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STANDARDS RESEARCH

Supporting Mental Health and Well-Being in Community Residential Care Settings

A Framework for Standard-Based Solutions

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Foreword

This document presents two separate but related pieces of work:

Part A presents a detailed research report that provides a summary of existing guidelines, research literature, and expert opinion relevant to supporting the mental health and well-being of people living in community residential care settings. This report is **intended for those who want to better understand the recommendations made in Part B,** the evidence reviewed, and limitations in the body of evidence that restrict generalizability.

Part B provides an evidence-informed guidance document comprised of recommendations that community residential care facilities should follow in order to promote and support the mental health and well-being of residents, their families, and care providers. The recommendations are **intended to provide guidance to all levels governing residential care in order to ensure the mental health and well-being of residents and a supportive work environment for staff.** Resources to support the implementation of the recommendations are provided in the Appendices.

Table of Contents

Executive Summary 6

Part A: Supporting Mental Health And Well-Being In Community Residential Care Settings – A Review Of Evidence 8

1 Introduction 8

2 Purpose 10

3 Methods 10

3.1 Literature Search 10

3.2 Key Informant Interviews 11

3.3 Survey 11

4 Results and Discussion 11

4.1 General Overview of Search Results and Gaps 11

4.2 Literature Describing Demographics of Residents, Family Caregivers, and Staff 12

4.2.1 People Living in Residential Care in Canada 12

4.2.2 Family Caregivers 12

4.2.3 Residential Care Staff 12

4.3 Mental Health and Well-Being in Residential Care Homes in Canada 12

4.3.1 Residents' Perceptions about Factors Contributing to Mental Health, Well-Being, and Quality of Life 12

4.4 Applying a Mental Health Promotion Framework to Findings 13

4.4.1. Enabling Physical Environments That Support Mental Health and Well-Being 13

4.4.2 Strengthening Individuals' Mental Health and Well-Being 17

4.4.3 Strengthening Relationships That Support Mental Health and Well-Being 22

4.4.4. Positive Social Environments That Support Mental Health and Well-Being 26

4.4.5 Supportive Work Environments That Support Mental Health and Well-Being 30

4.4.6 Workforce Capacity and Training to Support Mental Health and Well-Being 32

5 Limitations 44

6 Conclusion 44

Part B: Considerations and Recommendations Arising From the Research Report 46

1 Guiding Principles and Best Practices 46

2 Scope 47

3 Recommendations 47

3.1 Enabling the Physical Environment 47

3.2 Strengthening Individuals 47

3.2.1 Residents 47

3.2.2 Family Caregivers 48

3.3 Strengthening Relationships 48

3.3.1 Staff-Resident 48

3.3.2 Staff-Family 49

3.4 Positive Social Environment 49

3.5 Supportive Work Environment 50

3.6 Workforce Capacity and Training 51

3.7 Policy and Practice 51

References 53

Appendix A – Key Informant Script and Questions 70

Appendix B – Community Residential Care Survey: Supporting Mental Health 72

Appendix C – Resources to Support Implementation of Recommendations 75

Executive Summary

On March 11, 2020, the World Health Organization (WHO) declared the novel coronavirus disease (COVID-19) to be a global pandemic and it soon became apparent that community residential care settings, and in particular nursing homes and long-term care (LTC) facilities, were the epicentre for infection and death. Pre-pandemic systemic and structural deficiencies (such as a precarious front-line workforce fuelled by decades of deregulation, privatization, contracting out of support services, inadequate staffing levels, antiquated hospital-like institutions, reduced care services, and lack of effective oversight), created an overstretched system unable to respond to the pandemic. The systematic reduction of staff providing medical coverage, regulated nursing staff, physical and recreational therapists, and social workers left inadequately trained care aides struggling on their own with little support to meet the complex needs of residents. In these circumstances, in many facilities, an institutional model of care with a focus on basic physical and personal care, and on task completion, has resulted. Psychosocial, mental health, and emotional needs, as well as factors that promote well-being and quality of life, have been largely ignored as staff struggle to provide even basic physical care compassionately, and as residents languish.

Mental health problems are common in LTC, with the majority (76%) of residents diagnosed with a mental disorder (40%) or Alzheimer's Disease and Related Dementia (36%) [1]. As well, delirium affects 40% of residents in LTC facilities [2], up to 20% of residents live with an anxiety disorder, and between 6.5% and 58.4% of residents experience clinically significant symptoms of anxiety [3]. Two to three per cent of residents in LTC live with schizophrenia [4]. Dementia has a median prevalence of 58% in LTC facilities, and 78% of individuals with dementia are affected by behavioural and psychological symptoms of dementia (BPSD) [5]. Approximately 19% of residents have severe to very severe aggressive behaviours [6]. Access to ongoing training for facility staff about recognizing and managing mental illness and BPSD is limited, as is access to mental health consultants, particularly in rural and remote areas. Given these circumstances and an overstretched front line, pharmacological interventions may be implemented rather than psychosocial ones, sometimes inappropriately.

The aim of this report is to develop a comprehensive guidance with recommendations to support the mental health and well-being of people living in community residential care settings, and that could provide a framework for a new standard.

The methodology included (1) a review of peer-reviewed scientific literature, and grey literature, about strategies/interventions, practices, programs, training, and policies that support the mental health and well-being of people living in community residential care settings, (2) key informant interviews, and (3) an online survey of people with lived experience in community residential care settings. A summary of the results was compiled into a research report (Part A), organized around a mental health promotion framework. The key points from the research literature were then used to develop a guidance document (Part B).

A mental health promotion framework focuses on the mutuality of residents, family caregivers, and staff within the residential care environment, and applies to those without mental illness as well as those at risk of or living with mental illness. A mental health promotion framework is in line with the World Health Organization's *Global Strategy and Action Plan on Aging and Health.* Key actions include orienting health systems around intrinsic capacity and functional ability, developing and ensuring access to quality older person-centred and integrated clinical care, and ensuring a sustainable and appropriately trained, deployed, and managed health workforce [7].

The physical and social environments, often interacting, are potent influences on the daily life of residents and their capacities and functioning. Evidence and expert opinion are provided about how facilities can be designed, modified, and adapted to support residents' mental health, well-being, and quality of life. Likewise, there is evidence presented that a social environment underpinned by a relational person-centred care model has positive effects on residents' mental health, well-being, and quality of life, and on the staff's morale, satisfaction, and retention. There are many effective approaches to reducing social isolation, strengthening residents' capacities, and addressing mental health problems that can be implemented in community residential care settings. Relationships between residents, their families, and staff are important to the residents' well-being and can be supported and enhanced.

The link between residents' quality of care and quality of life with a supportive work environment and staff well-being has been made explicit by the effects of the pandemic. More front-line/direct-care staff, empowered and with better working conditions, changes to how care is organized, supportive person-centred leadership, and an increase in allied health care professionals are all required to enable facilities to create environments and conditions that support the mental health and well-being of all residents, families, and care providers. Additionally, given the diversity and complexity of the resident population in LTC facilities and the prominence of mental health issues/illness, access to specialized dementia and mental health training, consultation, and management of challenging behaviours is imperative to both increasing the capacity of facility staff to provide competent mental health care and to ensure the well-being of residents.

COVID-19, by exposing the flaws in how community residential care is provided, has also given us a map and an opportunity to implement the changes that will make LTC and other residential care settings places where residents thrive and where staff look forward to going to work. Policies and practices to facilitate a positive residential care environment for residents, families, and staff are outlined while recognizing that the government has a responsibility for funding facilities and for building and adequately supporting a workforce, sufficient in number, and with the diverse skills and knowledge required to meet the holistic and complex needs of our most vulnerable citizens.



"Long-standing deficiencies in community residential care settings, exacerbated by the COVID-19 pandemic, have led to devastating failures in the care of these vulnerable residents, ranging from neglect and abuse to death."

Part A: Supporting Mental Health And Well-Being In Community Residential Care Settings – A Review Of Evidence

1 Introduction

In Canada, approximately 225,000 older adults (about 1.2% of seniors), mostly women (65 to 70%), live in long-term care (LTC) facilities or nursing homes, and another 168,000 older adults live in other community residential care settings [8]. Relatively little is known about the characteristics and needs of those living in community residential care settings such as lodges, assisted living, or supportive housing as variation in definition, eligibility criteria, services provided, and terminology across the country make it difficult to collect data or to develop research evidence. By contrast, though terminology also differs between provinces, much more is known about the population in nursing homes, personal care homes, or LTC facilities (the term that will be used most frequently in this document).

The LTC population, predominantly women and those over age 85 [6], has the highest care needs and is composed of culturally diverse individuals living with dementia, debilitating illnesses, mental health issues, challenging/responsive behaviours, substance use, and severe psychiatric illnesses, as well as those who are developmentally disabled or physically disabled without cognitive impairment, and those physically able and significantly cognitively impaired. The majority have at least one chronic disease and need extensive (47%) or complete (35%) assistance with Activities of Daily Living [6]. Mental health issues are prominent with the majority (76%) of residents diagnosed with a mental disorder (40%) or Alzheimer's Disease and Related Dementia (36%) [1]. As well, delirium affects 40% of residents over the course of their time in LTC [2], up to 20% of residents live with an anxiety disorder, and between 6.5% and 58.4% of residents experience clinically significant symptoms of anxiety [3]. Two to three per cent of residents in LTC facilities live with schizophrenia [4]. Dementia has a median prevalence of 58% in LTC facilities and 78% of individuals with dementia are affected by behavioural and psychological symptoms of dementia (BPSD) [5]. Approximately 19% of residents have severe to very severe aggressive behaviours [6].

Long-standing deficiencies in community residential care settings, exacerbated by the COVID-19 pandemic, have led to devastating failures in the care of these vulnerable residents, ranging from neglect and abuse to death. The systemic and structural factors exposed to the public by COVID-19 (but known to those responsible for seniors' services and to those providing care for many years, as evidenced by a plethora of research and media reports) include:

- Decades of funding cuts, deregulation, contracting-out of support services (e.g., dietary, laundry, and housekeeping), privatization, inadequate staffing levels, reduced care services, and lack of effective oversight;

- Antiquated "hospital like" facilities;
- Limited access to technology and equipment that would support care;
- An unstable front-line workforce, primarily care aides[1] who are poorly paid and neither adequately trained nor supported to meet the complex needs of residents;
- Practices such as hiring temporary, casual, and part-time front-line and support workers over creating full-time or permanent positions;
- Systematic reduction of staff providing medical coverage, regulated nursing staff, physical and recreational therapists, and social workers;
- Limited access to on-the-job training for care aides;
- Limited access to specialized mental health or palliative care services; and
- An Institutional/medical model of care with care practices that are centred on task completion, in "hospital like" physical settings [8], [10], [11], [12].

These factors, fuelled by a long-standing under-resourcing of long-term care, may reflect ageism where older adults, especially those with high dependency needs, are framed as burdens on society rather than as citizens with human rights [13], [14], [15].

The pre-existing deficiencies exposed by COVID-19 were exacerbated when an overstretched residential care system could not cope with the additional pressures of the pandemic. Many residents experienced increased loneliness and social isolation; declines in cognitive functioning, physical, and mental health; and a worsening of responsive behaviours, while during the same period the use of psychotropic medications and physical restraints increased [16]. Since the pandemic, 44% of Canadians say they dread the thought of LTC facilities, and three-quarters say either significant changes (45%) or a total overhaul (31%) of LTC facilities is necessary [17].

Residents, staff, and family members are affected by the long-standing deficiencies in how LTC facilities are resourced, organized, and provide care. Residents, like all of us, need meaningful activities and, at times, emotional support. They also need to have enjoyment, feel like they matter, feel they belong, and that they are valued. Chronic short-term staffing, high staff turnover, and use of casual employees on the front line demands that staff focus on tasks with little opportunity to get to know the residents. Additionally, standardization of tasks to promote efficiency removes autonomy from front-line staff and provides little or no space to address the individual needs and preferences of residents/families [18]. Under these conditions, in most facilities, physical/body/personal care tasks are by necessity prioritized, with no time to relate to the resident or attend to psychosocial and mental health needs. If the resident is not "known" as a person by the care aides who provide almost all the direct care, the care can only be custodial, even if kindly carried out, and the resident's well-being is compromised and their mental health and quality of life undermined. Similarly, there is little time to support the resident's family.

A time-stretched institutional environment, unleavened by relational and individualized care, is unlikely to promote and support the mental health and well-being of residents without existing mental health challenges, placing these residents at risk of developing mental health problems. If the psychosocial and mental health needs of the "average" resident are overlooked, then certainly the more specific cultural needs of residents who are part of minority groups (e.g., LGBTQ2S+, non-seniors, Indigenous), will not be met. Likewise, the needs of residents who have mental health problems and illnesses, or experience BPSD, will not be adequately addressed. Although there are examples of excellence around the country, our residential care system fails to support residents' psychological, emotional, mental, relational, cultural, and social well-being or to provide specialized support for complex needs. This is largely due to inadequate staffing, the culture and organization of care, and resulting limited knowledge of individuals' needs.

Care aides on the front line not only lack time but also the necessary training, knowledge, leadership, and organizational support to effectively identify and

1 Care aides include health care, residential care aides, nurse aides, and other non-professional staff who provide almost all direct and personal care.

meet the diverse and complex needs of residents with mental health challenges, mental illness, or responsive/challenging behaviours. Care aides frequently need to rush the care they provide and, in doing so, may unwittingly precipitate or exacerbate BPSD events that they lack the skills to defuse. Especially in rural areas, facility staff have little opportunity for education and skill building in the management of challenging behaviours, and have limited access to consultants on seniors' mental health teams for support assessment and care planning. Mental health challenges and issues are too often dealt with by medications alone rather than being complemented by holistic, non-medical supports and care.

The well-being of residents is linked to the well-being of those providing care, at individual, organizational, and larger health care systems levels [19]. The workforce providing direct care to seniors in residential care is gendered and racialized – about 90% are women, approximately 60% speak English as a second language, and about half of those in urban centres are immigrants – many of whom have experienced fear, grief, and moral distress, especially during the pandemic [8]. This workforce is poorly paid and vulnerable to exploitation as a result of human resource and business practices. Additionally, these care providers require support themselves, as well as the time and the "tools" (e.g., appropriate training, access to consultants, and a more positive work environment), to enable them to provide quality care to the complex resident population. Thirty-nine per cent of Canadians say they would increase the minimum number of staff per facility and 38% say they would increase their pay in order to recruit and retain quality employees [17].

There is increasing empirical evidence that challenges such as inadequate staffing, lack of staff training, inter- or intra-professional conflict, and moral distress can adversely affect the quality and safety of health care delivery [20]. A shift is needed from the current institutional/custodial model of care to a culture/social environment that prioritizes quality of life; promotes and supports mental health and well-being and is respectful of the whole person and their preferences; is culturally sensitive; and involves the sharing of power within a therapeutic alliance to improve clinical outcomes and satisfaction with care [21].

Residential care in Canada would benefit from the development of a coherent, integrated, and principle-based framework that prioritizes mental health and well-being and guides the planning, development, and implementation of services, programs, education and training, and policies. Such a framework could provide a map for facilities to create positive environments that support residents, their families, and care providers. It would include clear principles and standards by which to judge policies and performance and evaluate proposed reforms for delivery of care, which in turn would shape particular policies and guidelines at the individual level of care [22]. Clear standards are needed for residential care facilities to ensure that the residential care system is shaped around the comprehensive health needs of individual residents, their families, and communities [23].

2 Purpose

The purpose of this report is to develop a comprehensive guidance with recommendations to support the mental health and well-being of people living in community residential care settings, and that could provide a framework for a new standard.

3 Methods

Three sources of information inform this research report: a review of Canadian and international research literature about strategies/interventions, practices, programs, training, and policies that support the mental health and well-being of people living in community residential care settings; key informant interviews; and an online survey of people with lived experience in community residential care settings.

3.1 Literature Search

The two review questions used for this literature review were as follows: (1) What factors influence the mental health and well-being of (i) diverse people living in residential care settings, including those with and without mental illness, and (ii) families and staff, as it affects residents? (2) What factors and interventions support the mental health and well-being of residents, families, and staff in residential care settings? Searches were made using Medline, PsycINFO, EMBASE

(through OVID), and CINAHL, for empirical research published in peer-reviewed journals from 2010 to 2021. Terms used were (long-term care facility, nursing home, assisted living facility and supportive housing) and (mental health and well-being, quality of life, emotional well-being, and positive mental health); and outcomes in relation to each of the following: physical design, social environment; work environment; care models; staffing; social isolation; social connection. A separate search was carried out on resident and family caregivers' experiences. Seventy-two systemic reviews, 58 meta-analyses, 65 outcome studies, 110 reviews, and 48 qualitative studies were examined. The academic and international grey literature (using LibrisDocs) was searched for relevant Canadian and international policies; program design and implementation; and best practices. Additional data base searches and hand searches were conducted for areas that yielded few results: young adults, LGBTQ2S+, ethnicity, Indigenous, gender.

3.2 Key Informant Interviews

Key informant interviews were conducted by telephone with individuals chosen for their expertise in specific areas where literature was scant or more in-depth perspectives was required on particular topics. Sixteen interviews were conducted and included a residential care home architect; a sociologist; a gerontologist; a policymaker; a national seniors' organization representative; a national MS Society representative; two geriatric psychiatrists; a culture change leader; an operator of an Eden Model facility; an operator of an Indigenous LTC facility; a mental health consultant to Northern communities including Indigenous communities; an LGBTQ2S+ leader; a chair of a provincial association of Family Councils in LTC facilities; a leader in technological approaches to training care providers; and a leader in innovative approaches to support older adults' quality of life. There were interviewees from Quebec, British Columbia, Manitoba, Saskatchewan, Ontario, and Nova Scotia. Interviewees were advised that selected information they provided would be integrated into the report but anonymized and their names would not be included, to which all interviewees gave their consent. Key informant script and questions are appended (see Appendix A).

3.3 Survey

People with lived experience (defined as residents in a community residential care facility or as a family or friend of a resident) were surveyed about their views related to supporting residents' mental health and well-being. An anonymous online survey was developed in French and English that allowed residents or family/friends to complete the survey on their own behalf, or family/friends to complete the survey with the resident. Closed and open-ended questions were designed – see Appendix B. The survey was distributed to relevant organizations and associations identified through our networks, and recipients were asked to forward it to others. Five residents and 96 family/friend caregivers, 18 of whom responded in collaboration with a resident, completed the survey. Results from the survey are integrated at relevant points throughout the report.

4 Results and Discussion

4.1 General Overview of Search Results and Gaps

The vast majority of research literature identified for this report relates to long-term care (LTC) settings and pertains to people (most frequently seniors) living with dementia. Most research about families relates to those caring for someone in community, usually with dementia. Minimal literature was found on the mental health of residents in assisted living and supportive housing. Although not reviewed for this report, the fairly extensive research about community-dwelling seniors and family caregivers could have relevance to residents living in assisted living settings. The intervention research identified is largely focused on residents in LTC settings and on individuals living with a dementia, with a smaller amount focused on the general facility population and even less on those living with significant mental illness.

