

# THIS IS LONG-TERM CARE 2018



ONTARIO  
LONG TERM CARE  
ASSOCIATION





It's natural to want to stay in our own homes as we age, but that isn't possible for everyone. Many people, particularly those with dementia, will eventually need a level of support and supervision that family, friends, and home care can no longer provide.

Ontario's long-term care homes provide support to more than 100,000 people and their families every year. Homes offer 24/7 nursing care and supervision, support with daily activities, and a safe, caring environment, helping people live comfortably and with dignity.



**9 OUT OF 10  
RESIDENTS  
HAVE COGNITIVE  
IMPAIRMENT**

### Who lives in long-term care?

Seniors whose dementia has progressed to the middle or advanced stages are the core population in long-term care homes. Two out of three (64%) residents have been diagnosed with Alzheimer's disease or another dementia. Overall, 90% of residents in long-term care have some form of cognitive impairment, not solely from dementia but from other causes such as stroke and memory loss.

In one-third of residents, this impairment is severe.<sup>1</sup>

In recent years the Ontario government has been investing more funds in home care and aging-at-home strategies. New residents to long-term care must now have "high" or "very high" physical and cognitive challenges in order to qualify for admission. This means that people are now coming to long-term care at a later

stage in the progression of their conditions, when their health is more likely to be unstable, they are more physically frail, and their care is more complex.

In particular, an increasing number of residents are admitted to long-term care at a later stage of their dementia, with increasing needs for support with daily activities.



**1 in 3  
HAVE SEVERE  
COGNITIVE  
IMPAIRMENT**

### Higher needs, more care

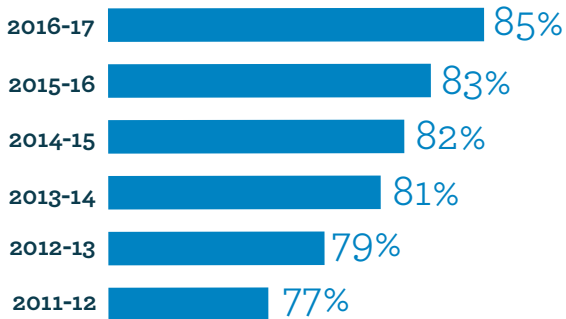
The Ontario Long Term Care Association analyzed data over the last five years, from 2011-12 to 2016-17. During that short time, there has been a steady increase in the number of new residents with moderate and moderately severe cognitive impairment (6% increase), with a corresponding decrease in the number of new residents who don't have cognitive impairment, or whose function is

described as borderline or mildly impaired (7% decrease).<sup>1,2</sup>

There have also been steady year-over-year increases in the number of people who need extensive or complete support with everyday activities such as getting dressed or feeding themselves. Today, 85% of long-term care residents need extensive or complete help with daily activities, compared to 77% just five

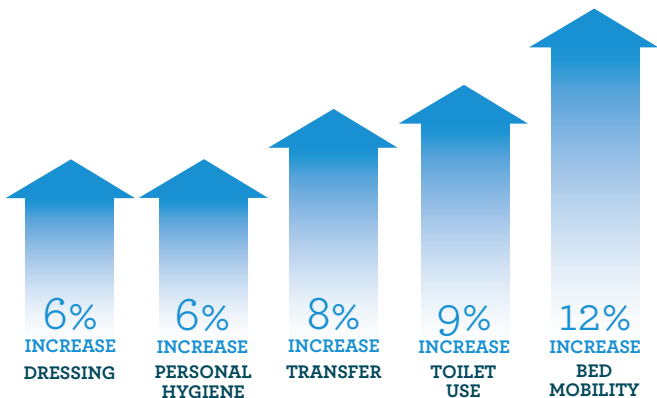
years ago. At the same time, the number of long-term care residents who can carry out daily activities without assistance has dropped by half, from approximately 6% to 3%.<sup>1,2</sup>

These increasing high needs have significant implications for the support that residents need, and the additional staffing and funding that homes require to provide this support.



**More residents need extensive or complete support**

Over the last five years alone, the proportion of residents who need extensive or complete support with daily activities such as eating and getting dressed has increased by more than 7%, from approximately 77% to 85%. *Data source: Canadian Institute for Health Information, Continuing Care Reporting System (CCRS 2011-2012 to CCRS 2016-2017).*



**More residents need support with important daily activities**

The majority of residents in long-term care need help with daily activities such as getting dressed, getting out of bed, and toileting. This figure shows the rise over a five-year period in resident needs for physical assistance from one or more staff with these activities. The increased needs for support are accompanied by a need for more staff time, skills, and resources to provide care. *Data source: RAI-MDS 2011-12 to 2016-17, Ontario Ministry of Health and Long-Term Care, Intellihealth Ontario.*

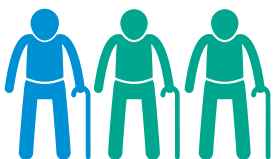
**A changing culture**

At the same time that the population is changing, so too is the culture of long-term care. Like many other areas of health care, long-term care was built on what is often called an “institutional” model, focused primarily on providing physical and medical care.

are provided through a sensitive understanding of each resident’s individual needs and preferences. Even when someone has advanced dementia, long-term care homes provide a life of purpose and connection, as the stories in this report illustrate.

