback as part of inspections, which meant that their experiences weren't being used to learn and improve the development and implementation of public health standards and mandates
Inconsistent implementation of IPAC measures	• Several participants described the inconsistencies they experienced with respect to the use of IPAC measures in LTC homes, with specific examples related to personal protective equipment (PPE) and ventilation systems provided • Participants also noted that they understood the inconsistent (or variations in the) use of IPAC measures were shaped by a mix of geography (i.e., urban vs. rural areas), and health-system factors such as management capacity, levels of funding for LTC homes, staffing (levels and training), and infrastructure (e.g., facility size)
Challenges with LTC staffing	• Many participants suggested that ongoing staffing shortages in LTC were a major contributor to the problem, with the following issues raised as factors that have continued to make the situation worse: ○ recruitment that prioritizes the wrong individuals, such as those without a real interest in working in the LTC sector, and those who were 'rushed' through training and licensure processes to fill vacancies (which can lead to staff who are unqualified or underprepared for implementing IPAC measures) ○ a lack of proper onboarding and ongoing learning opportunities to help build a workforce that is capable of adapting to evolving IPAC measures ○ low wages for those working in LTC, forcing many workers to hold multiple jobs, which increased workloads and burnout risk • Most participants also focused on the challenges associated with persistent burnout among those working in LTC homes (particularly since the COVID-19 pandemic), noting that they view staff as: ○ chronically overwhelmed, tired, and emotionally exhausted ○ unable to function in ways that support the delivery of high-quality, personalized care consistently to residents (with some participants noting that their loved ones often lacked basic care such as brief/incontinent product changes and bathing during disease outbreaks, which can lead to secondary health challenges) • Participants reported that staffing shortages and burnout required families to take on additional caregiving roles, causing distress and exhaustion
Poor and incomplete communication	• Participants reported that residents, families, and staff often received conflicting or unclear information during disease outbreaks (especially during crises), and this can create confusion, and

Themes about the problem identified by panel participants	Insights and examples from citizens
	lead to a loss of trust and confidence; during this discussion, they provided the following examples of factors they felt contributed to this issue: ○ messages coming from multiple sources (e.g., their families and caregivers, staff, managers in LTC homes, and government via the media) ○ few opportunities for residents and their families to communicate with care staff and managers about the IPAC measures being planned and implemented, and about how these measures may influence care (compounded by too few updates, or not enough detail in updates) ○ lack of mechanisms to ensure residents, their family and caregivers as well as staff are kept up to date with the latest mandates ○ lack of mechanisms to provide residents, their family and caregivers, as well as staff with opportunities to provide feedback (although some participants noted residents and their families and caregivers sometimes fear providing honest feedback that is negative because they worry it will result in them receiving worse care) ○ no accommodations for residents with specific communication needs (e.g., alternate methods for communicating messages for those with vision or hearing impairments) ○ media coverage that amplifies confusion and mistrust, especially when messaging conflicts with the lived realities inside LTC homes • Participants also noted that communication among LTC home staff and managers also appeared to be inadequate and fragmented, and provided the examples of inconsistent information-sharing during shift changes and limited access to shared records as examples
Increased isolation and unintended harms resulting from IPAC measures	• Many participants voiced their concerns about the many downsides of IPAC measures for residents, their families, and caregivers, with many comments focused on the isolation, emotional harm and broader health harms such as depression and anxiety that resulted (particularly during the COVID-19 pandemic); specific examples of what they perceived as the biggest challenges included: ○ restrictive visitation policies that made visits from family members difficult (e.g., only one family member allowed to visit if at all), which contributed to depression, anxiety, and confusion for everyone ▪ a few participants also noted that this contributed to caregiver burnout (e.g., if only one family member was allowed to visit, the burden of being engaged fell solely on them even if others in the family wanted to help) as well as guilt ○ face masks that made it harder to make connections with staff (given you can't see their face) and made communication harder for some residents (i.e., those who were hard of hearing and rely on reading lips) ○ social distancing rules that deprived residents of meaningful social contact (e.g., conversation and touch) ○ too few supports that enabled residents to navigate the use of technology that could help them make connections with family through virtual visits (e.g., teaching them how to use an iPad for FaceTime conversations)
Challenges balancing IPAC measures with ethical concerns	• Some participants raised the issue that pandemic responses in LTC homes – and the use of more stringent IPAC measures more generally – often posed ethical challenges, such as: ○ focusing narrowly on controlling the spread of disease without respecting residents' autonomy, dignity, and quality of life (with some participants suggesting this illustrated a broader lack of respect for older adults in society "who built the country") ○ deploying the military into settings that should be respected as residents' home and that need to offer a safe and respectful place for them to receive the care and supports they need