There is research on workforce issues, staffing, leadership, training, organization of work, culture, and models of care but almost all relates to systems, structures, and populations in LTC facilities. Similarly, the research about person-centred care and its impact on residents' well-being and staff satisfaction primarily relates to LTC facilities, as does the influence of organizational factors on care.

Little research literature was found related to community residential care residents who are young adults, people living with serious mental illness, or members of the LGBTQ2S+ or Indigenous communities. A small amount of research literature was identified about minority ethnic groups living in community residential care settings, but the populations studied were too small and too diverse to make generalizations.

4.2 Literature Describing Demographics of Residents, Family Caregivers, and Staff

4.2.1 People Living in Residential Care in Canada

Approximately 225,000 older adults (about 1.2% of seniors) and mostly women (65 to 70%) live in long-term care (LTC) facilities or nursing homes and another 168,000 older adults live in other community residential care settings [8], [24]. The average age of residents in LTC facilities is 83 years, 54.4% are over age 85, and 6.7% are under the age of 65 [6]. The average length of stay in LTC facilities is two and a half years.

The LTC population is more dependant and older than in previous years, with complex social, medical, and mental health needs, along with multiple co-existing health conditions. Mental illnesses are prominent. A quarter of those admitted to LTC facilities have a mental health diagnosis [25] while many develop depression soon after they are admitted. About 87% of LTC residents have some degree of cognitive impairment; about two thirds have a formal diagnosis of dementia; and about 25% of LTC residents have a severe cognitive impairment [8]. BPSD affects 78% of individuals with dementia in LTC facilities [5]. Eighty per cent or more of older adults living in LTC suffer from some form of mental disorder with depression, dementia, and anxiety the most common problems [8]. About 23% of LTC residents have depression and dementia, 27% residents have depression and up to 20% have an anxiety disorder [5]. Additionally, some LTC residents live with bipolar depression, major depressive disorder, and schizophrenia, independent of dementia [26]. In Ontario alone 40% of older adults in LTC need psychiatric services, but less than 5% receive that care [27].

Data are not collected across Canada about community residential care settings other than LTC facilities. Within the LTC system, data about diversity – race, ethnicity, LGBTQ2S+, and so on – are not collected. In the care of seniors generally, inequity and inequality have been identified, based on poverty, mental illness, substance abuse and addiction, homelessness, absence of family or friends, intellectual and physical disability, visible minority status, Indigenous status and LGBTQ2S+ identity [8]. It is very likely these factors have also impacted the lives of those living in community residential care facilities, including LTC.

4.2.2 Family Caregivers

Family caregivers are a gendered population. Two thirds to three quarters of caregivers providing unpaid care to adults are women, many of whom have responsibilities for children and work [8].

4.2.3 Residential Care Staff

Care aides provide about 70 to 80% of direct care in LTC facilities [28]. Those caring for seniors are predominantly women, and more so amongst those caring for people living with dementia. The majority of allied professional staff are women [11] as are care aides (90%), up to 70% of whom are over the age of 40 [8]. Results from research in Western Canada indicate the majority of care aides (60%) speak English as a second language, and about half working in urban centres are immigrants [29]. Care aides are poorly paid and often work part time and without benefits. Prior to the pandemic, about 30% of care aides worked in more than one facility due to human resource practices of those facilities [8]. The precarious nature of their positioning makes them vulnerable to exploitation by their employers.

4.3 Mental Health and Well-Being in Residential Care Homes in Canada

4.3.1 Residents' Perceptions about Factors Contributing to Mental Health, Well-Being, and Quality of Life

There is considerable overlap in the literature amongst the concepts of mental health, well-being, emotional health, joy of life and quality of life, and in how adults in residential care speak of their well-being. Taking this

into account, there is a commonality in what people in residential care describe as important to themselves. From the perspective of those over age 85 in residential care, staying healthy and maintaining independence contributes to their **positive mental health and well-being,** as does having close relationships with family and friends [30].

Several studies have examined **quality of life** in residential care settings. In LTC settings, older adults perceive their ability to maintain independence, autonomy, and individuality as the most important criteria for determining their quality of life [31]. Other researchers, based on extensive observations and interviews with residents (with and without dementia), their families, and staff in 100 LTC facilities in the United States, identified autonomy/choice; dignity; food enjoyment; functional competence; individuality; meaningful activities; physical comfort; privacy; relationships; safety/security/order; and spiritual well-being as being important to the residents' quality of life [32]. Spiritual well-being and food enjoyment, based on another study, were identified as predictors of overall facility satisfaction, while dignity was also identified as a predictor of residents' satisfaction with both the facility and with staff [33]. A systematic thematic review of qualitative studies about LTC residents' perspectives of what influences their quality of life identified four key factors: the person's acceptance and adaptation to their living situation, their "connectedness" with others, living in "a homelike environment", and carers displaying "caring practices" [34]. Privacy during visits and staff being honest with them (73.6%) have been rated by residents in LTC as having a highly positive impact on their quality of life, more than other factors such as autonomy, staff-resident bonding, and personal relationships [9].

Joy of life and **meaning of life** have also been studied and are congruent with quality of life studies. A study in Norway found that LTC residents conceptualize the essence of joy of life as positive relationships, belongingness, meaning, moments of feeling well, and acceptance [35]. These findings are echoed in the findings from another study about meaning of life. Residents in LTC identified four factors as enhancing meaning in life: connectedness, survival despite declining functional capacity, engaging in "normal" activities, and seeking a place of refuge [36].

4.4 Applying a Mental Health Promotion Framework to Findings

A mental health promotion framework will be used to structure the remainder of this research report. Mental health is understood as "a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community" [37]. A mental health promotion framework focuses on the mutuality of residents, family caregivers, and staff within the residential care environment, and applies to those without mental illness as well as those at risk of or living with mental illness. A mental health framework takes a holistic and systems view, encompassing the following approaches, each of which contributes to the whole and interacts with the others [38]:

1. Enabling physical environments;
2. Strengthening individuals;
3. Strengthening relationships;
4. Positive social environments;
5. Supportive work environments;
6. Workforce capacity and training; and
7. Policies and practice.

This approach is in line with the World Health *Organization's Global Strategy and Action Plan on Aging and Health.* Key actions include orienting health systems around intrinsic capacity and functional ability, developing and ensuring access to quality older person-centred and integrated clinical care, and ensuring a sustainable and appropriately trained, deployed, and managed health workforce [7]. The mental health promotion framework also supports the concept of recovery, rooted in the importance of choice, hope, respect, empowerment, and individualized and person-centred care [39]. "Recovery means that a person is able to live a satisfying, hopeful and meaningful life, even when there are ongoing limitations caused by mental health issues" [40].

4.4.1. Enabling Physical Environments That Support Mental Health and Well-Being

The physical environment in which residents live, encompassing the building and design features, influences their mental health, well-being, and quality



"Improving the quality of the physical environment is increasingly seen as an important strategy for supporting the mental health and well-being of residents and for improving their quality of life."

of life. The physical environment to a large extent shapes the day-to-day life of residents by supporting or undermining their capacities, functioning, social opportunities, and connection, and by adding stress or mitigating it. As well, the physical environment influences families' attitudes towards the facility and how staff can provide care [41].

Improving the quality of the physical environment is increasingly seen as an important strategy for supporting the mental health and well-being of residents and for improving their quality of life. An enabling environment that supports independent transferring, mobility, Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL), is facilitated through building design (e.g., wheelchair accessible doorways) and technologies (e.g., motorized wheelchairs), and can allow residents to maintain autonomy, dignity, and self-esteem. A physical environment designed to support the capacities of residents living with dementia, and to reduce environmental stressors, may also prevent BPSD and with other mental illnesses. A review of evidence has found that the prevalence of BPSD increases if factors in the physical environment, such as room temperature, light levels, noise levels, and institutionalized ambience, are not addressed [42].

Systematic reviews of the empirical literature have found evidence that behaviours and well-being of residents living with dementia residing in LTC facilities are influenced by unit size, spatial layout, homelike character, sensory stimulation, environmental characteristics of social spaces, and engagement with outdoor spaces [43], [44]. There is consensus that single rooms, unobtrusive safety measures, varied ambience, and controlled levels of stimulation should be incorporated into LTC design to maximize residents' functioning and mental well-being [45]. Although all of these findings relate to dementia, utilizing evidence-based design principles is likely to benefit residents without dementia as well.

1. Unit Size

Many of today's residential care facilities are older and institutional, modelled on hospitals and reflecting the traditional medical model – central nursing stations, large units with long halls, shared bedroom and bathrooms, and so on. Research suggests that larger units (more than 30 residents) are associated with more agitation, aggression, cognitive decline, emotional disturbance, and negative interactions around territory [46]. By contrast, a comparison of resident outcomes in small units (5–10 beds) with traditional units (20 plus beds), found that those in smaller units experienced increased social engagement, greater positive affect, improved ADL function, felt more at home, and had higher quality of life scores [43]. A longitudinal study showed residents living in smaller units had significantly less decline in global cognitive functioning than those living in larger units [47]. These findings are supported by relocation studies where residents who moved from a larger unit to a smaller unit experienced improved ADL function, social engagement, and non-verbal social behaviours

[48]. Interviews with residents in smaller units suggest that the small size supports a sense of self and social connection with others [49].

Family and staff are also influenced by unit size. A systematic review found that family caregivers experience significantly less burden and are more satisfied with the nursing staff in small-scale units as compared with larger traditional wards [44]. The same review found that nursing staff working in small-scale environments, compared to those working in more institutional/traditional settings, were more satisfied and motivated, and less likely to quit, than were their colleagues. Additionally, large-scale units are correlated with increased time pressure among staff and with reduced quality of life for residents.

2. Spatial Layout

A review of dementia-friendly design literature concluded that a poorly designed space is detrimental to residents' well-being by increasing neuropsychiatric symptoms, confusion, memory and cognition decline; disrupting sleep, reducing visual clarity and way-finding; and increasing the rate of morbidity and mortality [46]. The spatial layout of a care unit can facilitate or undermine socialization, mobility, wandering, and way-finding. The long double corridors with equally spaced doors and little distinguishing décor, typical of traditional institutions, do not provide adequate visual cues for many residents to find where they are going, often leading to agitation and going into others' rooms, precipitating conflict. Open plans and shorter hallways with clear cues and signage can support residents' capacity to orient themselves, promoting a sense of competence and security [50]. Design strategies such as painting doors, light switches, and wall-mounted fittings a different colour from the background; using more varied colour choices; making surfaces non-glossy; and installing solid floor patterns can reduce confusion and support way-finding [51].

3. Homelike Character

Homelike settings for dementia care have been associated with improved emotional and cognitive functioning; increased social interaction, autonomy, and engagement in daily activities; and with reduced verbal and overall aggression, verbal agitation and anxiety, trespassing and exit-seeking. Small-scale dining spaces with homelike décor are associated with reduced anxiety and agitation and increased social interaction [43]. Residents' independence, autonomy, and social interaction are increased by access to kitchenettes with a microwave, fridge, and coffee machine [52]. Both staff and family members identify homelike environments as pivotal to decreasing behavioural disruptions and improving residents' quality of life [52].

In contrast to traditional institutional LTC facilities, and in concert with the culture change movement, several innovative small-scale housing models have emerged with positive influences on residents' mental health, well-being, and quality of life. Implementation of the Eden Alternative has been found to improve residents' psychological well-being, including reduced rates of depression, loneliness, helplessness, and boredom [53]. A longitudinal comparison of the Green House environment with that in larger facilities found that Green House residents had higher scores on quality of life domains of privacy, autonomy, relationships, and meaningful activities, as well as greater satisfaction and emotional well-being [54]. Staff in the Green House model who provide personal care, meal preparation, and laundry for 5 to 15 residents, spend more time with residents than staff in other LTC models [55]. Implementation of the Butterfly model, characterized by training care providers to use emotional intelligence in caring for residents, resulted in higher levels of resident social engagement, fewer staff sick days, fewer falls, and a decrease in antipsychotic use in an Ontario facility [56]. Dementia villages, such as Hogeweyk in the Netherlands, made up of small group homes within a secure village with shops and cafes that appear familiar, benefit residents' quality of life by enabling residents to participate in daily life and community as much as possible [56].

4. Environmental Stimulation

Environmental stimulation influences residents' levels of apathy (characterized by social withdrawal, lack of interest, and flat emotional responses), which are associated with resident and family well-being [57]. High levels of residents' apathy are associated with

decreased quality of life and reduced function in activities of daily living for residents, which in turn increases risk of depression and caregiver burden for the residents' families [58]. Results from one study suggest that if clear and strong environmental stimulation is provided, residents with dementia show significantly less apathy [57].

Noise levels in facilities influence residents' mental health, well-being, and quality of life.

Based on a systematic review, reduced social interaction, increased agitation and aggression, disruptive behaviour and wandering are associated with increased noise levels, while reduced noise levels are positively associated with improved quality of life [43].

Residents' well-being is positively impacted by levels of light [44], but facility lighting is generally dim and below recommended levels of greater than 2,000 lux [43]. Sleep can be improved and the agitation and anxiety that is often associated with late afternoon or evening can be reduced by exposure to two to three hours of early morning natural light, at 1,000 lux minimum [59]. Higher lighting levels (using a bright light box 2,500–10,000 lux) are associated with better nighttime sleep and daytime wakefulness, improved mood, increased alertness and Mini-Mental State Exam scores, and decreased agitation and disruptive behaviours [43].

5. Outdoor Spaces

Access to outdoor spaces can improve residents' mental health, quality of life, mood, sleep, and socialization, and reduce their agitation, aggression, falls, and the use of medication for behaviour management [60]. Design elements that create a calm and safe environment and support way-finding include open and safe access from inside (with signage); non-slip, non-shiny wide level walkways in a loop design; handrails; fencing and hidden gates; textures and materials for a tactile experience; continuity of surfaces; plants, seating areas, and shade [46].

6. Guidelines for Dementia-Friendly Physical Environments That Promote Mental Health and Well-Being

Dementia-friendly "Universal Design Guidelines" [61], developed in Ireland and based on an international review of best practices, can be used to support residents' mental health, well-being, and quality of life. Based on person-centred care and evidence that behavioural and affective symptoms associated with dementia can be reduced by an appropriately designed physical environment, a dementia-friendly design aims to:

- Encourage social connections and meaningful engagement with family, friends, and members of the local community;
- Reinforce familiarity and personal identity;
- Support meaningful activity;
- Promote positive risk taking, autonomy, and choice;
- Enhance self-esteem and confidence; and
- Ensure the ethical use of assistive technology, where relevant [61].

Strategies to create a dementia-friendly physical environment are outlined in the Universal Design Guidelines as follows:

- "Encourage a participatory design approach where people with dementia, their families, and caregivers can take part in the design process;
- Use familiar design with the use of recognizable features consistent with user expectations;
- Support personalization of the environment to enhance continuity of self;
- Provide an environment that is easy to interpret and calm, paying close attention to the reduction of acoustic and visual disturbances;
- Provide good visual access to key areas of the dwelling or to important objects to remind and prompt the occupant when required;
- Provide unobtrusive safety measures and appropriate technology such as Assistive Technology (AT), Ambient Assisted Living (AAL), Telecare or Telehealth to provide a safe and secure environment;
- Create distinct spaces for different domestic activities so that the meaning and function of these spaces is legible and more memorable;
- Provide safe and accessible outdoor spaces which are perceptible from the interior to encourage occupant use of these spaces" [61, pp. 8-9].

A key informant, an architect who has designed residential care facilities in Manitoba, strongly believes

that the physical environment influences residents' mental health, well-being, and quality of life and advocates for household units of 6 to 10 residents in single rooms, with access to outdoor spaces, that feel like a home [62]. He believes that even the best physical environment alone cannot support mental health, well-being, and quality of life and that the philosophy of care is crucial. He supports the Green House model with its universal staff positions that reduces hierarchy and allows staff to act as "house parents". He believes that ageism ("nobody cares about what goes on in facilities") and corporate interests make adoption of household models in Canada slow. He thinks, however, that research showing that COVID-19 incidence and mortality rates were less in Green House and other small facilities (fewer than 50 beds) compared to rates in traditional facilities (more than 50 beds) [63] may spur change. The informant felt that large facilities with three to four residents to a room should be eliminated or modifications made in order to ensure single rooms or a few double rooms. This is possible to do as borne out by other key informants, facility operators, who have modified traditional four-storey 60-bed facilities to create household pods that are staffed and operated using a universal staffing model and follow Green House philosophy [64]. One informant recommended that operators use the Built Environment Audit Tool [65], developed in Australia, to audit their physical environment and to develop action plans based on leading practices.

Clearly the physical environment, which for most residents in LTC is their whole world, can have a profound effect on mental health, well-being, and quality of life. There is ample evidence and guidelines that can help designers and operators create or modify the environment so it supports residents' optimal physical, emotional, and cognitive functioning while mitigating stressors as much as possible. While elimination of old traditional facilities in favour of more human-scaled settings that better support relational care is ideal, in the meantime modifications are often feasible [47], [65]. Attention to the physical environment will not only enhance residents' lives, it will also improve families' experiences of the facility and staff's capacity to provide quality care [41].

4.4.2 Strengthening Individuals' Mental Health and Well-Being

4.4.2.1 Interventions Strengthening Residents

Residents, as do all of us, need meaningful activities and, at times, emotional support. They also need to have enjoyment, feel like they matter, feel they belong, and feel that they are valued. Participation in meaningful activity and engagement with others is important to residents and to their families [66], and it also contributes to enjoyment, maintaining functions and capacities, the development of skills and a sense of purpose, all of which support resiliency, mental health, well-being, and quality of life.

Many people living in residential care have sensory and cognitive impairments that affect communication, and many have reduced autonomy and increased dependence that impact opportunities for social connection. These factors, as well as disruptions to pre-placement relationships, are especially potent for those who feel different from others and place residents at risk for social isolation [67]. Behavioural and psychological symptoms of dementia (BPSD) that may manifest, for example, as apathy, agitation, or inappropriate behaviours also affect social relationships, isolating the individual. Social isolation can erode mental health through loneliness, emotional distress, depression, and cognitive decline, and can increase the risk of mortality that is often associated with such isolation [68]. These diverse factors, which can impact residents' mentally, socially, and physically, frequently interact with one another, as well as with factors in the social and physical environmental. This complexity requires a comprehensive biopsychosocial approach to assessment and treatment that takes into account all contributing factors and their effects on each other and makes corrections where possible.

Strategies to strengthen individuals' capacities can mitigate or modify limitations and support well-being. There is a recognition that social connection is good for health and well-being and important to the quality of life in LTC homes [69], [70]. There is a fairly extensive literature examining psychosocial interventions designed to support residents' mental health and well-being and to reduce or prevent BPSD by increasing

social connection and participation. Many of these focus on facilitating meaningful activity and enjoyment or on building/strengthening skills and increasing social participation.