That is changing rapidly. Caring for medical and physical needs is still very important, but homes are shifting to a resident-centred or relationship-centred approach, where care and quality of life

*This is Long Term Care* is designed to provide readers with a better understanding of what homes do, the people they serve, and some context behind the headlines.



**1 in 3 RESIDENTS ARE HIGHLY OR COMPLETELY DEPENDENT ON STAFF**

## A caring community

A movement to holistic, person-centred care has been rapidly evolving over the last decade, changing the way we think of disabilities and dementia, as well as what we expect from services such as hospitals, home care, and long-term care homes. As a society, we have been redefining what good care means for those with dementia, and what people really need.

In person-centred care, the focus is on the person's preferences and their emotional and social needs, in addition to physical and health care needs. This is a movement away from caring for residents according to set schedules and routines, to caring for residents according to their lifetime practices, habits, and preferences — even if those can be hard to decipher in the face of advanced dementia.

## What does resident-centred care look like?

### Hush, no rush

Bloomington Cove, a Sienna Senior Living home, was the Ontario Long Term Care Association's Resident-Centred Home of the Year in 2016. In this specialty home, every resident has a diagnosis of dementia.

Bloomington Cove has moved away from caring for residents according to staff schedules and routines to caring for

residents according to their lifetime practices and habits.

Residents are offered choices of meals, clothes, programs, and bathing. A Hush, No Rush care philosophy reminds staff to adjust the way they approach residents, programs, and physical space. This includes supporting natural wake-up times.

“The change we are experiencing is a change in the culture of LTC; a sweeping, cleansing movement that embraces person-centred care. The picture of living life in LTC is changing to a full recognition of the wholeness of each person, even those living with severe cognitive or physical changes. Teamwork is flourishing, empathy is growing, a social model of living is sweeping over our LTC homes, replacing the institutional model of care that has existed for decades. Great work is being done across our province!”

– Dee Lender, Executive Director, Ontario Association of Residents' Councils

Staff continuously try new programs and care techniques that improve each resident's quality of life. Craniosacral treatments have led to a reduction of antipsychotic medications and have improved speech, appetite, and sleep. Doll therapy is a particular source of comfort for residents who have difficulty falling asleep, and for those who experience continuous pacing as a result of their disease; sitting with dolls provides them with rest and reduces the risk of falls. The home also uses a technique called Gentle Persuasive Approach to respond respectfully and skilfully to the challenging behaviours that can accompany dementia.

### Focusing on abilities

Leacock Care Centre, a Jarlette Health Services home, received the Ontario Long Term Care Association's Quality Improvement Innovation of the Year Award in 2017 for its use of the

DementiAbility program, which has rolled out across all Jarlette homes.

The program teaches staff techniques for engaging residents with dementia and introducing activities that leverage their abilities, passions, and curiosities. The idea is that by keeping residents active and engaged, they have a richer quality of life and fewer challenging behaviours that are often a side effect of dementia.

“We had one resident who was often agitated. We learned that she always cooked and made sure everyone else was taken care of before eating. So we got her involved in escorting residents into the dining room, clearing tables, and helping staff get dinner ready. She enjoys the activity and you could see it gave her a sense of purpose. She's also a great help to staff in the dining room!”

– Leacock Care Centre staff







**78,872 BEDS  
FOR LONG-STAY  
RESIDENTS**

**80,000 STAFF**

## Living and working together

Dedicated staff in long-term care homes provide daily care and supervision when someone's needs have become too great to be cared for at home by family and community supports.

While the most visible staff at a home are registered nurses, registered practical nurses, and personal support workers (PSWs) who provide the daily health care and support, there are many other people involved in each resident's care and support. Each home has a medical director along with other health professionals and support staff in areas including pharmacy, dietary, physiotherapy, occupational therapy, recreation therapy/resident engagement, social work, housekeeping, maintenance, and administration.

Some homes are also experimenting with the use of staff such as porters and health care aides to support resident care, but these positions are not currently eligible for funding from the government.

### Residents' Council

Each home has a Residents' Council, which has powers under the *Long Term Care Homes Act* to approve certain decisions in the home (such as the menu), provide the resident's perspective and advice to the home's leadership, and help to support resident-centred care.