Themes about the problem identified by panel participants	Insights and examples from citizens
	○ a lack of transparency and communication about the trade-offs that are considered when developing and implementing IPAC measures in LTC homes (particularly during crises like a pandemic, and when measures have a high likelihood of negatively affecting residents' autonomy, dignity, and quality of life) • Many participants shared their view that these ethical concerns likely deepened mistrust and reduced confidence in the LTC system's ability to protect the safety and well-being of residents

Elements of a potentially comprehensive approach for addressing the problem

Three elements of a potentially comprehensive approach to address the problem were developed and refined through consultation with the Steering Committee and key informants who we interviewed during the development of this evidence brief.



Build stronger implementation supports that enable LTC homes to adopt mandated IPAC measures and guidance

This element would aim to make it easier for LTC homes to put mandated IPAC measures into practice during disease outbreaks by bolstering the implementation supports offered to LTC home operators, their staff, and residents. Components that could be considered as part of this approach include:

- creating a framework and supporting 'workbooks' to guide LTC homes (and their IPAC leads) through the process of implementing standards, guidance, and best practices related to IPAC in LTC homes, with a focus on supporting the identification of barriers and facilitators and overcoming them with proven evidence-informed strategies
- improving how LTC residents and staff are engaged in decision-making about implementing mandated IPAC measures and guidance, especially when there is flexibility in how they are implemented
- strengthening the connection between LTC homes (and their IPAC leads) with existing assets in the system that have a mandate to provide coaching and technical implementation support, including the IPAC Hubs and local PHUs (if they're not the same organization)
- facilitating peer sharing and learning among LTC homes through the establishment of regional networks, working groups, or a community of practice.

In our searches for the best-available evidence, we found evidence documents that showed the importance of resident, family, and staff engagement, as well as clear communication, as part of implementing IPAC measures. Some specific findings include:

- regular briefings, email updates, and team huddles can help LTC homes put guidance into practice,(16-30) and this is further supported by flexible and responsive leadership (16; 23)

- residents' families also benefited from frequent updates about the health and well-being of their loved ones,(18-20; 25) and engaging them as part of the infection control team to keep access to loved ones can help improve the implementation of measures (18; 19; 28; 31-33)
- putting in place protocols and virtual tools can help homes react more quickly to IPAC changes during disease outbreaks, including crises like COVID-19 (17; 19; 20; 28)
- coordination can help ensure guidance is appropriately implemented (16; 21; 27; 29; 33-35) as can the clear assignment of roles, and availability of necessary tools and resources (16; 21; 27; 29; 33-35)
- some studies identified ways to overcome barriers and downsides to implementing IPAC measures, such as digital technologies that can help reduce residents' isolation,(22-24; 29; 35) and the need to ensure system supports match the realities in homes (16; 17; 27; 31; 34; 35)

See Appendices 2 and 3 for details about each included document.

Establish structures and processes to facilitate the co-development of context-specific responses to disease outbreaks in LTC homes

This element would focus on enabling LTC residents (and their family and caregivers) and front-line staff to shape how their home responds to a disease outbreak, particularly in areas where government mandates and guidance offer flexibility that promotes the development of local, context-specific solutions. As with element 1, this element would require stronger connections between LTC homes (and their IPAC leads) and existing supports in the system including IPAC Hubs and local PHUs (if they're not the same organization). This element would also focus on:

- creating structured processes *within homes* for engaging of LTC residents, their families and caregivers, and staff in understanding challenges as they emerge in real time, co-developing context-specific responses to disease outbreaks in their home (balancing the views and experiences of residents and staff with the best-available data and evidence), developing implementation strategies for putting the chosen responses in play, and monitoring and evaluating what worked well and what could be improved
- building LTC homes' capacity for resident and staff engagement, and for using data and evidence to drive decision-making processes (e.g., through the development of tools and resources)
- developing a 'streamlined' version of the approach for times of emergency.

What evidence can inform this solution?