Loneliness, which is a subjective experience, is a risk factor for social isolation and its attendant impacts on mental health and well-being, morbidity, and mortality. In Britain, loneliness in care homes has been identified as a significant issue and is almost twice as prevalent among those living in LTC facilities compared to community [71]. Loneliness in residents is associated with significantly higher limitations in activities of daily living, poor self-reported health, disability, mobility problems, reduced cognitive function, depression, poor psychological well-being, and ultimately a significantly higher mortality risk [72]. Loneliness can be reduced over time, as evidenced by results from a systematic review of interventions (15 studies) to address loneliness, primarily among LTC residents living with dementia [73]. The majority of interventions (approximately 87%) were successful in reducing loneliness, specifically leisure/skill development (six studies), such as exercise and pain programs, gardening, and radio listening; psychological therapies (five studies); and animal support interventions (two studies). Laughter therapy, reminiscence therapy, and horticultural therapy had the most effect on decreasing loneliness. Another systematic review found that canine-assisted therapies are feasible and can produce positive quality-of-life experiences for institutionalized people with dementia [74].

Effective strategies to help build and maintain social connection have been identified through a systematic review of research literature (61 studies) that included addressing pain, sleep disturbances, and visual impairment; creative expression programs; religious activities; animal-assisted therapy and therapeutic robotic animals (PARO); laughter therapy; reminiscence therapy; tai chi; and regular visits or videoconferencing with family members [75]. Based on their analysis, the researchers suggested that these strategies could be adapted for COVID-19 situations. Similarly, technology-mediated strategies [76], facilitating at-distance social interactions for seniors that expanded social networks, strengthened existing ties, provided social support or built community, and supported intergenerational relationship could also be used in COVID-19 or similar situations. The interventions identified through a systematic review (25 studies) primarily used telephones, video chat, e-mail, and Internet (for forum discussions), and most enabled interaction with an online group or with family and friends. In community residential care settings, and particularly in LTC settings, staff assistance might be required to use technology, depending on residents' abilities and the availability of personal equipment.

One of our key informants, a leader in innovative approaches to support older adults' quality of life [77], spoke of the need for more technological strategies to reduce social isolation or increase social connection among older adults in community residential care settings that had been highlighted by the pandemic. The organization, Centre for Aging and Brain Health Innovation (CABHI), supports "real-world" solutions tested in real-world settings. Front-line care providers, managers, and clinical researchers are funded through a competitive process to pilot and evaluate their innovative ideas/solutions, supporting them through to dissemination, or marketing them where warranted by results. Some of the promising projects can be seen on the CABHI website[2].

The mental health of older people can be promoted, and depression prevented, through psychosocial interventions, based on evidence from a systematic review of 69 prospective controlled trials and meta-analysis of 44 of the studies. Psychosocial interventions (categorized as physical exercise, skill training, reminiscence, social activities, group support, and multicomponent intervention) had a positive effect on quality of life and positive mental health, and the pooled interventions also had a statistically significant effect on reduction in depressive symptoms [78]. When analyzed separately, skill training interventions (i.e., playing video games, cognitive rehabilitation programs) increased positive mental health, and meaningful social activities (i.e., family style meals, volunteer tutoring and choir singing) improved positive mental health, life satisfaction and quality of life, and reduced depressive

2 CABHI website (https://www.cabhi.com/our-impact/)



"In that many residents spend long periods of the day with minimal interaction, and often alone, all exacerbated during COVID-19, researchers have examined the effect of non-facilitated activities on residents' well-being."

symptoms. One multicomponent intervention, an individualized activity intervention based on activities of daily living, had a positive impact on life satisfaction. On the other hand, the physical exercise, reminiscence therapy, and group support interventions had no effect on mental health and well-being outcomes. Although the studies reviewed excluded individuals with a mental illness or dementia, and only 15 were in LTC facilities, the interventions identified could be adapted to LTC populations if tailored to the residents' individual abilities and preferences.

In that many residents spend long periods of the day with minimal interaction, and often alone, all exacerbated during COVID-19, researchers have examined the effect of non-facilitated activities on residents' well-being. (The majority of research examining interventions to promote and support individuals' mental health and well-being in LTC has been facilitated by care providers.) Based on a systematic review [79], the impact of meaningful non-facilitated activities (i.e., music, simulated family presence through audio or video connections, robotic animal, plush toys, and lifelike dolls) on psychological outcome measures, such as quality of life, loneliness, mood, and BPSD, was examined. The meta-analysis found varying benefits overall: music was associated with lower levels of depression and agitation and improved sleep quality and social participation; simulated family presence was associated with lower agitation levels; activity with robotic animals was associated with lower agitation and increased pleasure; and doll activity was associated with increased pleasure. However, the benefits were only observed "in the moment" and not sustained. The researchers conclude that the evidence to support non-facilitated activities is insufficient and too inconclusive to warrant taking the place of facilitated activities. Similarly, a scoping review examining the role and potential of new technologies to enhance meaningful engagement for those with dementia concluded that while these could be an adjunct to human activity, the evidence indicates the focus must remain on creating human-to-human interactions while taking individual preference and person-centred principles into account [80].

BPSD, affecting up to 90% of those living with dementia [81], impact the individual's social activity, relationships, and quality of life, and are distressing to families, adding to their feeling of burden [82]. BPSD is very challenging for front-line staff to manage as they often have little training in this area. Further, when staff is unfamiliar with a resident, or care is rushed due to time constraints, the staff person may inadvertently precipitate or exacerbate the challenging behaviour. A comprehensive and integrated approach is required for effective intervention and management of BPSD and may include pharmacological and/or non-pharmacological approaches.[3] Two broad categories of non-pharmacological strategies have been identified

3 Pharmacological treatments, while recognizing their importance in treating mental illness and BPSD, are not included in this research report. For more information, see [89], [248].

in the research literature: (a) indirect interventions, including working with caregivers or adapting the environment, and (b) direct interventions, including those that focus directly on individuals with dementia (e.g., individualized recreation therapy, sensory-based therapy, exercise, music therapy, massage) [83]. To understand how indirect and direct interventions to address BPSD "work", a realist review examined empirical studies that evaluated non-pharmacological interventions to decrease BPSD, aiming to answer the question "What nonpharmacological interventions work to manage BPSD? And, in what circumstances do they work and why?" [84]. The researchers reviewed 77 intervention studies (LTC and community settings), which resulted in 14 different types of nonpharmacological interventions ranging from specific indirect interventions (e.g., training and education, light focused) to specific direct interventions (e.g., massage, music based) that were analyzed for the relationships between context, mechanism, and outcomes. They concluded that three mechanisms are essential – the caring environment, care skill development and maintenance, and individualization of care – for the effective implementation of interventions to reduce BPSD. They also concluded that design and implementation of interventions must take into account both the physical and the social environment, and that both initial and ongoing training in dementia and BPSD supported by enabling organizational factors are required. The strongest evidence for effective interventions was from studies using individualized approaches that promote self-determination and autonomy of persons with dementia. Congruent with this, a systematic review of meaningful or individualized tailored activities for people with dementia living in LTCs found they had positive effects on a range of behavioural and psychological symptoms [85].

Depression and anxiety, which are common in people living with dementia and are linked to reduced quality of life, worsened cognition, and increased functional impairment, behavioural disturbance, and mortality rates [86], can be alleviated through antidepressant medications and/or psychosocial interventions. A meta-analysis (six RCTs) to assess the effectiveness of psychosocial interventions for persons living with dementia and experiencing depression and anxiety [87] found that multicomponent interventions (Tai Chi, problem adaptation therapy, and exercise/walking) reduced symptoms of depression while music therapy and cognitive behavioural therapy (CBT) reduced symptoms of anxiety. Similarly, another systemic review found that for residents with dementia, preferred music had a positive effect on agitation, depression, and anxiety, while reminiscent therapy had a positive impact on mood and cognitive functioning [85]. It is recommended in the *Canadian Guidelines on Prevention, Assessment and Treatment of Depression Among Older Adults* that cognitive behaviour therapy and problem solving therapy, both supported by evidence from meta-analyses, be made available to all older adults with depression (symptoms and disorder) [88].

Social connection (defined to include social networks, social engagement, social support, social inclusion, and social capital) can mitigate some BPSD among those living in residential care settings. A systematic review of studies that tested the association between social connection and mental health reported associations between social connection and a decrease in responsive behaviours, specifically aggression, screaming, and agitation (6 studies); better mood, affect, and emotion (8 studies); and anxiety (2 studies). Better social connection was associated with less depression (28 studies) and less boredom (2 studies) while social engagement was associated with reduced cognitive decline (2 studies) [75]. Two of the studies, from Chinese nursing homes, reported impacts of social support, loneliness, and social engagement in relation to suicidal ideation.

Music therapy and behavioural management techniques are effective in reducing behavioural disturbances in older adults living with dementia, evidenced by results from a systemic review of systemic reviews of non-pharmacological treatments [89]. The researchers categorized interventions as (1) sensory stimulation that encompassed acupressure, aromatherapy, massage/touch therapy, light therapy, and sensory garden therapy; (2) cognitive/emotion-oriented (13 SRs; 26 primary studies) that included cognitive stimulation, music/dance therapy, dance therapy, Snoezelen, transcutaneous electrical nerve stimulation, reminiscence therapy, validation therapy,

and simulated presence therapy; (3) behaviour management techniques (6 SRs; 22 primary studies); and (4) other therapies (5 SRs; 15 primary studies) comprising exercise therapy, animal-assisted therapy, special care unit, and dining-room environment-based interventions. Due to comparability of studies being limited by heterogeneity, the researchers concluded that the evidence for effects of sensory interventions and other therapies on BPSD was not strong enough to support broad adoption in clinical practice. Among the cognitive/emotion oriented interventions only music therapy demonstrated an impact on BPSD, specifically on agitation, aggressive behaviour, and anxiety. Behaviour management techniques to enhance communication skills, formal caregiver training, and dementia mapping in residential care were found effective in reducing agitation. The researchers also found evidence that severe behavioural problems in LTC residents can be reduced using a comprehensive, integrated multidisciplinary behavioural management approach combining medical, psychiatric, and nursing interventions.

4.4.2.2 Interventions Strengthening Families

Placement of a family member in a residential care setting and changes in the relative's health and well-being can engender feelings of guilt, grief, and powerlessness among family [90]. The prevalence of psychological distress, such as depressive and anxiety symptoms, is high in caregivers of people with dementia [91]. Families often contribute to their family member's well-being and quality of life by continuing to provide hands-on care and by monitoring care, advocating for the resident, and maintaining the resident's continuity and connectivity with other family members and friends [16], [92]. The importance of these roles to families, and the need to support them, can be seen by the devastating effects on some families who were not able to visit during the pandemic.

Skilled psychosocial interventions are effective in supporting family caregivers through their family member's placement in residential care, and with changes in the resident's health and well-being [93]. For example, a four-month psychosocial intervention designed to help families manage their emotional and psychological distress following placement of a cognitively impaired relative had positive effects on participants, reducing caregiver burden, emotional distress, role overload, and negative reactions to challenging behaviours [94]. As well, a 12-week, group-based Chronic Grief Management Intervention (CGMI) that delivers knowledge about dementia and teaches skills in communication, conflict resolution, and chronic grief management reduced chronic grief and feelings of guilt among participants and increased their positive interactions with staff [95]. Other evidence, mostly from community settings but largely adaptable to those caring for people in residential care settings, demonstrates that skilled psychosocial support is effective in strengthening the resiliency, mental health, and well-being of family caring for a relative with dementia [96]. A meta-review of 66 systematic reviews and meta-analyses on nonpharmacological interventions for family dementia caregivers found that psychoeducation, counseling/psychotherapy, occupational therapy, mindfulness-based interventions, and multicomponent interventions have positive effects on depression. Additionally, psychoeducation had positive effects on quality of life and mastery, while communication training had a positive effect on communication skills.

The WHO's global action plan on dementia has identified a need for Internet and mobile phone technologies to provide education, skills training, and social support [97], which has become urgent with the pandemic. A systematic review of online training and support programs designed to improve the mental health of caregivers and reduce their burden of caring for people with dementia identified positive effects on caregivers' depression and anxiety [98] and on their knowledge and skills [99], [100]. The reviewers were unable to complete a meta-analysis due to methodological and statistical diversity in the studies.

To conclude, there is ample evidence that individual's capacities and strengths, mental health, well-being, and quality of life can be supported through targeted, individualized and skilled psychosocial interventions. There are strong links between social connection, mental health, and well-being that have been underlined by the detrimental impact of social isolation imposed on residents by the COVID-19 pandemic's protection

measures [101]. Activity workers and recreation therapists are required to design appropriate group and one-on-one activities, social workers to support residents and families, and mental health consultants to design behavioural interventions. A key informant who operates several LTC facilities spoke about the importance of having adequate resources and a team approach to develop and implement individualized psychosocial interventions, and, as equally important, having management support for flexible and creative approaches [64]. In her facilities, care aides attend care planning meetings and are trained to observe and report changes in residents' behaviours and moods, and they are trained to implement the interventions during the care of residents.

4.4.3 Strengthening Relationships That Support Mental Health and Well-Being

That positive social relations support the mental health of LTC residents living with dementia is evidenced by a systemic review examining the relationship between social connections and mental health outcomes [75]. Better social connections and engagement were associated with less depression and a decrease in some responsive behaviours; better mood, affect, and emotions; and less anxiety and less cognitive decline.

Relational care, a tenant of person-centred care and the culture change movement, recognizes that strong reciprocal and interdependent relationships among the person receiving care, their family members, and staff are integral to the well-being of all and to the quality of care and the quality of life for the residents [11].

4.4.3.1 Resident-Staff Relationships

Nurse-resident interactions influence residents' well-being – physically, emotionally, socially, functionally, and spiritually. In LTC, the majority of residents have more interaction on a daily basis with staff than with anyone else, often in intimate circumstances, making these relationships crucial to residents' well-being. Nursing practices that contribute to relational/person-centred care include those that acknowledge peoples' cultural and spiritual beliefs, preferences, and rights; empower people to make informed decisions about their care; provide a sympathetic presence; and provide holistic care [102]. How LTC residents evaluate nurses' attitudes, appearances, and behaviours acts as a measure of confirmation of their dignity, worthiness, or worthlessness [103].

Positive nurse-resident interactions provide a sense of being understood, valued, empowered, and facilitate and nurture coping abilities, while experiences of not being attended to or being treated with indifference create a sense of meaninglessness and loneliness [34]. A cross-sectional study examining the relationship between nurse-resident interactions and joy of life (encompassing perceived meaning, emotional, spiritual, meaningful activity, connectedness, relationships, and enjoyment) found a highly significant association between the quality of interactions and residents' perceived joy of life [35]. They concluded that enhanced nurse-resident interactions, through encouraging and allowing time for positive interactions, could facilitate/support residents' joy of life and well-being. This approach could also benefit residents living with dementia. The literature suggests that quality of life and well-being for people living with dementia are promoted by a personalized approach that is based on active listening, recognition, compassion, attentiveness, and sensitivity to the residents' needs and preferences in providing care [104]. There is evidence that residents' quality of life is positively impacted when staff are trained to tailor their communication strategies to address a resident's individual abilities [105].

Relational person-centred care supports residents' mental health and well-being and is highly valued by residents in LTC [34]. A systematic review of qualitative studies examining residents' perspectives on contributors to their quality of life concluded that residents desire and benefit from a reciprocal "friendship-like" relationship with care staff. Residents value being seen as who they are, and who they once were, as well as knowing about the staff persons' lives. This reciprocity contributed to the residents feeling understood and psychologically safe during care, affirmed their feelings of worth, and gave them confidence that their preferences would be respected. For these important relationships to be developed and attachments formed, continuity of staffing is crucial, as is allowing staff the time to get to know and relate to the

residents. Residents' dignity is supported when the care is unhurried ("slow care") and the nurse is perceived as being fully present [106]. Several studies have shown the importance of developing relationships with residents that are characterized by autonomy, independence, respect, and choice, thus replacing disempowerment, overprotection, and stigmatization [107].

Providing relationship-centred care requires a therapeutic relationship, built on mutual trust and understanding between the care provider and the care recipient. The Australian College of Nurses has identified professional competence, well-developed interpersonal skills, self-awareness, commitment to patient care, and strong professional values as the attributes of a nurse that enable him/her to deliver person-centred care [102]. The College notes that for these attributes to be applied to person-centred care requires "an appropriate staff skill mix; the presence of transformational leadership enabling the development of effective nursing teams, shared power, potential for innovation, supportive workplace culture and effective organisational systems; and the functionality and aesthetics of the built environment" [102, p. 1]. A key informant with a background as an LTC operator but currently working as a provincial policymaker [108] contends that not everyone is able to form relationships with residents, and especially with those residents whose cognitive or communication impairments limit their ability to express needs directly or to participate in forming relationships. In this situation, the care aide may receive little acknowledgement from the resident and must use his/her compassion, empathy, and keen observational skills to understand and relate to the resident in a caring manner. The informant spoke about the need to screen staff for emotional intelligence and empathy, and to incorporate these factors into staff supervision and evaluation.

Interactions between staff and residents with BPSD can be problematic and a source of tension between the staff and the residents and often the staff and the residents' families. Staff strain has been associated with less willingness to help residents, low optimism, and negative emotional responses to residents' behaviour [109]. A qualitative cross-sectional study [110] with staff in LTC facilities reported that the main difficulties staff experienced were related to lack of time to provide individualized personal care; lack of knowledge about dementia and managing BPSD; communication challenges; and stress and burnout related to BPSD. Interventions focused on caregiver/patient communication/interactions and dementia care can improve communication between staff and residents during care routines, increasing use of positive statements and not requiring more staff time for the daily activities [111]. These findings indicate the importance of receiving training in dementia care and receiving support to deal with stress and burnout.

A psychogeriatric consultant working in Northern facilities spoke of the importance of cultural safety for Indigenous residents in non-Indigenous facilities and reported on the benefits of having the staff in these facilities trained in SAN'YAS Indigenous cultural competency [112]. She spoke about the importance of all staff having access to information about each resident's background and how this might impact resident's behaviour [113]. She spoke of a wheelchair-bound residential school survivor whose fear was triggered by the facility's long hallways in the evenings. Once the staff understood this, they were able to ensure her chair was always positioned so the hallway was out of her line of vision. A gerontologist whose work focuses on diversity and aging observed that without an understanding of residents' cultures, or timely access to translation, behaviours can often be wrongly attributed to culture, or conversely to dementia, affecting staff-resident interactions [114]. Applying cultural safety principles and practices to all minority populations residing in community residential care settings would be beneficial to them.