### Families and volunteers

Families are not just visitors; they are a crucial part of the care team. The majority of people with moderate to severe

“As a young nurse, when I found long-term care, I knew I was home. It's a community: you build relationships with residents and families that just aren't possible in other settings.” – *Candace Chartier, RN, CEO, Ontario Long Term Care Association*

cognitive impairment can no longer make decisions about their care, and a family member or friend serves as the "substitute decision maker" who is regularly consulted by the long-term care home about the resident's treatment and quality of life. Each home's Family Council is also empowered by the Act to advise the home about meeting the needs of residents.

Volunteers also support individual residents and programs that enrich the life of the home.

### What about more staff?

In late 2017, the provincial government committed to an additional 15 million care hours per year for long-term care, to bring the provincial average for resident care to four hours a day. This is good news but a tall challenge, as there is currently a recognized workforce shortage in both long-term care and home care.

The Association believes that this new funding commitment also needs to be accompanied by changes to the *Long Term Care Homes Act* that currently puts tight restrictions on the type of staff and roles of staff – restrictions that don't exist for staff in home care, for example. Long-term care needs more flexibility to be able to provide the care that residents need.

“Long-term care homes do an amazing job. Your first-line health care workers, the PSWs, are jewels. There aren't enough of them, and they don't get rewarded enough, but they still have the drive to come into work every day and deal with me with empathy, which impresses me.” – *Bill Jarvis, long-term care resident and OLTCA Lifetime Achievement Award recipient 2017*



**2 OUT OF 3**  
**LONG-TERM CARE**  
**RESIDENTS**  
**HAVE DEMENTIA**

## The specialty of dementia care

Alzheimer's disease and other dementias are complex, progressive, and ultimately fatal conditions. When families can no longer manage to care for their loved ones at home, long-term care homes offer the support and services they need, along with expertise in dementia and end-of-life care.

The general perception of dementia is that it primarily involves memory loss and confusion. What's not well understood is that as the brain deteriorates because of the dementia, the organs that it directs will deteriorate as well. As the disease progresses into middle and later stages — which is usually when most people come to long-term care — they have lost the ability to speak or understand speech, to accurately interpret what's happening around them, and to care for themselves. For example, they may no longer recognize that they need to eat, or what utensils are for.

People in these stages of the disease need extensive or complete help with daily activities such as personal hygiene, toileting, and eating. The vast majority of people also have two or more health conditions that require treatments and medications.

Providing personal care and medical treatments requires a specialized approach because dementia is often accompanied by challenging behavioural symptoms, also called responsive behaviours (see more about behavioural symptoms on page 8).

When people with dementia don't understand what is happening, they may react negatively when staff approach to help with daily activities or medical treatment. They may refuse verbally or physically to have a bath, to eat a meal, or to have a dressing changed. Even something as simple as hair combing or a fingernail trim can be confusing or frightening, triggering angry or fearful responses, including physical aggression.

Caring for someone with dementia requires a compassionate understanding of the many different ways that the disease can affect each individual, and experimenting with behavioural management strategies that soothe the resident's symptoms, improve his or her quality of life, and allow staff to provide care.

## Physical space matters

The design of a home's environment is important for improved privacy, dignity, and quality of life. Nearly half of Ontario's long-term care homes are due for significant renovation or rebuild in order to meet current design standards that include more private rooms and more lounges, wider hallways, and smaller, more intimate dining rooms in every resident area.

The right design can also help to reduce dementia-related behaviours. Resident altercations are more likely in older homes, where four-bed rooms, crowded hallways, and limited lounge space create an environment that lacks privacy and is too close for comfort.

The provincial government is providing a capital redevelopment program to help older homes redevelop, but there are still a number of barriers, including insufficient construction funding and excessive municipal development charges, that are making it difficult for all homes to participate.

“Roughly 70% of people who live with dementia will eventually live at the end of their lives in a long-term care home, because of the nature of the disease. Long-term care is an excellent setting for palliative care for people with dementia, while of course understanding that people are still living life to the fullest.”

– Mary Schulz, Director, Education at Alzheimer Society of Canada



## Behavioural Supports Ontario (BSO)

Some excellent behavioural management programs have been implemented in recent years that are helping to reduce behavioural symptoms and improve residents' quality of life. Homes have been using a variety of strategies with success. One of the biggest contributors to homes' ability to implement behaviour management strategies is a provincial program called Behavioural Supports Ontario, because it is accompanied by the funding to hire and train specialized staff teams.

BSO rolled out in 2012 in a limited number of homes, and has been shown to be effective in supporting the shift to a behaviour management approach and in reducing severely aggressive behaviour, antipsychotic use, and restraint use.<sup>3</sup>

In the 2017 provincial budget, the government committed to fund BSO teams in each of the province's 625 long-term care homes.