In our searches for the best-available evidence about this element, we found that engaging residents, their families, and staff and communicating clearly as part of decision-making processes during disease outbreaks is important. Some specific findings included:

- communication through regular updates, and 'unit huddles,' as well as providing opportunities for two-way engagement helped clarify guidelines, set expectations, reduce confusion, and build trust (16; 36-43)
- it is important to include learning from the lived experience of residents, their families, and staff as part of decision-making processes during outbreaks, and in planning for future ones,(41-43) and it is similarly important to involve the full range of LTC interest holders as part of this process (16; 41; 42; 44-49)
- clearer governance structures, internal leadership, supportive supervision, and stronger engagement from senior health officials can strengthen accountability (43; 46; 48-52)
- there are ways to plan for and mitigate the potential downsides of IPAC measures (including social isolation, distress, and mental decline) and these should be prioritized as part of responding to a disease outbreak (16; 42; 47; 53-57)
- special considerations should be taken to ensure:
  - unique needs of residents are thought through, including for those with dementia (57-60) or in need of supports that are culturally appropriate (40; 45; 53; 61; 62)
  - system-level realities are planned for, such as the way homes are built and staffing planned for and retained.(44; 48; 53; 55; 59; 63-65)

See Appendices 4 and 5 for details about each included document.

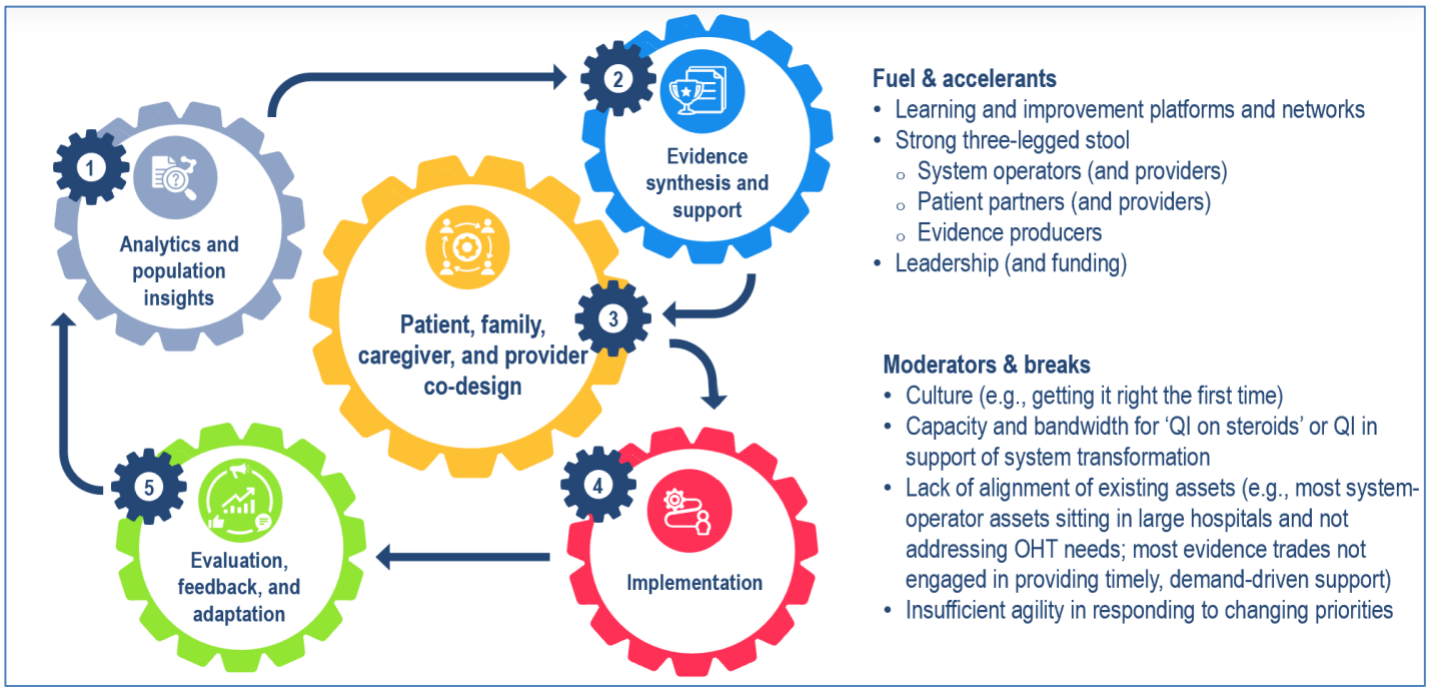
Strengthen capacity for evidence support and learning and improvement cycles in the LTC sector more broadly