4.4.3.2 Family-Staff Relationships

Families who place their relatives in residential care settings usually continue to provide personal, social, and emotional care to them, contributing to their well-being and quality of life [115]. Families are important to ensuring that all residents, especially those from marginalized communities (e.g., LGBTQ2S+ and Indigenous residents or those with language barriers), receive culturally safe and appropriate care [116]. The transitional phase of placement is one of heightened

uncertainty and stress for family members and their first impressions can set the tone for their relationship with the staff and with the facility [117]. Frequently, they take on the role of monitoring care and staff performance, and act as advocates for their relatives [118]. Encouraging continued family involvement in care may eliminate potential guilt and can foster a closer relationship between family and staff [119].

Despite the fact that families have the most investment in their relatives' well-being, some families have reported feeling excluded and unwelcome in the facility, and they are often reluctant to express concerns to administration for fear of repercussions against their relatives [20]. These feelings of powerlessness have been magnified by being prohibited from visiting their family members for months during the pandemic, resulting in many family members experiencing symptoms of anxiety, feelings of helplessness, and anguish [120].

> "The emotional wounds are deep and likely will affect me for the rest of my life".
>
> **—Family Member Survey Respondent**

Responding to caregivers' experiences, the Centre for Research and Expertise in Social Gerontology of CIUSSS West-Central Montreal has documented family caregivers' needs during the pandemic, inspiring practices to address them and making recommendations to LTC managers and decision-makers on how to best support families [121].

Relationships between residents and staff are an important influence on the experience and well-being of residents' families in residential care settings. Nurses who form "good" relationships with residents are considered not only more responsive, respectful, and trustworthy but also more ethical and effective in the care they provide [122]. Family members' well-being is promoted when staff involve them and make them feel they are a significant partner in the care and an important resource to the staff [123]. Conversely, families feel a sense of isolation when staff do not seem to value sustaining relationships with them or do not encourage their participation in caring for their loved ones. When family members feel excluded or ignored by staff, the quality of visits with their relatives is poor. Greater resident and family satisfaction with care can be achieved through shared decision-making with staff and by increasing the quality of decisions about and relevance of care interventions [124]. However, lack of privacy for family members to visit, limited access to supplies for provision of care, not having a consistent staff person for family members to contact, and restrictive policies may hinder involvement [125]. Additionally, there are structural barriers to staff engaging with and supporting families, which include increased resident acuity, shorter resident stays, irregular staffing schedules, and high staff turnover [126].

Results from a systematic review of factors contributing to family satisfaction with dementia care indicates that families value consistent, knowledgeable staff who interact well with both them and their relatives [127]. Clear communication with a consistent staff person is especially important for long-distance caregivers and can influence their perceptions about care and relationship with staff [128].

Three main areas of staff-family misunderstanding in residential care settings have been identified: how much influence over and participation in the resident's care that family members have; role uncertainty; and communication difficulty [129]. Family-staff conflict has significant consequences for both parties. In a study of 20 assisted living facilities, interpersonal conflict between family and staff was positively associated with perceived caregiver burden among family members whose relatives had dementia, and with depression and burnout among staff [130]. Front-line staff, primarily care aides, generally lack training and ongoing education in how to interact supportively with families and how to communicate effectively with family members who are distressed and upset with care/routines. Studies focusing on improving communication among older adults, nursing staff, and family members have demonstrated beneficial effects for residents (less depression, irritability, and abusive verbal behaviour) but not on the nursing staff's management of problem behaviours [131]. Based on a systemic review of interventions that promote constructive relationships between staff



"The quality of the relationship that care aides have with residents plays an enormous part in the residents' sense of being valued, cared about, respected, and safe."

and family members, the researchers found that effective interventions are based on collaboration in care planning and decision-making; promote effective communication skills; have a defined process; and involve the multidisciplinary health care team [132]. Further, interventions should include education on relationship development, power and control issues, communication skills and negotiating techniques, and involve documentation of expectations, goals, and responsibilities [133].

A key informant, an advocate for family councils [134], said that in many facilities families are at best, tolerated, and those who "complain" about care are seen as troublemakers. In his view, it as though ownership for the resident's safety – very broadly defined – is taken by the staff at admission, creating tension with families who wish to continue assisting with personal care. He notes that families often observe care aides working in very difficult circumstances, and blame administration rather than the care aides for deficits in care. This informant observed that where facilities embrace families as partners in care, there is mutual trust and respect, and everyone benefits. He has also noted that when families are supported from the point of admission and through transitions by a facility social worker, grief and guilt are less likely to become anger. This informant advocates the creation of mandated independent Family Councils in all LTC settings.

Supportive and collaborative staff-family relationships support residents as well as families and require planning, supportive procedures, and a real commitment from the organization, management, and staff at all levels. Policy, staff training, family orientation, resident care planning involving family, staff-family rapport and communication, and collaboration are core components of a family-oriented culture [135].

To conclude this discussion, the quality of the relationship that care aides have with residents plays an enormous part in the residents' sense of being valued, cared about, respected, and safe. As the primary human contact most residents have, the relationship with staff influences how residents' experience care, their well-being, and their mental health. Care aides hold most of the power in the relationship and may need guidance in how to use/share it positively with residents and likewise their families. Families often feel disempowered by care staff and the facility rules and regulations, and about who has decision-making power for the resident. The power relations between residents, families, and facilities were in sharp relief during the pandemic when families were unilaterally disallowed to visit the resident. All residential care staff need to be sensitive to their use of power, especially when responding to families' concerns, communicate with families clearly, and share decision-making as much as possible. In response to caregiver experiences and loss of trust in LTC during the pandemic, researchers have recommended staff be trained in developing effective partnerships with caregivers that are characterized by trust, equality, and mutual understanding and knowledge of the caregivers' realities, with the goal of improving communication [121].

4.4.4. Positive Social Environments That Support Mental Health and Well-Being

The social environment of residential care facilities, made up of an amalgamation of the norms, rules, practices, and other social and cultural elements that are brought in by the different people living and working in the setting, creates a world of its own [136]. This social environment includes interactions between individuals directly influenced by patterns of the culture in the environment formed (e.g., facility policies and practices), which in turn interact and influence each other [137]. This dynamic interplay between the residents and the environment shapes the "goodness of fit" between the individual's needs and capacities and the structure of the social environment, which influences mental health, well-being, and quality of life [138].

A positive social environment is about supporting seniors' mental health and well-being, so that they may enjoy the best possible quality of life, stay as healthy and active as possible and participate in things that matter to them [139]. Life in many LTC facilities is, however, largely institutionalized, representing loss of social relationships, privacy, self-determination, and connectedness for residents [140]. The roots of today's institutional model are grounded in the medical model and "care" is largely equated to physical/body care, including safety [141].

> "Physical health is well-funded and well-understood. Mental and emotional health and well-being needs to be more of a priority to improve quality of life".
>
> **—Family Member Survey Respondent**

The resulting social environment creates a regimented, routinized daily life, over which residents have very little control, and which does little to acknowledge, promote or address their mental health, well-being, or quality of life [142]. Care aides, who provide the vast majority of direct care and are best positioned to know residents and their needs and preferences, are task and time driven, and have minimal opportunity for using their knowledge in care or care planning [8].

A culture change from the current institutional model with its overemphasis on safety, uniformity, and medical issues to a relational, person-centred, holistic care social model is required to support the well-being of both residents and staff [8], [12], [143]. Culture change refers to the progression from institutional or traditional models of care to more individualized, consumer-directed practices that embrace choice and autonomy for care recipients and providers [107]. Tenets of culture change models are that residents do not live in the staff's workplace but rather the staff work in the residents' home, and "life is the program" [144].

There are a number of culture change models but most share a common vision to create a culture that is inclusive, life-affirming, satisfying, humane, and meaningful. Common elements of culture change include: resident-direction in care and daily activities; a home atmosphere; close relationships between residents, family members, and staff; staff empowerment; collaborative decision-making; and quality improvement processes [145]. Based on a review, the focus of culture change models is "care as a relationship, and on individualization; flexibility for residents and staff as well as in the division of labour, which requires structural empowerment; physical environments, especially small, homelike units, plants, outdoor access; leadership committed to the guiding principles" [146, p. 4].

LTC facilities that have implemented culture change have demonstrated positive effects on the well-being of residents, families, and staff. The Eden Alternative aims to relieve loneliness, boredom, and helplessness through values and practices that put the resident first, and by creating person-centred physical environments, organizational structures, and psycho-social interactions within the home [147]. Staff are empowered to provide care that is based on residents' preferences and that involve the families. Implementation of the Eden Model is associated with improvements in residents' mental health and well-being, specifically in reduced rates of depression, loneliness, helplessness, and boredom [53]. Additionally, visits by families and their perception of respect for residents by staff has been shown to increase. The Green House Project, an offshoot of the Eden Alternative, aims to facilitate a meaningful life for residents by using consistent empowered teams that provide clinical, personal, and social care in small households of ten residents. Because the care team

in each house does laundry, meal preparation, and housekeeping as well as personal care, they are able to spend more time with residents [55]. A key informant, the CEO of an Eden Alternative facility, reported that they have been able to successfully implement culture change philosophy and practices in a conventionally designed institution [148]. Other culture change models, such as the Butterfly Model of Care, Wellspring, and Hogeweyk Dementia Village, have all demonstrated positive impacts on residents' well-being and quality of life [56].

Person-centred care has been acknowledged as the linchpin for culture change in LTC and a best practice approach to providing quality care [149]. Both residents and family members have identified supporting personhood as the foundation for quality of life, through facilitation of meaningful activities and opportunities to feel useful and valued [66].

The goals of person-centred care are as follows:

- Create a positive social environment that promotes dignity and overall well-being;
- Deinstitutionalize the delivery of care to residents;
- Place decision-making with the residents or those who work closest to them;
- Empower both care providers and residents;
- Flatten the traditional hierarchy of decision-making;
- Nurture relationships between front-line staff and residents; and
- Create greater independence over each resident's daily life [150].

A systematic review of reviews of person-centred care has identified six components to the care: (1) establishing a therapeutic relationship; (2) shared power and responsibility; (3) getting to know the person; (4) empowering the person; (5) trust and respect; and (6) communication [151]. Key practices that personalized and tailored to the individual include the following: coming to know the whole person; ensuring family members are identified and included in assessing, planning, and implementing care as the resident wishes; exploring the person's goals and preferences for care; assessing the person's desired level of involvement in decision-making; and providing information to meet the resident's identified needs. Other practices that contribute to person-centred care include those that acknowledge peoples' cultural and spiritual beliefs, preferences, and rights; empower people to make informed decisions about their care; provide a sympathetic presence; and provide holistic care [102]. To enable staff to practise person-centred care requires "an appropriate staff skill mix; the presence of transformational leadership enabling the development of effective nursing teams, shared power, potential for innovation, supportive workplace culture and effective organisational systems; and the functionality and aesthetics of the built environment" [102, p. 1].

Person-centred interventions are multifactorial, comprising elements of environmental enhancement and opportunities for social stimulation and interaction, promoting the mental health and well-being of residents. A systematic review evaluating the evidence for the impact of person-centred interventions on residents and nursing staff [152] found that person-centred interventions are associated with improvement in the psychological status of residents (lower rates of boredom and feelings of helplessness), and reduced levels of agitation in residents with dementia.

In a person-centred care model, care providers are envisioned as "demonstrating person-centred care attitudes and behaviours that are respectful of the whole person and their preferences, are culturally sensitive, and involve the sharing of power within a therapeutic alliance to improve clinical outcomes and satisfaction with care" [21, p. 7]. Researchers examining culture change in LTC report that a fully implemented person-centred culture change results in residents experiencing improved perceptions of their quality of life, and reductions in symptoms of depression and use of antipsychotic drugs [153].

At its core, person-centred relational care is about really knowing residents well as individuals and empowering staff to create a positive and inclusive social environment that facilitates a sense of security and belonging for each resident. If a person-centred approach is taken, the uniqueness of all the residents, their background, life experiences, and culture, the ways they self-identify, and their values and

preferences are discovered, facilitating individualized care, thus supporting mental health, well-being, and quality of life. Care practices must be flexible enough to respect the needs of all individuals regardless of lifestyle, gender, age, sexual orientation, or disability.

Diversity and the social environment

The population in residential care is very diverse with groups of residents who are young or who are part of LGBTQ2S+, Indigenous, or ethnic minority communities. Applying a person-centred approach means that staff are supported in developing relationships that allow them to understand and appreciate the uniqueness of each individual and to tailor their approach and care accordingly.

Younger adults (under 65) are a minority in community residential care facilities designed for older adults. Their life stage means they may still have dependent children, their careers were cut short, and lacking pensions they may have very low incomes. A key informant, a manager within the Multiple Sclerosis (MS) Society, pointed out that while many of these individuals would benefit from electric wheelchairs, technology to facilitate communication, and specialized rehabilitation and occupational therapies, few are able to afford them. As well, many are "heavy care" but facilities lack the equipment, such as ceiling lifts, which would improve their care. Many younger residents have long-standing physical, and often cognitive, disabilities related to, for example, brain injury, Multiple Sclerosis, Parkinson's disease, stroke, Huntington's disease, and young onset dementia, and live in residential care facilities for many years. Most have significant physical disabilities with complex care needs relating to fatigue, pain, and depression. The literature reports that people with young onset dementia often have delay in diagnosis, loss of employment, financial issues, social isolation, changes in relationships, and lack of meaningful daytime activities, all of which has negative impact on their quality of life, and this is likely true for other young adults [154]. One study reports that young onset dementia is associated with a lower quality of life compared to people with late onset dementia [154]. Younger adults with an intellectual or developmental disability may also enter community residential care settings as they frequently have significant age-related health and mobility issues that develop earlier than those without developmental disabilities [155].

Resources for appropriate rehabilitation, programming, schedule, environment, and technology are often lacking in LTC for younger adults, and staff are not trained to meet their specific needs. Following a Continuing Care symposium for younger adults with disabilities in Alberta, *A Place to Call Home,* participants developed an action plan with the following key principles and priorities [156]:

Key principles to guide further planning and services:

- Person- and family-centred;
- Supporting independence;
- Collaborative and integrated;
- Flexible, adaptive, and responsive; and
- Accessible.

Five priorities for action to start working on in the immediate future:

- Better living environments for more independence;
- Personalized packages of integrated care that follow individuals along the continuum of care;
- Strategies to address individual lifestyles;
- Enhanced navigation and transitions;
- Caregiver education and respite.

Culture is a key part of how an individual defines who they are. Person-centred care is well placed to address the varied and specific needs of diverse individuals in residential care settings, belonging to ethnic, Indigenous, LGBTQ2S+, and other communities, recognizing that there is diversity within each community. Knowing residents and their needs comes through obtaining basic information on admission, asking about practices that are important to the individual, consistent staff assignments and adequate time to form a relationship, and sharing that information with other staff and volunteers through documentation and discussion [157]. Given the tremendous number of different ethnic groups in Canada, when designing appropriate programs and activities for a specific group, it is helpful to consult relevant community agencies for input, while never forgetting diversity among individuals.

If residents feel that their culture is not supported or respected, or if they find themselves in an environment where the culture is radically different than their own, they may experience social isolation and loneliness, spiritual isolation, health consequences, and alienation [157]. Likewise, when residents are uncomfortable with their surroundings because of language barriers or differences in social norms, they can feel threatened, leading to extreme anxiety, frustration, and depression, and there is a higher risk of negative health consequences, poor quality of care, or dissatisfaction with care [158].

Indigenous residents share a legacy of colonization, historical trauma, racism, distrust of Western medicine and ways, and sometimes geographic isolation that is unique to them [159]. The Ontario Centres for Learning, Research and Innovation in Long-Term Care (Ontario CLRI) point out that there can be a reluctance to engage with non-Indigenous organizations due to "inappropriateness of the programming, fear of racism, and discomfort with the pace of western medicine and its failure to understand cultural values" [159, p. 6]. One key informant operates a 60-bed LTC facility in a First Nation's community [160], where about 85% of residents and staff are Indigenous and speak the native language. The facility has implemented a person-centred care model underpinned by the Seven Grandfather Teachings: wisdom, love, respect, bravery, honesty, humility, and truth. She stressed the importance of knowing each resident and his/her story and preferences so that the continuity of his/her life as a hunter or gardener, for example, can be maintained through personalized conversation, food, and activities. She also stressed the importance of having the same staff person care for the same person as much as possible so that relationships can be formed.

According to the Ontario Seniors Pride organization, although there are LGBTQ2S+ seniors in LTC, they are largely invisible and data either do not exist or are unreliable. Health care professionals and consultants to LTC surveyed about their experience and knowledge about working with LGBTQ2S+ residents reported they had little education about issues, and identified a lack of training, stigma, and residents concealing their identity as the greatest barriers to quality care [161]. Their findings suggest that providers would benefit from more training in mental health problems and evidence-based treatments that are specific to LGBTQ2S+ residents. They also suggested that efforts to destigmatize LGBTQ2S+ identities in LTC might improve access to mental health care. Strategies to support the inclusivity of LGBTQ2S+ residents in LTC [162] have been proposed by researchers as:

- Development of LGBTQ2S+ community–LTC sector alliances;
- Outreach to LGBTQ2S+ communities;
- Inclusive employment practices and staff training;
- LGBTQ2S+ inclusivity training; and
- Practices more visible to residents and families, such as LGBTQ2S+-themed programming, inclusive language and symbols, or joint initiatives with LGBTQ2S+ communities.

Ontario CLRI, based on a literature review, discussions with diverse stakeholders, and guidance by an expert advisory group, has identified issues in supporting cultural diversity in LTC related to the acuity of residents, the complexity and constraints of the system and regulatory context that homes operate within, and the potential for cultural conflict between and among residents, families, and staff. They suggest that barriers to culturally appropriate health care services (including LTC) could be overcome by changing the structure of the system by integrating cross-cultural policies; by training staff to reduce conflict arising from cultural and communication differences; by enhancing culturally appropriate resources; and by increasing knowledge among ethnic minorities about available services [159].

It seems self-evident, and is also supported by research, that a positive social environment can be achieved through implementation of a person-centred care model. The resulting culture and processes it drives is demonstrably superior to a task-driven institutional model in supporting resident mental health, well-being, and quality of life. Further, a person-centred model is designed to acknowledge individuality in all its diverse forms. Successful implementation, however, rests on an adequate number of staff empowered to develop relationships with residents and to utilize their knowledge in providing care. Caring work is emotionally and physically demanding and direct care staff must be adequately supported themselves.

4.4.5 Supportive Work Environments That Support Mental Health and Well-Being

Sustaining a person- and family-centred social environment and approach to care delivery requires a supportive work environment for all staff [21]. The work environment affects how well staff are able to provide quality care and to support residents' mental health, well-being, and quality of life [163], [164]. Quality of care and life for residents that supports their mental health and well-being can only be provided by a healthy and well-supported workforce [8].