These teams are critically needed. Frontline staff are juggling the needs of many residents and most need to continuously increase their knowledge of how to manage challenging behaviours. BSO teams are their support system — they provide education about dementia, problem-solve and suggest strategies, and help to create a culture where all staff are focusing on making each day better for every resident.

## Making connections

Long-term care homes care for the physical, medical, social, spiritual, and emotional needs of their residents. People who have dementia have all these needs, but they may need help in tapping into the activities, memories, and relationships that provide them with a sense of purpose and meaning.

Long-term care homes use a variety of therapies including personalized music, art, and animals to help improve mood, reduce pain, and reduce dementia-related behaviours. These activities create moments of pleasure for people with dementia, and treasured moments of connection with their families and staff.

But it's not just these therapies that are making a difference. Many residents were accustomed to an active life with multiple responsibilities. It can give them a sense of renewed purpose to work alongside staff to help set the table, sweep the floor, fold towels, and water plants. Homes report that involving residents in meaningful activities typically reduces responsive behaviours and allows staff to form closer relationships.



## Sensitive care, successful care

- Having a blood test can be upsetting for people with dementia if someone simply shows up to take blood. One home has incorporated doll therapy for their residents to help ease this stress. About 20 minutes before the blood test, staff bring in a doll and involve the resident in talking about it. Then they explain the blood test is coming, and ask the resident to show the baby how to be brave. Many residents did this for their own children, and it taps into that memory. Mechanical pets are equally effective for some people.

- Maintaining good nutrition and hydration can be challenging, as people with dementia can lose interest in eating and drinking. It can take some creativity. One home discovered that one of their residents used to love Coca Cola, and found he will take chocolate nutritional drinks if they call them his Coke.

- A resident who was a former nurse manager would become agitated and yell at staff when they tried to provide her care. After observing her behaviour and talking to her family, they concluded she was reacting because she was

accustomed to being in charge in a health care environment. The staff gave her a clipboard and a checklist, include her in their home's nursing meetings, and speak to her as a former nurse manager when they are providing her care. These are familiar and comforting activities that make her feel in control, and her resistance to care has stopped.

- Many people with dementia are resistant to having a bath because they don't like to be wet, or they don't understand what is happening. In one home, residents who struggle

at bathtime are given a personalized playlist on headsets about 20 minutes before bathtime and during the bath if needed. Familiar music is known to be pleasurable and calming for people with dementia.

*Each of these examples comes from a home with a Behavioural Supports Ontario team as part of their staff. Research shows that staff in homes with BSO teams feel significantly more supported and capable of developing solutions that help their residents and reduce behaviours in the home.<sup>3</sup>*



## Understanding aggressive behaviour

In the course of their disease, 80% of residents will exhibit behavioural symptoms of dementia, such as pacing and wandering, repetitive questioning or actions, uninhibited behaviour (including sexual), and irritability.<sup>4</sup> These behaviours can unfortunately aggravate and intrude on the space of other residents. As dementia destroys social skills and the ability to manage emotions, residents may react reflexively by hitting, or by using angry and accusatory responses.

The vast majority of altercations between residents with dementia are minor and result from the belief that someone is intruding on their space or behaving in a way that frustrates or angers them. Sometimes the cause makes sense to us, as when another resident wanders into their room and rummages in their dresser; many times it does not.

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## A word about abuse

No abuse of a resident is ever acceptable. Long-term care homes have a zero-tolerance approach to this very serious issue.

When the current *Long-Term Care Homes Act* came into force in 2010, it introduced very specific definitions of physical, verbal, and sexual abuse, along with new requirements for reporting and managing any suspected incident.

The definition has a very low threshold. For example, if a resident with dementia swatted away another resident's hand when they both reached for something at the dinner table, homes must report this as abuse. From a staff perspective, behaviour and language that might have been acceptable a generation ago, such as calling a resident "dearie", is now considered disrespectful and requires reporting as verbal abuse.

Long-term care homes prefer to call these reactions "responsive behaviours" because the person is responding to a trigger in their environment. Very little of this is true aggression; the behaviour is unfortunately mislabelled by the national reporting system that provides statistics. Aggression implies malicious intent, and this is rarely the case.

Behaviour management approaches work well in reducing the frustration and irritation level of individuals as well as the overall level of resident-on-resident tension in a home. This involves finding ways to engage people with dementia in productive activities that tap into their pleasurable memories, current abilities, and sense of self. Homes also create activities to diffuse common "hot spots" for resident altercations, such as mealtimes. As mentioned earlier, long-term care homes need Behavioural Supports Ontario teams in every home in order to support their work in this area.