This element would create a foundation for an 'evidence-support system' that could help decision-makers at all levels of the system to engage in the 'five gears' of a learning health system (see **Figure 2**). Ongoing cycles of learning and improvement would allow those working and living in LTC homes (and the many organizations supporting them) to use the best-available data and research evidence to identify problems – including but not limited to disease outbreaks – as they emerge in real time, co-develop evidence-informed solutions with the input of LTC residents and staff, develop implementation strategies, and establish robust monitoring and evaluation approaches that feed back into the next round of learning and improvement. Importantly, this would facilitate rapid course correction if things aren't working as anticipated or making an approach the 'new normal' if it is working.

Specific components of this element could include:

- mapping and engaging existing 'assets' that contribute to an evidence support system in LTC, including organizations on the 'demand-side' for evidence (e.g., decision-makers at all levels, including government, and those operating LTC homes), those on the 'supply side' (e.g., researchers based in units committed to providing timely, demand-driven evidence in all of the forms it can be used in decision-making), and 'intermediaries' who can help make connections between the producers and users through efforts such as demand- and supply-side coordination (see **Figure 3**)
- establish rapid-review mechanisms within LTC to generate and synthesize emerging evidence in real time, providing a low-resource means to identify issues, inform quality-improvement initiatives, and update policies while building local capacity for ongoing learning (66)
- build timely 'ways in' for the best evidence in advisory and decision-making processes in LTC homes and at all levels of decision-making
- help to build and sustain a culture of evidence use and decision-making processes centred around constant learning and improvement.

Figure 2: 'Five gears' of a learning health system



Source: Reid R., et al. (2024) Actioning the Learning Health System: An applied framework for integrating research into health systems.(67)

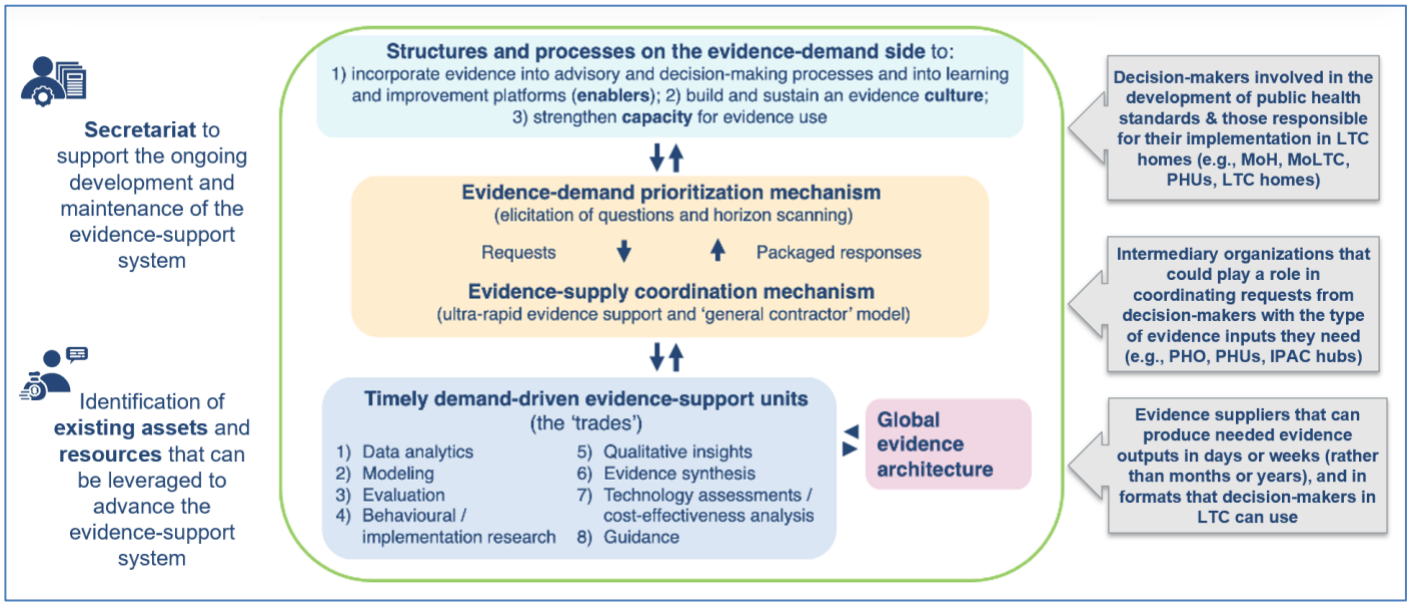
What evidence can inform this solution?