The Alzheimer Society states that direct care staff is the single most important determinant of quality dementia care, which is doubtless true for residents without dementia as well [165]. A principle of culture change models is that quality of care depends on an empowered staff that is valued and well supported [148]. The pandemic has drawn attention to deficits in LTC work environments and to inadequate support for front-line workers [8]. The Royal Society of Canada, in a review of working conditions in LTC facilities during and before the pandemic, contends that care aides are a disempowered group in the traditional institutional model of LTC [8], [11] , [166], with little input into decision-making about resident care even though they may know the residents best. Primarily women, many of whom are from minority groups and/or are recent immigrants, care aides work at the bottom of a rigid hierarchy, receive the lowest wages in the healthcare sector, and often have to work at more than one facility to make a living. It was also noted that staffing numbers are inadequate and short staffing is common in LTC facilities, as is the use of casual staff which adds to staff workload. This gendered and racialized workforce is vulnerable to exploitation by unethical facility operators. A Canadian study reports that 65% of care aides per shift say they must rush essential care due to insufficient time [166].

Care aides are poorly prepared through their formal education to address the needs of residents living with dementia or mental illness who often experience impaired communication, disorientation, confusion, and responsive and challenging behaviours. Care aides are generally not required to complete any continuing education and are often not offered it in the workplace beyond that which is mandated, further compromising their ability to provide quality care. In most facilities they are not allowed to read resident charts nor attend care planning conferences, which would give them insight into residents' backgrounds and behaviours. Without a good understanding of dementia and mental illness, and how to avoid or address responsive and other challenging behaviours, the consequences may be distressing to both the residents and staff and place the staff at risk of injury. Access to in-the-moment problem solving from team leaders, and to education and consultation from mental health consultants, is required but often unavailable.

A facility's working conditions influence the well-being of families and their meaningful participation in care home life. A rushed and task-focused model of care (i.e., emphasis on tasks, routine, and physical care) is not family-friendly, stifles family involvement, and leaves little time for effective communication [133]. Support by leadership is essential to ensure that time and resources are available for families and staff to interact and discuss care planning.

Not surprisingly, care aides are at high risk for burnout, mental health issues, and physical injury. The Royal Society of Canada, in response to their findings about inadequate support for LTC workers, has recommended that ongoing training, access to full-time employment, and appropriate pay and benefits, including sick leave, be made available to care aides [8], [167]. They assert that a well-supported workforce is likely to have less sick time and fewer injuries, be more easily recruited and retained, thereby increasing continuity of care and residents' quality of life.

Along with the aforementioned, the ongoing losses related to residents' (with whom they are encouraged to form relationships) deaths and transfers, or whose deterioration they witness, are significant, but seldom formally acknowledged or addressed [8]. Implementation of the *National Standard of Canada for Psychological Health and Safety in the Workplace* can facilitate a work environment that promotes and supports the mental health and well-being of those working in community residential care settings [168]. Access to mental health supports for all LTC staff has been recommended by the Royal Society of Canada

[8]. In recognition of health care workers' unique need for protection from moral distress and for psychological self-care, the Mental Health Commission of Canada (MHCC) and HealthCareCAN have compiled several resources to address these needs [169]. Additionally, Healthcare Excellence Canada has developed a Canadian Peer Support Network to assist health care organizations support health care workers by creating peer-to-peer support programs (PSPs) to improve the workers' emotional well-being, facilitating the best and safest care [170].

A work environment that is structured to support person-centred care benefits staff as well as residents, according to results from a national survey in the Netherlands [171]. A systematic review evaluating the evidence for the impact of person-centred interventions on nursing staff found them associated with positive influences on staff outcomes, specifically satisfaction and capacity to provide individualized care [152]. Among nurses there is evidence that being able to provide person-centred care is associated with increased job satisfaction [172].

Successful implementation of person-centred care models requires good leadership and stable management, strong teamwork and efficient communication systems [173]. In the literature, care aides have identified training, respect, and appreciation; communication and participation in decision-making; support programs, teamwork and caring; and engaged leadership as important to a positive work experience and as enabling them to provide quality person-centred care [165].

All staff need to understand person-centred care before they can implement it. A key informant, a CEO of an Eden Alternative facility, stressed the importance of providing a comprehensive orientation for new staff, as well as ongoing in-services for others, about person-centred care that includes the organization's vision, mission, and values [148]. Further, the values and principles are explicitly discussed at all care planning meetings and in staff supervision. Team leaders model person-centred care and staff are corrected if they are observed violating the values or principles. The "secret sauce" in supporting staff so they can support residents, according to our key informant, is genuinely valuing, respecting, and caring for them, and recognizing and celebrating their achievements in partnering with residents and in providing individualized care. Organizational leaders/administrators set the tone, establish the culture of LTC organizations, and significantly influence the work environment and thereby staff's capacity to implement person-centred care [174]. Effective leaders appreciate staff efforts and promote shared governance that allow for input and feedback related to the quality, design, and workflow of care and services [21].

Effective registered nurse (RN) supervisors facilitate positive work environments and support care aides through high-quality and frequent supervisor-staff interactions, as well as encouraging self-organization and fluidity of roles. This type of support from the supervisors has been shown to influence care aides' ability to respond to residents' needs in a timely, effective, and compassionate manner, which improves residents' quality of care and supports their mental health and well-being [175].

There is evidence that interdepartmental meetings that engage staff from all departments enhance a sense of team and community, open mindedness, and support for one another regardless of their roles [176]. Front-line staff are generally excluded from these meetings in institutional models, which serves to reinforce their low status within the facility hierarchy and devalue their knowledge. Data from a scoping review examining the effectiveness of team huddles point to their effectiveness at improving work and team process, leading to improvements in clinical outcomes [177].

A key informant and operator of an Indigenous facility reported that she had seen the facility's culture shift and change over the years under different administrators [160]. She said that the current administrator has made person-centred care possible by encouraging staff to think outside the box and establishing a culture where staff are valued and recognized in-the-moment and publicly for their successes. This administrator has invested in staff (including laundry, dietary) by providing training in gentle persuasion and validation therapy and in recognition of post-traumatic stress disorder (PTSD). Previously, she said, it was difficult to attract and keep staff, now staff love to come to work, and the facility seems alive and filled with laughter.



"In order to provide holistic person-centred care that supports the mental health, well-being, and quality of life for residents in LTC facilities, there needs to be a sufficient number of direct care staff with the knowledge and skills to competently care for the complex and diverse resident population."

A well-supported front line that is demonstrably respected and valued, provided with training, constructive supervision, and leadership, in the context of positive financial and psychological working conditions, is most likely to have the energy, motivation, and capacity to provide humane relational person-centred care. The fallout from the pandemic, which revealed that staff in many residential care settings were left to struggle unsupported, has increased awareness about the importance of supportive work environments and will hopefully lead to improvements.

4.4.6 Workforce Capacity and Training to Support Mental Health and Well-Being

In order to provide holistic person-centred care that supports the mental health, well-being, and quality of life for residents in LTC facilities, there needs to be a sufficient number of direct care staff with the knowledge and skills to competently care for the complex and diverse resident population.

4.4.6.1 Workforce Capacity

The Royal Society of Canada states that a high-quality, resilient, and supported workforce is, without doubt, the major component of quality care and quality of life for residents in LTC, but over the past two decades, the capacity of the workforce to provide quality care has been eroded [8]. They note that LTC facilities are neither structured nor staffed to maintain or improve the functional abilities of residents who often decline soon after admission. Staffing levels for direct care have not kept up with the increasing complexity of residents and the ratio of regulated nurses to care aides has dropped steadily, leaving care aides who do not have sufficient training to deal with the very complex resident population while lacking the supervision and support they need. Further, direct care and teamwork are undermined by chronic understaffing that increases the workload for staff on site. In addition to nurses, levels of staff providing medical coverage, and allied health professionals such as social workers and recreational, physical, and occupational therapists have been systematically reduced. Residents do not get the specialized care they may need, and direct care staff are left to manage as best they can.

A systematic review of qualitative evidence examining LTC residents' perception of organizational factors that influence the quality of care they receive, and their well-being, identified staffing levels, staff attitude, continuity, routine, environment, decision-making and choice, dignity of risk, activities, and culture and spirituality as primary influences [178]. All of these with the exception of the environment are related to whether or not there are enough direct care staff who have the necessary knowledge and skills, and the time, to appropriately address issues. For example, when staff levels are low or casual workers are employed, a staff person may unilaterally decide to put a slow but mobile resident in a wheelchair to take her/him to the dining room in the name of safety and time, undermining that resident's choice and dignity, as well as function. Further, without continuity of staffing, and again time, cultural and spiritual needs are unlikely to be addressed.

4.4.6.1.1 Staffing Levels – Direct Care

Staffing levels and staffing mix are linked to quality of care and quality of work life [8]. Continuity of care, integral to relational person-centred care and that supports residents' mental health, well-being, and quality of life, is only possible with adequate staff-resident ratios. Implementation of a person-centred care culture that promotes dignity and overall well-being of staff as well as residents, facilitates the staff capacity to support the residents' mental health, well-being, and quality of life [150]. However, staff need ongoing time to develop relationships with residents, to learn about their personhood and to be able to use their knowledge to honour residents' preferences. A systematic review of international nursing home staffing levels found a strong positive impact of direct care staffing on both care processes and resident outcome measures [179].

Investment in increased LTC facility staffing levels in New Brunswick has demonstrated better quality of care and increased quality of life for residents. The New Brunswick Department of Social Development conducted a pilot project to evaluate the effects of enhanced staffing levels in five LTC homes that each received funding to increase staffing levels to 3.5 hours per day, above and beyond the provincial standard of 3.1 hours per day per resident [163]. They found that increasing hours of care resulted in the following benefits:

- Greater attention and care to residents with improvement in some aspects of the residents' quality of life and quality of care – for example, residents were not being rushed through their day especially in relation to hygiene, grooming, and meals.
- Residents were also assisted with getting up every day and, in most instances, more than once per day (if they wished) and were able to participate in more recreational activities.
- Staff members got to know the residents better, provided greater choice and dignity to residents, and developed meaningful relationships with the residents.
- Residents received more attention from staff and were more engaged in recreational activities.
- Skin integrity improved as staff had more time to change residents' position and to facilitate better feeding/nutrition and hydration.

With extra time, the staff not only improved the quality of care, which is closely related to well-being and quality of life, but also promoted and supported mental health through development of therapeutic relationships that provided more choice and more meaningful activity, which in turn supported personhood.

A review of international research of direct care staffing benchmarks has revealed that LTC residents are at risk if staffing falls below the threshold of 4.1 hours worked (246 minutes) per resident day of direct care, comprising 0.75 hours (45 minutes) for (RNs), 0.55 hours (33 minutes) for licensed practical nurses (LPNs), and 2.8 hours (168 minutes) for care aides [180]. The Registered Nurses' Association of Ontario (RNAO) [181] has called for a basic care guarantee of 4.0 hours worked per resident day of direct care, which the Ontario Long-Term Care Commission has recommended to the provincial Minister of Health [12]. Additionally, the RNAO recommends one additional nursing staff member (preferably an RN) to support infection prevention and control, quality improvement, staff education, onboarding, and orientation [181]. The RNAO contends that these nursing allocations would provide each resident with safe care and quality of life [181], and there are several studies that have highlighted the importance of having a high professional staff mix (ratios of RN to total staffing levels) [180].

4.4.6.1.2 Staff Retention and Continuity of Resident Care

It is widely recognized that the front-line workforce is too small to meet the needs of the LTC industry today and that this will only be worse in the future. This accentuates the importance of facilities focusing on factors that support staff retention and recruitment. Staffing levels that leave care aides scrambling can affect staff satisfaction and retention, which in turn affects capacity to provide quality care and support mental health and well-being. In that staff-resident relationships are mutual, caring for residents that they never get to know can be unrewarding for staff, leading to job dissatisfaction, burnout, or quitting. Job dissatisfaction among LTC care aides is associated

with heavy workloads. Systematic reviews of the evidence on which factors are associated with job satisfaction identified an association between dissatisfaction and workload [28], and between burn out and time, staffing, space, managing responsive behaviours, unit culture and structural resources, and self-efficacy [29]. Another systematic review found that attraction to and retention of professional nurses in LTC dementia care was influenced by staffing levels, access to ongoing education and training in skills, leadership, and teamwork [182].

> "Often staff who are in a facility leadership position, have the minimal qualifications with little experience in leadership, difficult conversations, facilitating meetings, overseeing care, empowering staff to do better, mentoring, writing and evaluating relevant care plans".
>
> **—Family Member Survey Respondent**

Career development educational initiatives in LTC can have a positive effect on organizational and individual factors related to a positive work environment and on resident care. LEAP (Learn, Empower, Achieve, Produce), a comprehensive LTC workforce development initiative, aims to educate, empower, and retain LTC nurses and care aides [165]. Results from the initiative demonstrated increases in leadership effectiveness, work empowerment, job satisfaction, and perceptions of the organizational climate among staff. As well, there were improvements in quality indicators and a reduced number of health deficiencies, and a decrease in nurse and care aide turnover reported.

4.4.6.1.3 Staff Mix – Allied Health Care Provider and Consultants

Holistic and comprehensive care that supports quality of care, quality of life, mental health, and well-being requires more than nursing care. A more diverse staff and skill mix can result in improved quality of care, quality of life, and job satisfaction [183]. Multidisciplinary models have been shown to be particularly efficacious in treating older individuals with complex medical and/or psychiatric co-morbidities characteristic of LTC residents [184].

Further, a systematic review of nonpharmacological interventions to treat behavioural disturbance in dementia found evidence that severe behavioural problems in LTC residents can be reduced by using a comprehensive, integrated, and multidisciplinary behavioural management approach that combines medical, psychiatric, and nursing interventions [89]. Physicians, physical therapists, occupational therapists, speech/language therapists, recreation therapists, dieticians, pharmacists, pastoral care, psychologists, and social workers are needed to support residents' medical psychosocial, emotional, functional, and nutritional needs, all of which influence mental health [8]. The Ontario Long Term-Care Commission [12], the Office of the Seniors Advocate of British Columbia [185], and the Royal Society of Canada Report [8] have recommended that more allied professionals be employed in LTC facilities.

Occupational therapy and physical therapy services are critical in LTC facilities, as they improve physical function and occupational well-being, resulting in an improved quality of life for residents. Access to consistent occupational therapy and physical therapy services in LTC facilities has been shown to improve residents' function and quality of life [185], [186]. Facilities, however, are not resourced to support and improve residents' physical function, and mobility and independent transferring often deteriorate soon after admission [8]. Areas of therapeutic intervention might include, but are not limited to, enhancing mobility, appropriate seating, fall prevention, safe transfers, pressure wound management, activities of daily living, feeding and swallowing, adaptive equipment, pain reduction, incontinence reduction, cognitive activities, post-hospital rehabilitation, and splinting [187].

There is a strong correlation between nutrition and mental health. Residents may have swallowing difficulties, low energy, or other issues often requiring a special diet or assistance with eating. Registered dietitians can assess a resident's nutritional status and identify nutritional deficiencies and imbalances that may be contributing to a resident's well-being, health status, and level of functioning.

LTC residents are at high risk for isolation and loneliness when there are insufficient activities and stimuli, including individualized care and services

and recreational support, resulting in little meaningful engagement, inactivity, and a limited number of social relationships [67]. In most provinces, but not all, it is mandated that each facility has one activity or recreation therapist for 30 residents. Social workers are needed to provide psychosocial care to residents and to complement physical and body care provided by front-line staff by ensuring all staff are aware of the perspectives, needs, and values of individuals and their families; engaging in family counselling and support; organizing and supporting family and resident councils; assessing the psychosocial needs of residents through the transition to their residency and as their needs evolve; and advocating for institutional and systemic change.

Front-line staff also need access to palliative care resources that enable them to address the mental health and quality of life issues of residents at the end-of-life. Access to consulting seniors' mental health teams for support with assessment, care planning, and education is also needed to enable staff to support and manage residents with responsive and protective behaviours associated with dementia or with challenging behaviours associated with mental illnesses and substance use [188]. Without access to allied health care providers and consultants, many residents' needs are left unmet with significant consequences for their well-being and physical and mental health and, at the same time, leaving front-line staff unsupported.

Specialist Mental Health Services

Given that the majority (76%) of residents in Canadian LTC facilities are diagnosed with a mental disorder (40%) or Alzheimer's Disease and Related Dementia (36%), researchers contend that mental disorders should be considered a major focus for LTC rather than an afterthought [1].

> "The population in these care homes is vulnerable by nature and the inaction in addressing the gaps in this sector for DECADES are unbelievable. Depression and anxiety are not a part of the normal aging process and the seniors and persons with a disability are continued to be an afterthought".
>
> **—Family Member Survey Respondent**

Although it is generally accepted that non-pharmacological approaches are the first line of treatment to mental disorders, the most common reported intervention in LTC facilities is the use of antip¬sychotic drugs, not infrequently without a diagnosis of mental illness [189]. This issue could be addressed if more specialist mental health services were available and accessible to LTC facilities for consultative and collaborative, integrated care of residents with a mental disorder or Alzheimer's Disease and Related Dementia.

Results from a systematic review of well-being and residents living with serious mental illnesses concluded that well-being can be facilitated with specialized mental health care and by extra attention for depressed residents [190]. There are a number of models for providing mental health care provisions, including consultation, consultation-liaison, nurse-centred staffing, facility-based staffing, externally based multidisciplinary teams, and telepsychiatry [39]. Multidisciplinary team models that utilize the complementary skills and knowledge of allied health care providers to develop comprehensive biopsychosocial assessments and interventions can increase the efficacy of consultation and consultation-liaison. Training front-line staff to observe and flag mental health issues so they can be addressed early is needed in order to support specialized mental health care.

Specialized mental health services are often provided by visiting or on-call psychiatrists or clinical nurse specialists, who are trained in geropsychiatry, to assess, plan, and implement appropriate interventions for residents with mental and cognitive disorders [1]. Nurse-led multidisciplinary psychiatric consultations in nursing homes have been shown to be effective in reducing the frequency and severity of residents' psychiatric symptoms such as agitation, aggression, depression, anxiety, and disinhibition [191]. Nurses in LTC believe that geropsychiatric consultations would benefit residents with mental disorders but report they are often not available [192]. The use of telepsychiatry has been recommended as an option for LTC facilities where access to specialists is limited, often in non-urban areas [27].

> "Many residents need access to a mental health professional to talk to and provide support; it is not easy to access counseling or other mental health services in long term care; often it's a private service that the family must arrange themselves and there can be financial constraints or transportation challenges".
>
> **—Family Member Survey Respondent**

In Ontario, Behavioural Supports Ontario (BSO)[4] provides behavioural health care services for older adults with, or at risk of, responsive behaviours/ personal expressions associated with dementia, complex mental health, substance use, or other neurological conditions. In addition to providing direct care services, BSO also supports family care partners and health care providers. Evaluation of BSO models in LTC indicates that care planning, collaboration and team building, and home-level resident outcomes are all positively impacted by the Behavioural Support Embedded Teams that lead, coach, coordinate, and spread effective BSO strategies [193].