"When George first arrived, he would yell at residents and staff and raise his fist. He's a big man and that was intimidating. We learned from his family that he had been a real doer, someone who liked to tinker about in the garage. So we built him a cart full of tools and things to tinker with, all attached to the cart with sturdy chains so they don't pose a threat to anyone else. We also gave George the job of sweeping the floor in the dining room after meals with our staff. He's a man who needs to be busy and by having these jobs to do, it has significantly reduced his anger and frustration." – BSO team member

All incidents, even when staff are uncertain, are documented and reported to the Ministry of Health and Long-Term Care for follow up.

More serious incidents certainly do occur and these examples are not intended to minimize the importance of zero-tolerance reporting, but they do illustrate the types of behaviour that the public might be surprised to find classified as "abuse".

According to a report by Ontario's Auditor General, only a small number of reported incidents that required inspections were considered a "high risk" concern by the Ministry.<sup>5</sup>

Any incidents of suspected or confirmed abuse are taken extremely seriously by long-term care homes.



## Not suitable for long-term care

Residents who are known to have severe violent tendencies do not respond to behaviour management strategies, and they require the care of a psycho-geriatrician and/or 1 to 1 supervision to keep other residents and staff safe.

In several tragic cases, people who were extremely violent were suffering from a severe psychiatric illness or had a history of physical or sexual violence — sometimes in combination with dementia. Long-term care is not a suitable place for people with severe psychiatric conditions or a history of violence, who need specialized care where they are not among frail and vulnerable elders. When homes are informed of a prospective resident with severe psychiatric illness or a history of violence, they are currently not allowed by legislation to refuse them. This needs to change.



**46%** of residents exhibit some level of aggressive behaviour related to their cognitive impairment or mental health condition

## Responding to concerns

In early 2018, CBC aired a misleading series on resident-on-resident violence in long-term care. The thoughtful response below was written by Dr. William Reichman, President and CEO of Baycrest Health Sciences and former president of the American Association for Geriatric Psychiatry. Excerpted and reprinted with permission.

Dementia is among the most devastating health conditions associated with growing older, with Alzheimer's disease being the most prevalent cause. Over the past several decades, as the ability of families to cope with the many stresses of dementia caregiving have mounted, long-term care facilities in Ontario and across the world have become the places we look to in order to best meet the needs of affected patients and to give their families respite. This is hard, grinding work as patients with dementia need assistance in nearly all activities that the rest of us might effortlessly take for granted.

Along with the cognitive deficits of dementia, in which patients are forgetful, have difficulty communicating, cannot adequately organize themselves or problem-solve effectively, nearly all get confused navigating familiar surroundings. At mid to later stages of severity, these individuals need help dressing, bathing, eating and having their daily care needs met.

While the work is demanding of all of us who have dedicated our careers to this field, it is also immensely rewarding and of great benefit to families — that is why we do it.

One of the greatest challenges in caring for patients with dementia is that the disorder often results in changes in behaviour and emotional control. This is very troublesome and has to be addressed when patients are cared for in their own homes by family members as well as by staff in long-term care facilities. People affected with dementia can get easily excited or upset, be verbally abusive to others, resist care, are suspicious, and at times, might engage in violent behaviour.

Occasionally this aggression can be predicted and prevented, but often it is remarkably impulsive and occurs very suddenly. At present, we do not have medications that adequately prevent aggression without also so thoroughly tranquilizing individuals that they cannot safely move about, communicate, or meaningfully engage in social, recreational or other activities that support quality of life.

As a society we have rightly chosen to avoid limiting the freedom of movement of affected patients living in long-term care homes — we do not think it is morally right to physically restrain or lock up in seclusion our loved ones who are suffering from terrible brain diseases that cause them to behave in ways they would likely never choose.

Some believe that more staffing would solve the issue of assaultive behaviour. The reality is that we have very limited useful data to tell us the extent to which increased staffing levels for dementia care would reduce the occurrence of resident-to-resident violence and by what amount. We do know it would likely be impossible to completely eliminate the risk if patients with dementia continue to live together in congregate care settings, such as the contemporary long-term care home.

The CBC Marketplace episode titled *Crying Out For Care*, which first aired on January 26, 2018, highlights a serious public health challenge that will grow in importance as the global population ages. We want to talk about this issue, but it must be in a responsible, thoughtful way that informs the public. As a society, as well as focusing on care, we must also focus public efforts on brain health and invest resources into the prevention, diagnosis and treatment of brain diseases like Alzheimer's. Eradicating these threats to our well-being should be a major priority.