Our searches for evidence about element 3 found that efforts to improve the production and use of data and research are an important element of strengthening LTC. Some specific insights include:

- there is a need to invest in targeted research and knowledge generation for many forms of evidence (15; 42; 47; 48; 56; 68; 69)
- stronger data collection and monitoring is needed, enabled by efforts such as staff training, and digital tools to improve transparency and accountability (15; 42; 48; 68; 70)
- in many cases, surveillance systems were not well developed, with local data on healthcare-associated infections and antimicrobial resistance often missing, making it difficult to compare homes or track whether things were improving (48)
- the pandemic also showed that asymptomatic transmission was poorly understood, which complicated outbreak control and pointed to the need for stronger and timely studies (42; 56)
- some progress was made through initiatives like Implementation Science Teams, which tested interventions and supported promising practices, but evidence highlighted that without long-term funding these efforts are unlikely to deliver lasting change (42; 71)
- several reviews pointed to the usefulness of shared metrics and common frameworks to help align studies, which make findings easier to compare and support decisions that are consistent across the healthcare system (56; 69; 72)
- digital innovations are beginning to show promise, such as dashboards and capacity trackers piloted in England, which were credited with improving monitoring, communication, and accountability in real time.(42; 69)

See Appendices 6 and 7 for details about each included document.

Figure 3: An evidence-support system for the LTC system in Ontario



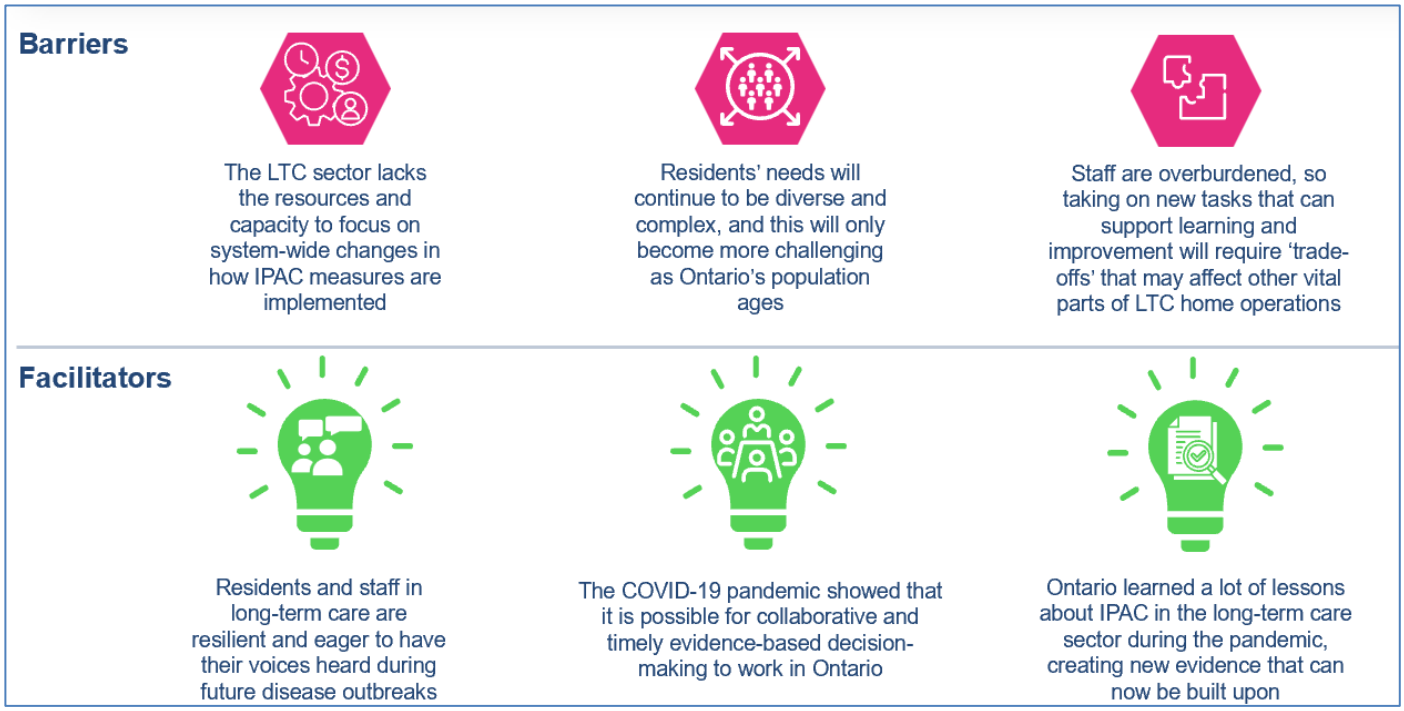
Key insights from citizens about the elements of a potentially comprehensive approach