The diversity of the LTC population, coupled with the diversity of staff, necessitate having access to cultural translators for the staff. One of the key informants, a researcher in aging, ethnicity, and LGBTQ2S+ [194], spoke about the need to have access to members from diverse communities on staff and as paid consultants to provide translation, to educate staff, and to assist in planning relevant programs. Without this, she said, too often staff identify mood, behaviours, and language barriers as dementia, or conversely, as cultural attributes. Another key informant from the LGBTQ2S+ community [195] reported that their members say they feel unable to be themselves or be fully "out", or that they feel discriminated against by staff. The informant suggested that staff be made aware that many LGBTQ2S+ seniors are at a heightened risk for loneliness, depression, social isolation, and a lack of supportive relationships. A pilot study that implemented an online tool to support cultural competency with LGBTQ2S+ demonstrated that training increased the visibility of LGBTQ2S+ concerns among participants and enhanced clinical care [196].

4.4.6.2 Training for Front Line Staff

> "To truly support individuals living in these facilities, I think it is important that staff working there have competencies to do so. This is not a job that anyone without formal education should be doing. They should understand the role medications plays in supporting or making behaviours worse. They need to have competencies to be able to critically think and problem-solve, not just assume a patient needs more medications".
>
> **—Family Member Survey Respondent**

Possessing the knowledge and skills appropriate to supporting the mental health, well-being, and quality of life of diverse and complex residents is imperative, as is organizational support to facilitate effective implementation of knowledge. However, as pointed out in the Royal Society of Canada report [8], care aides have little formal training in supporting mental health or in managing responsive or challenging behaviours, nor much in-service training. It is unrealistic to expect care aides to become experts in so many areas; instead, in terms of mental health and well-being, the focus should be on the skills to develop relationships with residents, communicate effectively with residents and families, and to be keen observers of changes in a resident's mood and behaviour. The expertise the care aides develop about each resident must be shared with, and valued by, other staff so they may apply their professional knowledge appropriately.

A systematic review of the literature found that staff who receive education on empowerment, communication, and shared decision-making (skills and processes) have an increased ability to deliver person- and family-centred care, while residents have better clinical outcomes and both their satisfaction with and perception of their quality of care is increased [21]. As well, there is ample evidence that person-centred staff training and education have positive effects on both resident and staff well-being [197], [198]. A systematic review of staff training in person-centred

4 Behavioural Supports Ontario https://www.behavioursupportsontario.ca/

care has demonstrated positive impacts of the training on residents living with dementia [199] and facilitates implementation of effective interventions with positive impacts on LTC residents and staff [200]. The ability to deliver quality care more consistently increased quality of life among residents, which in turn increased staff job satisfaction, and reduced job-related stress and turnover. However, the ability of care providers to translate their knowledge into practice is influenced by organizational factors such as staffing levels, workload, compensation and benefits, leadership, training opportunities, work climate, and communication with management [165]. When care aides had more than the mandated hours of training through regulations (implying management support), there was less depression, fewer adverse events, less pain and fewer falls with injury among residents [198].

The literature makes it clear that continuing education and training for care providers related to understanding dementia is necessary for the implementation of best practices in dementia care and that the lack of these opportunities can lead to increased prevalence of, and negative outcomes related to, BPSD [84]. There is some evidence that the most effective dementia training programs combine web-based delivery of information, in-person training, and ongoing in-person supervision and feedback strategies [201].

The evidenced-based dementia care training program STAR (Staff Training in Assisted Living Residences) has demonstrated significant reduction in BPSD in dementia patients residing in assisted living settings and is applicable to LTC settings [202]. There is evidence that initial training and structured clinical protocols successfully decrease BPSD behaviours but only if combined with ongoing training and clinical supports [203].

As noted earlier, the majority of residents (76%) in LTC have a mental disorder or Alzheimer's Disease and Related Dementia, often with physical comorbidities, that together impact their socialization skills, functioning, mental capacities and behaviours, and their health resource needs [1]. As well, these residents also exhibit higher rates of aggressive or other behavioural disturbances [204]. While training in person-centred care and in dementia care has positive effects on BPSD, it is also critical that front-line staff acquire training in geriatric mental illness, including understanding how to identify and respond to mental health conditions, but this training is not often available [201].

Staff in LTC facilities have identified the following as what they need to work with serious and persistent mental illness (SMI) and to engender hope and empowerment among residents with SMI [205]:

- Having more knowledge about SMI;
- Improving staff interactions and communication with residents with SMI;
- Decreasing mental illness stigma among staff; and
- Caring for residents with SMI alongside residents with dementia and other diagnoses in a long-term care milieu.

SMI training for care aides that emphasizes person-centred care, compassion, strategies for effective and therapeutic communication, and principles of behavioural management has demonstrated positive staff and resident outcomes. As a result of online training about SMI and recovery, care aides have reported positive effects on their attitudes about SMI and on their confidence in caring for these individuals [206]. A six-week training program for support staff in group homes for people with chronic mental illness also resulted in improved care, evidenced by reductions in the total number of incident reports and pre-specified outcomes of recipient right complaints, emergency calls, and psychiatric hospitalizations [207].

Education and training programs in geriatric mental illness that utilize key success features have been shown to encourage change in practice, but their success is contingent on the commitment of LTC administration to such programs, offering opportunities for staff to attend these programs and to integrate the new knowledge into practice. The following have been identified as key features of effective geriatric mental health education and training in LTC [184]:

- Curriculum content must be designed with the intended audience in mind, based on their assessed needs of and relevant to the needs of the LTC residents.



"During the pandemic there has been an increased interest and urgency for technological approaches to addressing training needs of care providers."

- The education and training materials should incorporate the philosophy of care being promoted within the LTC setting.
- Organizational leadership and commitment are essential for maintaining learning and transfer of knowledge into practice.
- Training should be conducted as a whole of facility approach.
- Training should be delivered by qualified people with expertise and experience in working with older people with mental illness, including dementia.
- Training sessions should be held at times that suit the intended audience.
- Content should be packaged to facilitate interactive classes with short and regular sessions that can be readily repeated.
- Positive staff behaviour change can be encouraged through activities such as online learning and tip sheets indicating essential features.
- A dedicated education and training resource person may increase sustainability of programs.

The Canadian Coalition for Seniors' Mental Health (CCSMH) has developed a number of national best practice guideline documents [208] that can facilitate evidence-based care of older adults related to depression, delirium, dementia, suicide prevention, and addictions and substance. These guidelines include evidence-based pharmacologic and non-pharmacologic recommendations. A participatory action project to implement guidelines in LTC [209] identified positive impacts on staff capacity to care for residents with mood and behavioural issues [24]. Improvements in perceived job satisfaction, leadership, and workplace resources, and in improved interprofessional collaboration, teamwork, support, and communication were reported. Staff also identified a stronger perception of being valued and increased confidence in their own contributions.

During the pandemic there has been an increased interest and urgency for technological approaches to addressing training needs of care providers. One key informant [210] described an Ontario CLRI online clinical care education program that was developed for health professionals and that was redeployed to care for LTC residents during COVID-19, which has proven to be an effective educational tool [211]. The Ontario CLRI also developed a successful orientation program for LTC front-line staff to augment on site orientation [212]. Some parts of the program are completed individually while others provide opportunity for interaction and feedback. Gaming and other innovative strategies to support evidence-based content are employed to maximize learning.

To conclude, the needs of residents in LTC and other residential care settings for quality care, including support for their mental health, well-being, and quality of life, are indisputable. This requires enough well-trained and well-supported staff who possess a broad range of skills, knowledge, and expertise, beyond the scope of care aides or of any one discipline. A

full multidisciplinary team that values and combines the diverse strengths, skills, and knowledge of each member, and consults outside the team when needed, is essential to support care aides, and each other, to meet the needs of the residents. The capacity to provide consistent and knowledgeable relational care to residents rests on a stable workforce supported by leaders who empower their staff and organize their work so they have the time to know residents and to adapt care to the unique needs of each. Well-trained and empowered staff in sufficient number, supported by positive leadership, will facilitate recruitment and retention which, in turn, will facilitate consistent and relational care that promotes the well-being of residents, families, and staff.

4.4.7 Policies and Practice to Support Mental Health and Well-Being

4.4.7.1 Policy Scope

Community residential care facilities are embedded in a web of legal, regulatory, and other policies that relate to funding, working conditions, accessibility, accountability for care and for public funds, and so on. All of these influence how community residential care facilities function, but they are beyond the scope of this report. Here we consider only facility/organizational level policies and practices in relation to their influence on residents' mental health, well-being, and quality of life.

4.4.7.2 Person-Centred Principles – A Guide for Policy and Practice

Person-centred care has been acknowledged as the linchpin for culture change in LTC and as a best practice approach to providing quality care [149]. Truly knowing the resident means that needs and preferences related to diverse identities will be acknowledged and addressed through relational care delivered by an appropriate mix and sufficient number of well-trained, well-supported front-line staff. Embedded in a positive social and physical environment, principles of person-centred care can frame policy and practices that promote and support the mental health, well-being, and quality of life of diverse residents, as well as the well-being of their families and care providers.

Multiple strategies are required to build a person-centred culture in organizations, with the resident and family both central to and the focus of the redesign [213]. Promising strategies have been proposed for initiating person-centred innovations: (1) effective leadership; (2) internal and external motivation to change; (3) clear and consistent organizational mission; (4) aligned organizational strategy; (5) robust organizational capability; and (6) continuous feedback and organizational learning [214].

A key informant and leader of culture change [215] asserts that leaders have a central role in creating and sustaining a relationship-based culture that supports innovation, and they must have the ability to project a clear vision that inspires and energizes staff as well as role-model change. In addition, the organizational mission must be clear and reflect the values, beliefs, and norms of culture change. In the informant's facilities, the mission statement principles and values are explicitly brought into staff supervision, team meetings, and planning, and any external training brought to staff is framed by the mission statement prior to delivery. The organizational strategy is driven by the mission shaping all the goals, policies, and actions of the organization, which in turn build a person-centred culture that empowers residents and staff.

Successful implementation of person-centred care models requires good leadership and stable management; strong teamwork; efficient communication systems; and investment in staff training and education about culture change [216]. The RNAO states that establishing a person-centred culture means organizations must take responsibility for the following [21]: (1) creating environments that exemplify the value of respectful person- and family-centred care partnerships and practices, and that enable care providers to use their knowledge, skills, and abilities; (2) providing continuity of staff to facilitate consistent therapeutic relationships; (3) allowing for input and feedback from all staff (including volunteers) related to the quality, design, and workflow of care and services; (4) ensuring resources are available for the ongoing educating and mentoring of staff in person- and family-centred care, and to improve their skills and their ability to deliver such care in practice; (5) driving organizational improvements based on

results of monitoring, collecting, and evaluating data on individuals' experience of care and services; (6) incorporating person- and family-centred care expectations into the organization's policy reviews, development of procedures, hiring practices, and performance reviews.

4.4.7.3 Resident and Family Role in Policy and Practice

Residents and families, although directly affected by the policies and practices in their residences, generally have little voice in facilities. Having a voice in the LTC policies and practice that affect them would empower residents and families and increase the likelihood of policies and practices facilitating their well-being and quality of life. In Alberta, unlike in most provinces, there is a legislative requirement that licensed residential care facilities support the development and maintenance of Resident and Family Councils [217].

Resident councils are a potential avenue for people living in LTC facilities to influence decision-making processes that reflect their wishes and needs, which would contribute to the development of "voice and collective empowerment" [218]. Results from a qualitative study that engaged resident groups in seven facilities to identify areas residents wished to see improved, identified the following topics: a sense of community, feeling at home, social contacts between residents, independence, maintaining own hobbies and lifestyle, interpersonal conduct between residents and caregivers, being informed, security within the LTC facility, and food [219]. In Holland, where resident councils have a legal right to advise the organization on matters that concern them, studies have shown that their actual influence is limited [220]. Residents have a unique and valuable perspective on LTC facilities, and their experiential knowledge should be involved in the development of practice improvements. This requires institutional structures, management support, and a willingness to make changes based on resident council input.

Family Councils are groups composed of family members (inclusive of friends) with the main purpose of protecting and improving the quality of life of those living in LTC homes. Some provinces such as Alberta mandate Family Councils in LTC facilities, while others do not. A cross-sectional survey of BC administrators of LTC homes identified benefits of Family Councils as enhanced communication between staff and families, peer support, and collective advocacy [221]. These participants identified lack of interest, tendency to focus on individual complaints, and the transitory nature of families as barriers to the formation and maintenance of Family Councils. A key informant, a chair of a provincial association of Family Councils, acknowledged these barriers but added that not all facilities encourage the development or functioning of Family Councils, and they are sometimes co-opted by operators [222]. This informant pointed to the unilateral exclusion of family from LTC facilities during COVID-19 as evidence of families' lack of influence on LTC policies that affect them. He is advocating for a provincial association of Family Councils that has a direct line of communication to the Minister of Health's office. The Office of the Seniors Advocate of British Columbia recommends support for Family Councils in LTC facilities as advocates and monitors [164]. Researchers recommend enhancing accessibility, information sharing, and meaningfulness of Family Councils to improve family engagement and expand their voice [221]. Family Councils can benefit family members by enhancing their experience and connection with a facility, through education, peer support, and community-building opportunities [223].

4.4.7.4 Guidelines for the Development of Mental Health Policy and Practice

As the majority of residents in LTC, most of whom are seniors, have a mental health issue or are at risk of one, system policies and practices need to reflect this reality by including those with lived experience on the advisory and planning committees of governments and relevant national organizations. The CCSMH has identified the following principles to promote and support the mental health and well-being of those residents with, or at risk of, mental illness, including BPSD:

- Residents should receive individualized personalized care, based on residents' directions and preferences as much as possible.
- Family ties should be respected and families considered partners in care.
- Care should focus on the resident's strengths and minimize the impact of his or her limitations.

- Care should take into account the physical, mental, social, and spiritual needs of the resident.
- Staff should receive ongoing education and training to provide informed and competent care.
- A supportive and helpful environment should be created to respond to residents' changing needs.
- A culture of caring should be facilitated that prioritizes quality of life.
- Strategies to prevent mental illness should be built into programming and included in training programs for staff and families. [209]

LTC facility operators can apply *The Seniors' Mental Health Policy Lens* [224] to determine how well their policies and programs promote and support the mental health of residents. The Lens, an analytical framework informed by academic and experiential evidence, can be used to assess current and planned policies. As well, to support development of a comprehensive, integrated, principle-based, and evidence-informed approach to meeting the mental health needs of residents, the Mental Health Commission of Canada's *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* [39] can be used. The recommendations made can be applied to seniors living with a mental health problem or illness, and those at risk of developing one, in all community residential care settings.

4.4.7.5 Cultural Diversity in Policy and Practice

There is wide diversity in race, ethnicity, religion, spirituality, language, ability, gender identity, gender expression, sexual orientation, and socio-economic status among residents in community residential care settings, as well as among those providing care [225], making it crucial to every one's well-being that these settings are inclusive and affirming. Supporting residents and their families in culturally appropriate ways supports person-centred care and is dependent on knowledge of the residents, their backgrounds, and the meaning of their identities to them.

Recognizing that care experiences can be influenced by an individual's identity and their "fit" within the care setting, the Ontario CLRI has developed resources that support diversity and inclusion with the aim of building workforce capacity and fostering person-centred care. *Embracing Diversity: A Toolkit for Supporting Inclusion in Long-Term Care* [226] focuses on seven impact areas where homes can improve, such as the organizational culture, employee education and training, and resident and family engagement. Included are resources for self-reflection of implicit biases designed for use by individuals, as well as organization-wide tools to assess a facility's strengths and areas for improvement, as well as a guide on ways to make the facility inclusive. The guide includes examples of facilities that are successful in celebrating and honouring diversity. Additionally, recognizing the unique history, experiences, and needs of Indigenous residents, the Ontario CLRI, in collaboration with Indigenous organizations, has conducted a needs assessment and published the report, *Supporting Indigenous Culture in Ontario's Long-Term Care Homes: Needs Assessment and Ideas for 2017–18* [159], which outlines needs and issues with suggestions on how to address them. The report notes that historical trauma, changing social structures, fragmented services due to jurisdictional issues, and often distance from family or home communities all place strains on residents. As well, the report points out the importance of recognizing that many Indigenous seniors were in residential schools and the negative impact of that experience can be triggered when moving into a LTC setting.

A culturally competent organization accepts and respects differences among and within different groups [225]. *Cultural responsiveness* moves beyond this to reflect the interplay between people who bring their own ethno-cultural realities to the interaction and requires that staff pay attention and connect to multiple aspects of an individual's cultural makeup. Cultural safety incorporates the idea of power structures and focuses less on the benefits of cross-cultural awareness and sensitivity and more on the risks associated with their absence [227]. Culturally unsafe practices have been defined as "any actions that diminish, demean or disempower the cultural identity and well-being of an individual" [159, p. 9]. Cultural safety is aligned with person-centred culture change models that aim to flatten the hierarchy in LTC facilities and empower both residents and care staff.

4.4.7.6 Protecting Residents from Stigma, Discrimination, Abuse, and Neglect

Stigma and Discrimination

Ageism occurs at the individual level as stereotyped attitudes about old age (which may be internalized or result in discrimination against others on the basis of their age) and in policies and the structure of services that deprive older people of opportunities and resource [228]. A representative of a national seniors' organization asserts that ageism is evident in the inadequate resources allocated for the care of the most vulnerable seniors in our society, those living in LTC. A commentary written by over 20 international researchers in the field of ageing states that COVID-19 has brought ageism to the surface, with older people misrepresented and undervalued in the public discourse surrounding the pandemic [13]. They identify issues in documenting the deaths of older adults, the lack of preparation for such a crisis in LTC homes, how some "protective" policies can be considered patronizing, and how the initial perception of the public was that the virus was really an older adult problem. A key informant (a sociologist) suggests that deconstructing myths related to ageing (e.g., dementia is a normal part of ageing) be part of every health provider's education and orientation to LTC [229].

People living with mental health and addiction problems frequently encounter stigmatization in health care environments, and often report feeling devalued, dismissed, and dehumanized by many of the health care professionals with whom they come into contact [230]. The MHCC has anti-stigma educational materials that could be used with LTC staff to reduce stigma. As noted earlier, education is effective in improving care staff's knowledge and attitudes about serious mental illness [206].

A key informant from the LGBTQ2S+ community reported that some of its members reported feeling discriminated against in community residential care facilities, leading them to self-isolate. The informant suggested that facilities develop and implement staff and resident policies for safeguarding LGBTQ2S+ people against anti-LGBTQ2S+ hostility and discrimination. Further, it is recommended that a clear interpretation of "family" and "partner(s)", which is fully and explicitly inclusive of LGBTQ2S+ chosen families and partner(s), be adopted by facilities. In the City of Toronto, the CLRI Long-Term Care Homes & Services has developed the *LGBT Tool Kit: Creating Lesbian, Gay, Bisexual and Trans Inclusive and Affirming Care and Services,* designed to enable LTC organizations to become socially and culturally competent [231].