## OUTSTANDING RESULTS OVER JUST FIVE YEARS



Restraint use has dropped by **more than half**



Nearly **40% fewer** residents are being prescribed antipsychotics



**50% fewer** residents are experiencing pain

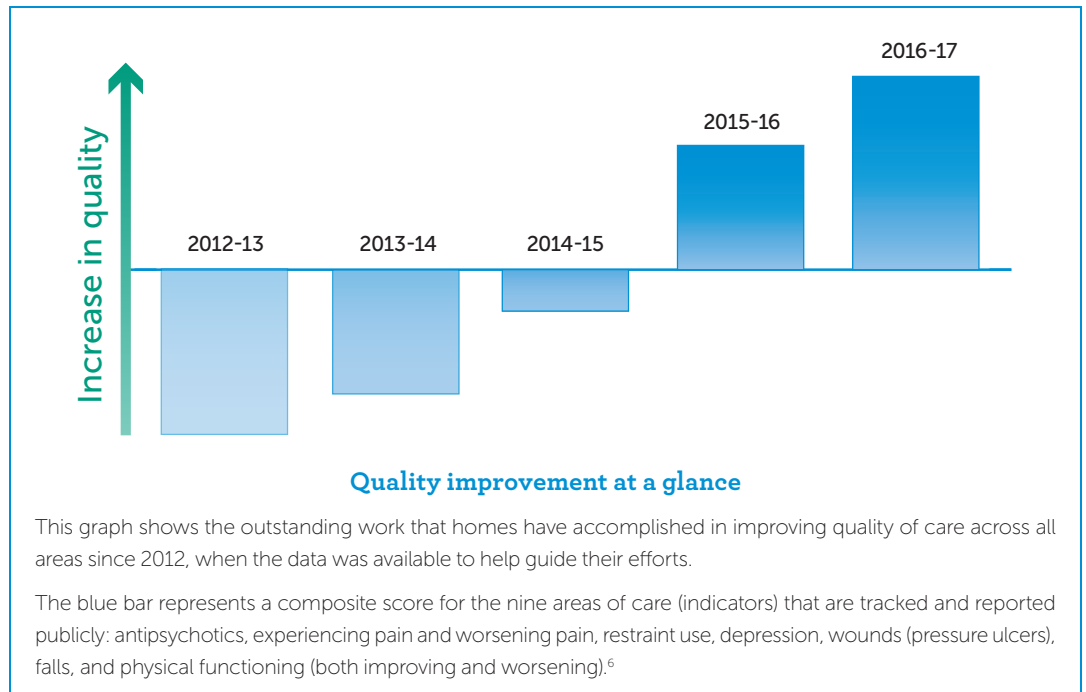
## 90% OF LONG-TERM CARE HOMES DO WELL ON THEIR INSPECTIONS



## Committed to quality of care

Since 2012, thanks to a new national reporting system, all long-term care homes in Ontario have been able to track the care they are providing. This new data provides homes with invaluable information about the quality of care they provide, and how they compare to other homes. It helps staff to identify where they can improve quality of care, and helps residents and families to see how their home is performing in key areas.

Recent data analysis shows that over the last five years, homes have made great strides in improving care outcomes for their residents. In particular, they have made outstanding improvements in reducing the use of restraints, pain management, and reducing antipsychotic medications.<sup>1,2</sup>



## Long-term care homes do well on inspections

Long-term care home operators adhere to Ontario's *Long Term Care Homes Act*, widely considered one of the toughest pieces of nursing home legislation in the world.

Homes are inspected annually by the Ministry of Health and Long-Term Care against more than 600 regulations — with more than 1,000 requirements — that look at everything from cleanliness to resident safety.

Homes take this commitment seriously. Ministry findings show that the vast majority of homes (90%) do well on their inspections.<sup>7</sup>

Staff are proud of the care they provide, the relationships they build with residents, and the work they do to meet the stringent requirements of the Act.

However, at a 2018 meeting on workforce challenges in long-term care, many participants identified the inspection process as highly demoralizing for their teams. They stressed that inspections need to move away from a punitive approach to a focus on supporting staff with quality improvement.



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## A closer look at antipsychotics

The understanding of dementia, and how to provide appropriate care, has undergone a significant evolution in the last decade. Many residents come to long-term care on an antipsychotic medication that was prescribed in the hospital or community. Until recently, it was believed that they would need to stay on that medication permanently.

There is now greater understanding that dementia symptoms wax and wane over time, and someone who needed an antipsychotic to manage symptoms at one stage of the disease may not need it later. Antipsychotics still have an important role in reducing major symptoms for some residents, such as severe aggression or paranoia, so the focus in homes is on ensuring that antipsychotics are used appropriately, not eliminated entirely. The goal is to ensure antipsychotics are prescribed for the right symptoms, at the right dose, and only for as long as needed.