Element as framed in the citizen brief	Insights and examples from citizens
Element 1 – Help long-term care homes put in place mandated infection prevention and control measures with input from residents and staff	• Participants emphasized the importance of supporting the consistent implementation of mandated IPAC measures province wide; during the discussion, they suggested several approaches that could be adopted to support this aim, which included: ○ clear communication from decision-makers to residents, their families and caregivers, and staff about which measures are mandated (vs. those that can be adapted locally) ○ guidance and tools that advise on how local factors – including residents' risk levels, health conditions and care needs, and those related to settings (e.g., rural vs. urban) – can be built into implementation plans, as well as the trade-offs that need to be considered (e.g., short-term expenses that may have long-term benefits for health and well-being of residents and staff) ○ advisory boards or councils in each LTC home that include residents, their families and caregivers, and staff to guide the interpretation and implementation of mandated measures ○ mechanisms to facilitate structured, ongoing feedback about the implementation of mandated IPAC measures (e.g., morning briefings, shift turnover meetings, meal-time discussions, or during home inspections), in ways that empower residents and staff ○ efforts need to be made to ensure that such a mechanism is accessible to everyone (e.g., accounting for different language needs and hearing and vision impairments)
Element 2 – Give long-term care residents, their families, and staff a 'seat at the table' when planning for how to respond to a	• All panel participants voiced strong support for greater involvement of residents, families, and staff in outbreak response planning, and they shared that this involvement should: ○ occur early, when potential outbreaks are being monitored – not after decisions have already been made ○ be driven by permanent advisory boards or councils that engage residents and their families and staff (and that facilitate co-governance and collaborative decision-making), ideally through regular meetings, such as morning check-ins and staff/resident discussions ○ include mechanisms that foster safe and confidential feedback from residents and their families so concerns can be raised without fear of retaliation (or worse care), and that includes communication about how concerns are being addressed

Element as framed in the citizen brief	Insights and examples from citizens
disease outbreak	• As part of this element, many participants also expressed the importance of several principles (which often overlapped with key themes raised when discussing element 1), such as: ○ inclusivity (e.g., ensuring diverse health and social needs as well as perspectives are embedded in the process) ○ transparency (e.g., clear communication about trade-offs considered) ○ accountability (e.g., feedback mechanisms that are clear about how challenges raised by residents and their families and staff are being addressed) ○ flexibility (e.g., multiple 'ways in' for resident inputs) ○ commitment to collaboration and continuous learning and improvement
Element 3 – Strengthen capacity for finding and using evidence to make decisions in the long-term care sector more broadly	• All participants acknowledged the importance of learning and improvement (e.g., building on lessons learned from previous outbreaks and making 'what works' the new normal), and drawing on the best evidence in making decisions about LTC more generally; several approaches were suggested by participants as ways to achieve this, including: ○ creating (or building on existing) centralized data collection and tracking systems, ensuring that residents, their families, and staff can provide input on what is measured and what targets are set ○ building processes for transparent reporting of progress in ways that are accessible to residents, their families, and staff ○ building 'feedback loops' that can accommodate varying preferences for providing input (with one participant suggesting home inspections could be leveraged to collect structured feedback from residents and staff to inform how standards evolve over time and how future policies are shaped) ○ facilitating opportunities for cross-sector and cross-jurisdiction learning (e.g., learning from acute care or home care, or from other provinces, territories or countries)

Implementation considerations

In the figure below we identify some barriers that may make it difficult to proceed with the elements, as well as facilitators that could create momentum for advancing them. When asked about what they perceived to be the biggest barriers to proceeding, citizen panel participants indicated that they viewed insufficient resources, staffing issues, and a lack of willingness on the part of government(s) to take action as key challenges. When asked about facilitators, panel participants indicated that they viewed motivated leadership in LTC homes and a general commitment by many different interest holders across the province as key to advancing the elements.



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