Abuse and Neglect

The Ontario Long-Term Care Task Force on Resident Care and Safety [232] has asserted that those factors contributing to abuse and neglect of LTC residents could be mitigated if facilities adopt person-centred care that recognizes each resident's uniqueness, and if facilities develop a healthy workplace culture that recognizes the importance of the emotional well-being of employees.

Older adults who experience abuse and neglect face mental health and quality of life issues. Consequences include physical trauma, reduced self-worth and dignity, a lost sense of safety and security, and even an increased risk of early death [233].

Mistreatment of older adults, including abuse and neglect, refers to actions and/or behaviours, or lack of actions and/or behaviours that cause harm or risk of harm within a trusting relationship, the frequency of which in community residential care settings remains unknown, although there is research to suggest it is not uncommon [234]. Chronic staff shortages and the failure to address the increasingly complex needs of older adults are believed to contribute to abuse and neglect in institutional settings. During the pandemic, gross negligence and abuse of residents was documented by the Canadian Armed Forces in Ontario and Quebec [235], [236].

The RNAO has developed best practice guidelines in its *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches* [234]. These practices address harms caused to seniors by physical abuse, emotional/psychological abuse, sexual abuse, financial abuse/exploitation, and neglect. The guidelines include:

- Practice recommendations for nurses and other health care providers who provide direct care for older adults and their families in community and institutional settings;

- Education recommendations directed to those responsible for staff education, such as educators, quality improvement teams, managers, administrators, and academic institutions; and
- Policy, organization, and system recommendations for managers, administrators, policymakers, nursing regulatory bodies, and government bodies.

Trauma-informed care can benefit residents who have been involved in and impacted by violence and victimization in their lives, which is not uncommon among marginalized populations, for example, Indigenous people, others in racialized, immigrant, and LGBTQ2S+ communities, and those living with serious and persistent mental illness [237]. The core trauma-informed principles are as follows [238]:

- Safety – emotional as well as physical e.g., is the environment welcoming?
- Trust – is the service sensitive to people's needs?
- Choice – do you provide opportunity for choice?
- Collaboration – do you communicate a sense of "doing with" rather than "doing to"?
- Empowerment – is empowering people a key focus?
- Respect for diversity – do you respect diversity in all its forms?

Direct care staff may discover trauma through their relationship with a resident and should be trained to identify historical trauma, to respond appropriately to the revelation, and to advise the facility's social worker for a follow-up.

4.4.7.7 Enabling and Supporting Staff

Best practice principles, based on evidence, can support the front-line workers in LTC and other settings. Principles, such as those listed below, will enable staff to provide quality care and facilitate well-being and quality of life for residents living with dementia [165]:

- Staffing levels and mix should be adequate to allow for proper care at all times – day and night.
- Staff should be sufficiently trained in all aspects of person-centred care, and in dementia.
- Staff should be adequately compensated for their valuable work.
- Staff should work in a supportive atmosphere that appreciates their contributions.
- Improved working environments will result in reduced turnover.
- Staff should have the opportunity for career growth.
- Staff should be enabled to work with families.

These principles are aligned with promising practices drawn from a six-country study of practices in 25 residential care facilities that met the following criteria: treats both residents and providers with dignity and respect; understands care as a relationship; and takes differences and equity into account. The researchers concluded that care relationships are central to treating residents, staff, and families with dignity and respect and that the following are essential to promoting and maintaining care as a relationship: adequate staff and an appropriate staff mix; a stable workforce; adequate time; standards effectively enforced; appropriate training and education; appropriate working conditions; an integrated system; and tolerating some risks. Based on their work, the researchers have published ideas that can inspire change in LTC [116].

4.4.7.7.1 Prevent and Address Workplace Violence

Violence, harassment, and bullying are not uncommon in health care settings: The Ontario Council of Hospital Unions found that 68% (in 2000) of front-line workers had been physically assaulted in the previous year, 86% had experienced verbal violence, and 42% had been sexually assaulted or harassed [239]. As described in the RNAO's *Preventing Violence, Harassment, and Bullying against Health Workers* [240], consequences of workplace violence to workers include:

- Physical injury;
- Psychological consequences such as post-traumatic stress disorder, hyper-vigilance, irritability, difficulties concentrating, sleep disturbances, depression, anxiety, and burnout;
- Emotional consequences such as anger, sadness, fear, and mistrust; and
- Increased risk of mental and somatic health concerns, such as anxiety and depression, suicidal ideation, and headaches and sleep disturbances as a result of prolonged and persistent bullying.

The RNAO includes best practices in its guidelines that can be used in community residential care facilities. The guidelines focus on risk assessment tools and strategies; organizational policies, procedures, requirements, and responsibilities; educational approaches and strategies; implementation strategies and tools for organizations; and evaluation criteria [240].

In sum, the implementation of policies and practices that support residents and staff in the context of principle-based person-centred care are feasible and many are not costly (e.g., philosophy, protecting residents and staff, valuing staff, effective leadership) but do require vision and commitment. As well, implementing culturally safe practices and addressing stigma and discrimination would benefit residents, their families, and staff at minimal cost. Empowering residents and families through Family and Resident Councils to share their lived experiences and insights about policies that affect them would increase a facility's transparency and accountability.

5 Limitations

There are a number of caveats about the generalizability of the research findings and recommendations in this report that must be considered. The majority of the research literature reviewed pertains to LTC facilities with other settings (where research exists) rolled into the community. In part, this is due to a lack of common definitions or common language for community residential care settings across the country. The principles and philosophy of mental health promotion and of person-centred care, as well as many of the recommendations about creating supportive physical and social environments that support mental health and well-being, could however be applicable to any community residential care setting. Some of the discussion and recommendations pertaining to supportive work environments and to staff training may also be relevant across settings, taking into account the heterogeneity of employees, size of the staff, and how the facility is organized.

Most of the research literature relates to people living with dementia, as does the literature about families and care providers. In many cases, these recommendations could also benefit the broader residential care population, but each recommendation needs to be assessed for unintended effects on those not affected by dementia.

Within the literature reviewed there is little attention paid to the intersectionality of age, sexual orientation, race, ethnic/racial identities, mental illnesses, and other differences, limiting the generalizability to specific populations. The effect of each of these intersections, and their interactions, on residents need to be considered before applying the recommendations. Very little data have been collected about different populations in residential care settings, and there are gaps in the research literature about their needs or how they are met. This is true of the LGBTQ2S+, ethno/racial, young adult, intellectually/developmentally disabled, cognitively intact, and Indigenous populations, and more consultation would be required to develop recommendations specific to each group. Nevertheless, the principles of mental health promotion, person-centred care, and cultural safety could be used to evaluate the appropriateness of the recommendations made and to adapt them as needed.

6 Conclusion

The community residential care system, and in particular LTC, is in need of reform, evidenced by the many structural weaknesses and deficits revealed by the COVID-19 pandemic. The conditions and issues exposed are not conducive to supporting the mental health and well-being of the diverse vulnerable resident populations with complex needs who live in residential care. Chronically under-resourced by an unstable and poorly supported workforce, often in outdated institutions, many facilities have been struggling even before COVID-19 to provide humane care.

Facilities have the power to create a culture that promotes and supports the mental health, well-being, and quality of life of those for whom they care. A positive social environment – arguably the most potent strategy – underpinned by relational person-centred care is possible, at little cost, with committed leadership that empowers front-line staff to provide individualized care. Likewise, creating a

supportive work environment can begin with respect, encouragement, and demonstrably valuing staff and the knowledge they hold. Culture change can be facilitated by integrating the values and principles underpinning this report into LTC facilities' mission statements, strategic plans, human resource and other policies, and be made explicit to residents, their families, and staff. While some modifications can be made to improve the physical environment, some facilities may require resources outside their budgets. Likewise, some of the interventions described to strengthen individuals and to strengthen relationships require enough staff and appropriate skills to implement them, often unavailable or difficult to access, especially in rural areas. Government and facility owners both have a responsibility for building and adequately supporting a workforce, sufficient in number and with the diverse skills and knowledge required to meet the holistic and complex needs of our most vulnerable citizens.

Several key informants have pointed out that the capacity of residential care facilities to provide quality care that supports residents' mental health, well-being, and quality of life, rests to a large extent on the public resources allocated to the care of residents, which is ultimately a political decision. One key informant, a sociologist, commented that the structural and systemic issues spotlighted by COVID-19 were already well known and hoped the publicity during the pandemic would motivate the public to demand more resources from government to make the changes needed. Another key informant (a gerontologist) suggested that funding for LTC is low because "we say we can't afford it because as an ageist society we do not prioritize these institutions or value the people with dementia in them" [114]. A policymaker interviewed stated that there is evidence that public funds provided to some LTC facilities are not spent on direct care, but instead go in to profit [108]. This informant, as well as three others, stated that in order for care to improve in LTC facilities, the profit motive must be removed, operators must be made more accountable for public funds, and the focus must be placed firmly on care, not profit. A representative of a national seniors' organization advocated for national standards for LTC based on human rights and on the best available evidence for mandatory minimum staffing levels and mix, with accountability and enforcement measures to ensure facility operators comply [241].

COVID-19, by exposing the flaws in how community residential care is provided, has also given us a map and an opportunity to implement the changes that will make LTC and other residential care settings places that thrive and places where staff look forward to going to work.

> "A clear predictable action plan is necessary moving forward. It is reasonable that every pandemic is different but the constant pivoting made it more difficult for staff to stay focused on residents when they were just coping with the change. I think a better strategy for caring for trauma for residents and staff should be in place so that people can maintain maximum effectiveness is critical".
>
> **—Family Member Survey Respondent**

All that is needed is commitment to a shift in culture and the political will to resource the changes.



"The evidence-based recommendations made in this report are underpinned by principles and best practices that support the mental health and well-being of all residents."

Part B: Considerations and Recommendations Arising From the Research Report

1 Guiding Principles and Best Practices

The evidence-based recommendations made in this report are underpinned by principles and best practices that (1) support the mental health and well-being of all residents, including those with, or at risk of, mental illness, including behavioural and psychological symptoms of dementia (BPSD), who are living in LTC and similar residential care settings, where applicable, and (2) support the capacity of staff to provide quality care.

1. Resident care and organizational practices should be guided by the following principles that promote and support the mental health and well-being of residents:
   - A person-centred relationship-based culture of caring, adequately resourced, is implemented.
   - Residents receive, based on their directions and preferences, individualized personalized care.
   - Families are partners in care and their family ties are respected.
   - Care minimizes the impact of residents' limitations and instead focuses on their strengths.
   - Care takes into account the physical, mental, social, and spiritual needs of the resident.
   - An enabling environment is created that responds to residents' changing needs.
   - Programming and training programs for staff and families include strategies to promote mental health and prevent/manage BPSD.
2. The best practice principles that follow should be implemented to support and enable front-line workers to provide quality care and facilitate the mental health, well-being, and quality of life for residents:
   - Staff are sufficiently trained in all aspects of person-centred care.
   - Staffing levels and mix – day and night – are adequate to allow for quality care at all times.
   - Ongoing education and training are provided to staff to facilitate informed and competent care.
   - Consultation by specialists (e.g., mental health, pain) is accessible.
   - Work is organized to enable staff to develop relationships with residents.
   - Working environments/leaders support and appreciate staff and their contributions.
   - Opportunities for career growth are made available to staff.
   - Staff are enabled to work with families.
   - Staff are adequately compensated.

2 Scope

This guidance document considers the following:

a. Actions that could be taken in Canadian LTC facilities and other community residential care settings;

b. The recommendations are intended to provide guidance to all levels governing residential care; and

c. The recommendations may be implemented differently in various settings, however the underlying principles and intent will remain similar.

3 Recommendations

The following evidence-based recommendations, which were derived from an analysis of the research literature and framed by a mental health promotion lens, provide guidance to facility operators for improving the LTC experience and well-being of residents, their families, and those providing care.

3.1 Enabling the Physical Environment

Facility operators should carry out an audit of the physical environment using the Built Environment Audit Tool[5] and develop an action plan for modifications/renovations.

The following building design elements should be incorporated into planned and renovated facilities, as applicable:

a. Create units/spaces for small groups of resident cohorts with consistent staff;

b. Provide single rooms;

c. Eliminate shared bathrooms;

d. Provide outdoor spaces that are accessible, secure, with looped pacing areas;

e. Ensure adequate levels of light of >2000 lux;

f. Reduce noise from outside and between rooms through acoustic strategies;

g. Provide homelike bathrooms and accessible kitchens that appear familiar;

h. Use unobtrusive technology for safety (e.g., coded entries; wander bracelets);

i. Minimize noise (e.g., silent call bells); and

j. Provide a variety of spaces that provide differing ambience, size, and function.

The following elements should be incorporated into facility design/décor, as applicable:

a. Involve residents, family, and staff in facility design/decor decisions indoors and out;

b. Use clear visual cues to support independent way-finding, such as very large names on residents' doors, arrows pointing to a picture of food for the dining room;

c. Use colour and images to clearly delineate spaces for different use – bathrooms, dining room;

d. Encourage residents and families to personalize their space to support continuity of personhood;

e. Promote calmness through use of colour;

f. Ensure high levels of lighting in public areas and in residents' rooms;

g. Reduce visual disturbances – non-glare lighting, flooring;

h. Provide accessible enclosed outdoor spaces visible from indoors;

i. Use paint, murals, curtains to disguise doors.

3.2 Strengthening Individuals

3.2.1 Residents

Facility operators and care providers should enable residents to participate socially with other residents, family and friends, staff and volunteers through strategies such as:

a. Family-style dining;

b. Connection through technology by providing equipment and assisting residents;

c. Visits by Zoom/Skype and telephone, and in person;

d. Internet group discussion and support, and in-person support; and

e. Facilitated human-to-human interaction with technology as an adjunct.

5 See Appendix C, Resources to Support Implementation of Recommendations, for description and reference.

The following physical issues that undermine residents' capacity or desire to participate socially should be addressed by providers:

a. Pain management;

b. Visual issues – cataracts, need for glasses;

c. Hearing problems; and

d. Sleep disturbances, including daytime sleeping.

A range of the following social/activity programs that have proven to reduce loneliness among residents should be implemented, based on the interests and capacities of individuals:

a. Creative expression programs – art, music, storytelling;

b. Religious activity;

c. Exercise – walking, Tai chi;

d. Interaction with pets and robotic pets;

e. Choir singing;

f. Laughter therapy;

g. Leisure/skill development such as gardening, and radio listening;

h. Reminiscence therapy; and

i. Horticultural therapy.

Care providers should address BPSD, depression, and other mental illnesses through the following measures, as applicable:

a. Create a physical and social environment that supports mental health and well-being;

b. Provide initial and ongoing training for staff in dementia and behaviour management techniques to enhance communication skills;

c. Ensure regular screening for mental illnesses takes place;

d. Utilize a comprehensive, integrated, multidisciplinary, behavioural management approach combining medical, psychiatric, and nursing interventions;

e. Utilize appropriate medications when symptoms are severe and persistent;

f. Provide specialized mental health consultation when needed;

g. Utilize dementia mapping;

h. Implement psychosocial interventions that are tailored to individual preferences;

i. Facilitate meaningful social connection, participation, and engagement;

j. Provide music based on resident preferences;

k. Facilitate exercise – Tai Chi, walking; and

l. Implement therapy programs;

- **i.** Reminiscing program;
- **ii.** Music therapy;
- **iii.** Cognitive rehabilitation program;
- **iv.** Problem adaptation therapy;
- **v.** Cognitive behavioural therapy.

3.2.2 Family Caregivers

Care providers should facilitate access to face-to-face, group, and technology-based supports to support family caregivers through transitions and emotional distress, through:

a. Counseling/psychotherapy;

b. Mindfulness-based interventions;

c. Dementia education;

d. Psychoeducation groups; and

e. Communication skill training.

3.3 Strengthening Relationships

3.3.1 Staff-Resident

Facility operators and care providers should promote and support positive interactions between nursing staff and residents, such as:

a. Hire staff with well-developed interpersonal skills;

b. Ensure staff have effective communication and relational skills necessary for person-centred care;

c. Provide ongoing training in relational and communication skills, and person-centred care;

d. Provide ongoing education and support in managing BPSD;

e. Ensure supervisors, policies, and workplace culture allow staff time to be present and to relate to residents – practising "slow care"; and

f. Ensure staff have access to support and mentoring related to impact of stress.

3.3.2 Staff-Family

Facility operators and care providers should take the following steps to promote and support positive interactions between nursing staff and family members:

a. Provide orientation to the facility prior to placement or immediately after placement that includes information about care practices, routines and relevant policies, lines of communication, where to go with issues;

b. Provide ongoing education to staff on how to understand family members' experience as caregivers, recognize their symptoms of grief, and to interact with families effectively and as partners in care;

c. Provide clear and timely information to family members about changes in the health and behaviour of their relative and in their care plan;

d. Involve families in decision-making and care conferences;

e. Make support available to family members as needed individually and/or in groups;

f. Encourage family members to join family councils; and

g. Recognize and support family councils.

3.4 Positive Social Environment

Facility operators and care providers should create a positive social environment that supports mental health, well-being, and quality of life by implementing principles of culture change and person-centred care.

Practices to gather and share information about residents so they are known as individuals should be put in place, such as:

a. Develop and share a detailed history of residents at admission, their identities and meaning of these to them, their goals, preferences, interests, strengths and limitations, capacities, social connections;

b. Engage families/significant others in knowing/understanding the residents;

c. Facilitate a process for care aides to share their knowledge about residents and effective care practices;

d. Engage families and cultural organizations as appropriate to deepen understanding of the residents' cultures; and

e. Implement methods for documenting and sharing information about the residents' histories, needs, and preferences.

Practices to acknowledge and accommodate diversity should be implemented, as follows:

a. Gather information from residents and families about their cultural identities and meaning of these to the residents;

b. Consult with residents, families, and consultants about ways to acknowledge and integrate customs, rituals, and practices into individual care and the facility's environment; and

c. Ensure staff understand and can apply principles of cultural safety.

Strategies to enable front-line staff to develop therapeutic relationships with residents should be implemented, such as:

a. Consistent and permanent staff and team assignments;

b. Facilitate "slow care" that allows for development of relationships;

c. Encourage reciprocal relationships with attention to professional boundaries;

d. Provide education in relational and communication skills, cultural safety; and

e. Ensure staff have access to emotional support related to relationship issues and the impact of resident death.

Care aides should be empowered to provide competent and person-centred care by implementing the following:

a. Provide education about principles of culture change and person-centred care, cultural safety;

b. Support staff to provide care based on residents' preferences rather than organizational schedule (e.g., bathing);

c. Support staff in developing innovative approaches to personal care based on residents' preferences and needs; and

d. Involve care aides in care planning and team conferences.