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## The importance of innovation

Over the next 20 years it is anticipated that there will be twice as many seniors over the age of 75 and, by extension, a growth in the number who need long-term care and other supports. Even with the recent announcement of another 30,000 long-term care beds over the next decade, there will not be enough capacity to meet all of these needs.

The way to meet the future needs of Ontario's seniors is by evolving our current ways of doing business, and taking action now. Long-term care homes are actively driving innovation by leading and partnering to design and test new tools and technologies to improve quality of care and quality of life and reduce administrative tasks for staff, allowing them to spend more time on resident care.

The Ontario Long Term Care Association is also leading a major project to implement standardized clinical guidelines in all long-term care homes (see Clinical Support Tools this page), researching different models of residential care for seniors (see LTC Plus, page 14), and leading a Strategic Innovation Council of government, academics, and educational partners to generate actionable recommendations to accelerate innovation in long-term care and the broader health sector.

Two major challenges with innovation in long-term care are the *Long Term Care Homes Act* and the current funding model, as both are very restrictive and make it difficult for homes to try new ways of doing things. The Ontario Long Term Care Association has raised this concern with the government.



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## Clinical Support Tools

Long-term care staff would benefit from having standardized, evidence-based guidelines and protocols that are written specifically by people who know long-term care — practical documents that address the real-world environment of long-term care.

Last year, the Ontario Long Term Care Association started an innovative project to develop these Clinical Support Tools. Ontario's Ministry of Health and Long-Term Care has provided significant project funding and the first phase of the project is underway. Guidelines are being developed for diabetes, dementia, incontinence, wound care, end-of-life care, chronic obstructive pulmonary disease (COPD), and seasonal influenza/respiratory virus prevention.

Long-term care homes have been quick to sign on to participate. They are committed to quality improvement, and eager for tools and support that are tailored specifically for the unique needs of long-term care residents.



**625** homes are licensed and approved to operate in Ontario

**58%** of homes are privately owned  
**24%** are non-profit/charitable  
**16%** are municipal  
**2%** other

**78,872** “long stay” beds provide permanent, residential care to more than **100,000** people each year

SOURCE: Long-Term Care Home System Reports, Ontario Ministry of Health and Long-Term Care, October 2017.

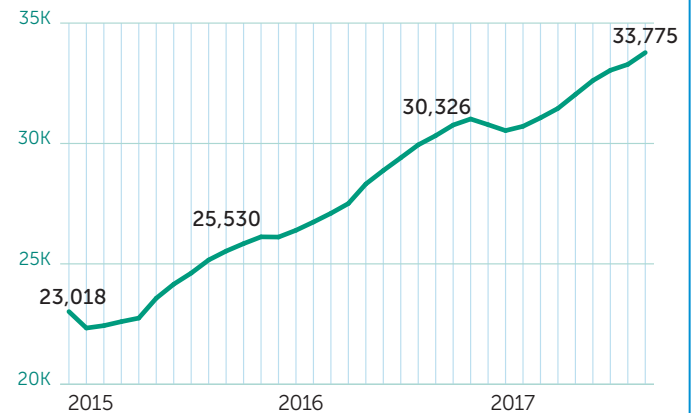
## The need for long-term care

**Long-term care is in high demand.** As of October 2017, there were nearly 34,000 people waiting for a bed. The wait lists have been growing at an astounding rate in the last two years alone (see below). The average wait time for placement is now 143 days.<sup>8</sup>

In late 2017, the Ontario government announced that it would be funding 30,000 more long-term care beds over the next decade, with 5,000 of those in the next four years.

### Growth in wait list for long-term care

The wait list for Ontario long-term care is growing rapidly by approximately 15% a year. Source: Long-Term Care Home System Reports, Ontario Ministry of Health and Long-Term Care, October 2017.



## Rebuilding and expanding long-term care

In addition to new beds, there is a significant program underway to renovate or rebuild approximately 300 older homes — almost half of the system’s supply. These homes need to be upgraded to current design standards such as sprinklers in resident rooms, on-site generators, and more spacious and private accommodations for residents.

More than 40% of all long-term care homes are small, with 96 or fewer beds, and nearly half of these homes are located in small

and rural communities. These communities often have limited home care or retirement home options, and are typically the only place where frail seniors can receive support, close to home and families.

The government currently provides all long-term care homes in need of redevelopment with construction funding based on a “per resident, per day” model, similar to the way it funds operations. This approach provides equal funding for all homes to participate, regardless of home location. However,

this funding has not been sufficient for many homes to participate, particularly for small homes and those found in urban areas, which lack available and/or affordable land to build on.

In its 2018 pre-budget submission (*More Care. Better Care*), the Ontario Long Term Care Association asked the province for added capacity, focused specifically on “topping up” redevelopment projects to avoid the need for amalgamation, particularly in more rural and remote areas. The government’s recent

commitment of added capacity will help support this goal.

The Association has also requested improved construction funding, a reduction or elimination of municipal development charges, the creation of an urban homes strategy, and a small homes retention strategy reinforced by additional operating funding. These additional measures need to be included in the government’s capital redevelopment program in order to support broader participation.





**Daily rate set by government that residents pay the home for “room and board” (accommodation and food)**

Basic:

**\$59.82**

Semi-Private:

**\$68.02–\$72.12**

Private:

**\$78.27–\$85.45**

SOURCE: LTC Home Accommodation Charges Bulletin, Ontario Ministry of Health and Long-Term Care, May 2017.

## How long-term care works

In Ontario, long-term care is regulated and funded by the provincial government. Government agencies called Local Health Integration Networks (LHINs) do the assessments to determine who is eligible to be admitted to long-term care, and they manage the wait lists.

Long-term care homes in Ontario are owned and operated by a variety of different operators including individuals, family-owned businesses, private corporations, publicly traded companies, non-profits and charities, and municipal governments (municipalities are required by legislation to operate at least one long-term care home). There’s a wide range in how they function: some long-term care homes are part of large corporations, while others are stand-alone independents.

Each home owner/operator is granted a licence to operate by the government, which then provides funding for the staff and supplies to provide nursing and personal care, resident programs and support services, and raw food (used to make meals). Homes are required to follow the requirements of the *Long Term Care Homes Act*, and are inspected annually to ensure that they are complying with the more than 600 regulations.

Residents are required to pay a copayment that ranges between approximately \$1,800 and \$2,600 a month, depending on whether accommodation is a basic, semi-private, or private room. In essence, this resident copayment covers their “room and board”. The government sets the rate, while offering subsidies to those who can’t afford the copayment.

This payment for resident accommodation is what long-term care homes use to pay expenses such as non-care staff, utilities, and mortgages as well as expenses that support infection control, regular building maintenance, and major capital repairs (such as a roof or heating system).

## PROVINCIAL FUNDING FOR LONG-TERM CARE, 2017



**\$4.1 billion**

(7.7% of overall health budget)

Approximately **\$96.26** per resident, per day for nursing and personal care such as assistance with personal hygiene, bathing, eating, and toileting

**\$11.82** per resident, per day for specialized therapies, recreational programs, and support services

**\$9** per resident, per day for raw food (ingredients used to prepare meals, including nutritional supplements)

SOURCES: 2017 Ontario Budget; 2017 Long-Term Care Home Level-of-Care Per Diem Funding Summary, Ontario Ministry of Health and Long-Term Care.



## Long Term Care *PLUS*



**POST-ACUTE  
CARE**



**SPECIALIZED  
CARE**



**THE HUB**



**CONTINUUM  
OF CARE**



**DESIGNATED  
ASSISTED  
LIVING**

### Looking to the future

How does our health care system need to evolve to meet the needs of seniors?

At the moment there is only one type of long-term care home in Ontario, providing 24-hour personal and nursing care for a population with advanced physical and cognitive decline.

There are regulations, admission criteria, and funding models that currently affect the kinds of residents that long-term care homes are able to accept. But with flexibility and innovation, long-term care could offer so much more.

In 2011, an expert panel made a number of key recommendations about expanding the current model of care to a number of different options. These models of care build on current long-term care homes and their expertise to provide a broader range of services to Ontario's seniors. Many of the models have been applied in the United States and other jurisdictions, and some components have been implemented on a small scale in some Ontario homes. The expert panel believed these models could be expanded more broadly in Ontario. Doing this would improve the options currently available to provide care to seniors and free up much-needed beds within existing long-term care homes.

Called Long Term Care *Plus*, these models of care could offer so much more than the traditional long-term care model that is currently funded in the province. Each model of Long Term Care *Plus* may require additional staff, equipment and training, a different mix of staff, or changes to the physical environment. The Ontario Long Term Care Association is currently researching these models of care and identifying the legislative, regulatory, and policy changes that would be required to allow seniors in Ontario flexibility in the care they need.



## About the Ontario Long Term Care Association

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### Photo credits

The Association would like to thank the residents and staff of Kensington Health, the O'Neill Centre, Schlegel Villages, Woodingford Lodge, Tilbury Manor and Trinity Village for the photos used in this report.



The Ontario Long Term Care Association is the largest association of long-term care providers in Canada and the only association that represents the full mix of long-term care operators — private, not-for-profit, charitable, and municipal.

The Association represents nearly 70% of Ontario's long-term care homes, located in communities across the province. Our members provide care and accommodation services to more than 70,000 residents annually.

For more information,  
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**This is Long-Term Care 2018**

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