Practices to support residents' autonomy and independence should be put in place, such as:

a. Identify and support capacities and mitigate limitations;

b. Engage residents and/or substitute decision-makers in care decisions;

c. Provide information and resources to support decision-making;

d. Prioritize residents' preferences (e.g., independent mobility) over safety as much as possible; and

e. Ensure that any restrictions (e.g., going outdoors) are least restrictive and as unobtrusive as possible.

Residents' dignity should be supported through the following practices:

a. Demonstrate respect. Use the name preferred by residents – no diminutives or pet names;

b. Staff need to introduce themselves, wear large name tags, and always ask for permission when carrying out care;

c. Allow privacy – knock before entering rooms; and

d. Acknowledge cultural, spiritual, ethnic, and gender identities.

Facility staff should engage residents in activities that are meaningful to them:

a. Identify and implement activities based on residents' preferences and capacities;

b. Engage family and community to identify and provide appropriate activities; and

c. Support care aides to provide "in the moment" activities.

A welcoming environment for families should be developed by implementing practices such as:

a. Open visiting times;

b. Engaging families in care based on their preferences as much as possible;

c. Sharing information about the residents within bounds of the residents' preferences;

d. Demonstrating openness to questions and feedback about residents care;

e. Providing free access to beverages and snacks; and

f. Making families aware of family councils and encouraging participation.

Care routines should be deinstitutionalized as much as possible by:

a. Ongoing access to breakfast based on preferences rather than a set breakfast at a set time;

b. Making snacks available and accessible to residents and families; and

c. Allowing bath times based on residents' preference rather than on an institutional bath schedule.

3.5 Supportive Work Environment

Facility operators should create a positive work environment that supports and enables staff to provide person-centred care that promotes and supports residents' mental health, well-being, and quality of life.

Facility operators should stabilize the LTC workforce by implementing the Royal Society of Canada recommendations:

a. Make full-time work available;

b. Provide a living wage, include benefits and paid sick time; and

c. Apply evidence-based staffing levels and mix.

Facility operators should ensure all staff are knowledgeable about person-centred care and underlying values and principles by:

a. Providing education at orientation and on an ongoing basis;

b. Integrating person-centred values and principles into hiring practices and staff supervision and evaluation; and

c. Making values and principles explicit in programs, residents' care, and team meetings.

Facility operators should ensure staff are supported in providing person-centred care by:

a. Having an adequate number of staff to provide care every shift without rushing;

b. Encouraging staff to share their knowledge about residents and families with other staff/departments;

c. Incorporating front-line staff in resident care meetings and interdepartmental meetings; and

d. Providing access to mental health consultants to address responsive and challenging behaviours.

Facility operators should ensure leadership is person-centred and constructively supports staff by:

a. Providing ongoing person-centred leadership training;

b. Integrating person-centred values and principles into staff supervision and evaluation;

c. Encouraging creative approaches to resident care based on staff knowledge; and

d. Implementing and supporting deinstitutionalization strategies as much as possible.

Facility operators should ensure that mental health support is accessible to staff by:

a. Following the principles of the *National Standard of Canada for Psychological Health and Safety in the Workplace* [171] using CSA Group's *Assembling the Pieces: An Implementation Guide to the National Standard for Psychological Health and Safety in the Workplace* [242]; and

b. Facilitating staff access to the Canadian Peer Support Network.

3.6 Workforce Capacity and Training

Facility operators should ensure front-line staff have the education, skills, and support to promote and support the mental health, well-being, and quality of life in LTC by implementing the recommendations below, where applicable.

Facility operators should implement strategies to increase attraction and retention of staff:

a. Make full-time hours available;

b. Provide benefits and paid sick time;

c. Provide appropriate ongoing training for front-line staff and leadership training and support for team leaders;

d. Screen and select staff for emotional intelligence, empathy, and capacity to form relationships with diverse residents;

e. Provide all new staff with a full orientation about person-centred care, dementia, and BPSD management; and

f. Incorporate factors such as emotional intelligence, empathy, and capacity to form relationships with diverse residents in staff supervision and evaluations.

Facility operators should staff the facility based on evidence and residents' needs:

a. Implement at least the minimum evidence-based staffing levels for care aides and professional nurses;

b. Facilitate continuity of care by developing an in-house pool of casual staff rather than using agencies;

c. Employ at least the minimum levels of allied health care providers required; and

d. Provide access to consultation where specific allied professionals are not employed.

Facility operators should ensure staff have the training and support to care for complex resident populations:

a. Provide training in person-centred care, dementia, and geriatric mental illness;

b. Employ varied methods, including technology, to train staff; and

c. Ensure access to consultants in palliative care and geriatric mental health.

Facility operators should ensure that leaders are trained in person-centred care and that they support staff to implement individualized interventions.

3.7 Policy and Practice

Facility operators should apply The Seniors' Mental Health Policy Lens Toolkit [224] to assess how well policies promote and support the mental health of residents and address deficits where applicable.

Facility operators should implement and resource a person-centred care model:

a. Ensure mission statement reflects values and principles of culture change and person-centred model;

b. Incorporate mission statement/principles explicitly into all policies and practices, staff orientation, training, and supervision;

c. Support leaders to model culture change innovations and to encourage support staff to provide individualized care;

d. Ensure staffing practices support relational care-consistent staff assignments;

e. Ensure the organization of work reflects the mission statement values and principles and supports relational person-centred care and allows staff time to develop relationships;

f. Ensure staffing levels and mix facilitate holistic relational care;

g. Ensure all public funding for direct care goes to direct care; and centred care:

h. Ensure all staff are trained in observational and relationship skills;

i. Ensure all staff are trained to identify signs of mental illness and of historical trauma and that there are appropriate and accessible resources to address;

j. Incorporate anti-ageism and mental illness stigma reduction strategies in staff orientation, education and supervision;

k. Implement the City of Toronto Long-Term Care and Services *LGBT Tool Kit: Creating Lesbian, Gay, Bisexual and Trans Inclusive and Affirming Care and Services* [231].

Facility operators should support the development and maintenance of Resident and Family councils and be open to their input.

Facility operators should implement the RNAO's *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches* [234].

Facility operators should implement the RNAO's *Preventing Violence, Harassment and Bullying Against Health Workers* [240].

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Appendix A – Key Informant Script and Questions

This appendix provides a list of the interview questions asked during the consultative process. The questions were developed based on the stakeholder group being interviewed and include:

1. Introduction of the project – goals and description

a. The purpose of this project is to develop evidence-informed recommendations to support the mental health (MH), well-being and quality of life of diverse residents living in Canadian community residential care settings (including long-term care facilities), and their families, during and beyond the pandemic.

b. Recommendations for supporting MH and well-being will address needs of those with and without mental illness or dementia, and include prevention of social isolation and of BPSD, as well as psychosocial management of challenging behaviours.

c. Recommendations will be based on a synthesis of evidence about how psychosocial interventions; models of care; supportive physical, social, and work environments; workforce capacity and training; and facility policies and practices influence residents' mental health, quality of life, as well as the mental health and well-being of family caregivers and front-line staff.

d. You are being interviewed because of your expertise regarding gender and minority groups and as a community engaged researcher. The interview will take approximately 45 minutes. Information gathered will be aggregated and incorporated into the report we are preparing, and your name will not be used. Please provide your verbal consent to be interviewed on these terms.

2. Ask for verbal consent

a. Recordings are for notes only and only Dr. Penny MacCourt and I will hear them – they will be destroyed by Sept 30, 2021.

3. General questions (additional questions to evolve based on KI expertise)

a. Tell me about your connection to community residential care (what type of care settings have you been had experience in?) — what has been your role, and what important experiences have you had?

b. From your perspective as XXXX, what do you think supports mental health and well-being and quality of life for residents generally? Specifically, residents with mental illnesses?

c. What are some strategies that can be used to promote and/or support residents' MH/QOL?

d. What would increase residents' social connections/relationships (and specifically during a pandemic)?

e. What system factors need to be in place to support residents' MH/QOL (staffing, organization of work, support for staff)?

f. What enables staff to support residents' MH/ QOL?

g. What kind of training/skills do you feel are required on the front line to support residents' MH/QOL? To manage challenging behaviours?

h. How can LTCs provide better support for families through transitions and COVID-19?

i. Can you describe the ideal environment for residents that would support MH/QOL? What are the barriers?

Appendix B – Community Residential Care Survey: Supporting Mental Health

Preamble

Thank you for participating in this anonymous survey from the Canadian Coalition for Seniors' Mental Health (CCSMH). The purpose of the survey is to incorporate resident and family perspectives as we develop a Research Report and Recommendations on Supporting Mental Health and Well-Being in Community Residential Care Settings (including long-term care facilities, assisted living, and supportive housing). The research paper and recommendations will inform national standards for long-term care and other residential facilities. Please feel free to forward this on to friends and family members who might want to provide input.

Participation in this survey is completely voluntary. Only anonymous testimonials and summary data will be used by our project team. If you have any questions about the survey, please contact the CCSMH at info@ccsmh.ca. We estimate the survey will take you 3 to 5 minutes to complete.

For the purpose of this survey, a Community Residential Care Setting is defined as a facility that provides accommodation and care based on a person's needs. For example, long-term care facilities, nursing homes, retirement homes, assisted living, supportive housing, personal care homes

Survey Questions

1. Are you a …?
(If you fit more than one category, please feel free to complete the survey multiple times.)

- Person living in a Community Residential Care Setting
- Caregiver/Family Member/Friend of a person living in a Community Residential Care Setting
- Caregiver/Family Member/Friend who is completing the survey in consultation with/on behalf of a person living in a Community Residential Care Setting

Please answer the following questions from your perspective as identified above.

2. In what province/territory do you/your family member in care live?

3. In what type of Community Residential Care Setting do you/your family member in care live?

- Long-term Care Facility / Nursing Home
- Retirement Home
- Assisted Living
- Supportive Housing
- Other (please specify)

4. How much do you agree with the statement: "My/my family member in care's mental health and well-being are well supported in the Community Residential Care Setting."
   - Strongly agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree
5. What do you feel is essential to supporting mental health and well-being in your Community Residential Care Setting? (Choose all that apply.)
   - Ability to visit with family/friends
   - High quality physical care
   - Compassionate staff who know me well
   - Adequate staffing levels
   - Excellent communication and relationships with staff/management
   - Meaningful activities
   - Formal Therapeutic Recreation programs
   - Informal opportunities to socialize
   - Homelike environment
   - Comfortable climate-controlled environment
   - Nutritious, tasty food
   - Access to outdoor spaces
   - Peer relationships with other residents (friendships)
   - Other (please specify)
6. In your opinion, which of these areas are done well by your Community Residential Care Setting? (Choose all that apply.)
   - Ability to visit with family/friends
   - High-quality physical care
   - Compassionate staff who know me well
   - Adequate staffing levels
   - Excellent communication and relationships with staff/management
   - Meaningful activities
   - Formal Therapeutic Recreation programs
   - Informal opportunities to socialize
   - Homelike environment

- Comfortable climate-controlled environment
- Nutritious, tasty food
- Access to outdoor spaces
- Peer relationships with other residents (friendships)
- Other (please specify)

7. In your opinion, what more could be done to support your/family member in care's mental health and well-being in the Community Residential Care Setting?

8. How have visitation restrictions in your Community Residential Care Setting affected you/your family member in care?

9. How would you like to see family/friend visiting handled in the case of future outbreaks (COVID-19 or other viruses)? (Choose all that apply.)

- Clear visiting protocols
- Safe, designated visiting areas inside
- Safe, designated visiting areas outside
- Staff support for in-person visits
- Staff support for virtual visits
- Technology support/available for virtual visits
- Protocols for short-term leave from Community Residential Care Settings
- Designation of approved visitors for each resident
- Daily updates on current protocols
- Other (please specify)

10. Is there anything else you would like to say about supports for your mental health and well-being in your Community Residential Care Setting?

No.

If yes, please specify.

Appendix C – Resources to Support Implementation of Recommendations

1. Supportive Physical Environments

- The Built Environment Audit Tool [65], developed in Australia, helps community residential care facilities to audit their facilities and develop action plans to improve the physical environment for older people. Action plans can include "easy to achieve" changes and more costly long-term changes.
- Dementia-friendly Environments [243] is a comprehensive and user-friendly online resource for service providers, carers, and families who support people with dementia in seniors' community residential care facilities. Developed by the Department of Health and Human Services in Australia, it is based on current research, knowledge, and practical experience in building or renovating physical environments and providing high-quality, person-centred services.

2. Strengthening Individuals

- *What Works to Promote Emotional Well-Being in Older People: A Guide for Aged Care Staff Working in Community or Residential Care Settings*, produced in Australia for service providers, summarizes the strength of evidence for psychosocial interventions that promote emotional well-being specifically for those with symptoms of anxiety and depression. Interventions can be applied in residential care and/or in community. Case studies and discussion of evaluation methods are included [244].
- *The National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms),* developed by the Canadian Coalition for Seniors' Mental Health, has evidence-based guidelines intended to promote mental health and address mental health problems (including mental disorders) in older residents of LTC homes, with a specific focus on depressive and behavioural symptoms [245]. Recommendations address general care and system issues, as well as the assessment and treatment of depressive and behavioural symptoms presented by individual residents.
- *The Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care: A Person-Centred Interdisciplinary Approach* [188], which incorporates the two-part *Algorithm for Accommodating and Managing BPSD in Residential Care,* will support physicians, nurses, clinicians, and care staff to provide interdisciplinary, evidence-based, person-centred care to those experiencing behavioural and psychological symptoms of dementia (BPSD), with a specific focus on the appropriate use of antipsychotic drugs in the residential care setting. The guidelines reflect the important culture of person-centred interdisciplinary care and decision- making that involves physicians, nurses, pharmacists, caregivers, family members, care staff, and persons in care.
- *Caregivers of Long-Term Care Residents in the Context of COVID-19: Current Knowledge, Inspiring Practices and Recommendations* [121] , developed by the Centre for Research and Expertise in Social Gerontology of CIUSSS West-Central Montreal, is intended for managers of LTC settings and decision-makers in the Quebec health and social services network. Its aim is to enhance the practices put in place to meet the needs of caregivers of LTC residents in the context of COVID-19. Based on a literature review, the needs of caregivers during the pandemic, and gaps in meeting them, are described. Inspiring practices that can be implemented to support caregivers in LTC are discussed, and recommendations to managers and decision-makers are made.

3. Strengthening Relationships

- Research carried out at the Mount Saint Vincent University Centre on Aging in Nova Scotia for the Care and Construction project was the basis for the brochure entitled "Relationships Matter", which focuses on the importance of relationships among residents, family members, and staff for resident quality of life. Suggestions for actions to facilitate relationships are made [246].

4. Positive Social Environments

- *The Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* [39] can be used to emphasize the importance of person and relationship-centred care in all settings.
- The Alzheimer Society of Canada has developed an evidence-based framework for strengthening the capacity of care home staff to implement person-centered care by influencing the culture of care and encouraging recognition of each resident's individuality. The framework is equally applicable to persons without dementia [247].
- The Registered Nurses' Association of Ontario has developed *Person and Family Centred Care* [21].
- University of Waterloo's Research Institute for Aging has developed *Working Together to Put Living First: A Guidebook to Change the Culture of Aging in Long-Term Care* [248].
- The Ontario Ministry of Children, Community and Social Services has developed Guidelines for Supporting Adults with A Developmental Disability When Applying To, Moving into and Residing in a Long-Term Care Home. The guidelines outline the importance of planning, choice and consent and adults with developmental disabilities receiving appropriate developmental services and supports in a LTC home [155].
- Ontario Centres for Learning, Research and Innovation in Long-Term Care has developed a report *Supporting Cultural Diversity in Long-Term Care* that outlines issues in providing cultural care to diverse populations in LTC and identifies additional resources [157].
- Ontario Centres for Learning, Research and Innovation in Long-Term Care has developed a report identifying the needs of Indigenous people in Ontario's long-term care homes, with evidence informed suggestions for meeting them [159].
- The Ontario Senior Pride's Submission to the Long-Term Care COVID-19 Commission, entitled "Long-Term Care COVID-19 and Ontario's 2S-LGBTQ+ Seniors: A Call to Action" [249], has made recommendations to integrate 2S-LGBTQ+ inclusivity and respect for 2S-LGBTQ+ seniors within the LTC system, and to promote greater understanding and awareness of their unique health and care needs and social well-being. The submission includes a review of issues in LTC and lists resources and tool kits available for service providers to inform care of 2S-LGBTQ+ seniors.
- Ottawa Senior Pride Network has developed a cultural competency tool for organizations [250] to enable them to assess policies, programs, and practices for how well they support the well-being of LGBTQ2S+ seniors.
- *Multi-Faith Practices: Guidelines for Caregiver* is a user-friendly resource to help team members in retirement and long-term care homes understand the traditions and practices of six major religions: Buddhism, Christianity, Hinduism, Islam, Judaism, and Sikhism [251].

5. Supportive Work Environments

- Best practice principles, based on evidence, have been proposed by the Alzheimer Society to support the front-line workers in LTC and other settings in order to enable/facilitate quality care for residents living with dementia [165].
- The Mental Health Commission of Canada (MHCC) has designed a toolkit, *Assembling the Pieces, t*o support organizations working to implement the *National Standard of Canada for Psychological Health and Safety in the Workplace* (the Standard). This toolkit is a companion to the Standard and provides practical advice for implementing key elements of the Standard, as well as links to tools that will assist organizations in taking action towards implementation [248].

6. Workforce Capacity and Training

- Algonquin College and the Ontario Centres for Learning, Research and Innovation (CLRI) Bruyère have developed the Clinical Nursing Leadership eLearning Toolkit/Training Course [252] to enhance the clinical leadership skills of nurses working in long-term care. The modules include realistic scenarios and scenario-based practice to help nurses navigate conflict, communicate with confidence, and learn how to thrive as clinical leaders.

7. Policy and Practice

- *Working Together to Put Living First: A Guidebook to Change the Culture of Aging in Long-Term Care* [248] describes how an LTC facility and a retirement living organization utilized a strengths-based approach to culture change guided by collaborative leadership and Appreciative Inquiry. There is also a compendium of resources to enable others to implement the approach [248].
- *The National Standard of Canada for Psychological Health and Safety in the Workplace* [253] can facilitate a work environment that promotes and supports the mental health and well-being of those working in community residential care settings.
- Alberta Health has created a toolkit to help residents and families set up and maintain resident and family councils, by providing sample agendas, minute templates, and describing steps to initiate a council. The toolkit is also a resource for operators in supporting resident and family councils [217].
- The BC Care Providers Association has developed a useful framework for defining and enhancing quality of life in LTC, assisted living, and other community settings, with suggestions for implementation [139]. The framework includes:
  - Guiding principles (person-centred approach, collaborative, leadership);
  - Values (engagement, respect, dignity, inclusion); and
  - Domains (supportive environments, meaningful relationships, fulfilling activities and cultural diversity).

CSA Group Research

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