CSA GROUP™

What We Heard Report

Public Review & Consultation Sessions

To inform the development of the National Standard of Canada for Mental health and well-being in long-term care and assisted living settings (CSA Z2004)

March 2024



Table of Contents

1. Executive Summary 4

1.1 Background 4

1.2 The public review and consultation sessions process 4

2. What we heard 5

2.1 Who we heard from 5

2.2 What we heard 5

2.3 Definitions 6

2.4 Guiding principles 6

2.5 Organizational commitment to mental health and well-being 8

2.6 Workforce 8

2.7 Design of the LTC and AL setting 9

2.8 Recreational therapy programs and activities to foster social connectedness, mental health, and well-being 9

2.9 Optimizing mental health and well-being through relationships within LTC and AL settings 10

2.10 Support for residents with mental health conditions 10

3.0 Next Steps 11

Annex A: Geographical breakdown of participants 12

Annex B: Breakdown of participant categorization 13

Annex C: Feedback on CSA Z2004 by clause 14

Legal Notice

This document is provided by the Canadian Standards Association (operating as "CSA Group") as a convenience only.

Disclaimer and exclusion of liability
This document is provided without any representations, warranties, or conditions of any kind, express or implied, including, without limitation, implied warranties or conditions concerning this document's fitness for a particular purpose or use, its merchantability, or its noninfringement of any third party's intellectual property rights. CSA Group does not warrant the accuracy, completeness, or currency of any of the information published in this document. CSA Group makes no representations or warranties regarding this document's compliance with any applicable statute, rule, or regulation.

IN NO EVENT SHALL CSA GROUP, ITS VOLUNTEERS, MEMBERS, SUBSIDIARIES, OR AFFILIATED COMPANIES, OR THEIR EMPLOYEES,DIRECTORS, OR OFFICERS, BE LIABLE FOR ANY DIRECT, INDIRECT, OR INCIDENTAL DAMAGES, INJURY, LOSS, COSTS, OR EXPENSES, HOWSOEVER CAUSED, INCLUDING BUT NOT LIMITED TO SPECIAL OR CONSEQUENTIAL DAMAGES, LOST REVENUE, BUSINESS INTERRUPTION, LOST OR DAMAGED DATA, OR ANY OTHER COMMERCIAL OR ECONOMIC LOSS, WHETHER BASED IN CONTRACT, TORT (INCLUDING NEGLIGENCE), OR ANY OTHER THEORY OF LIABILITY, ARISING OUT OF OR RESULTING FROM ACCESS TO OR POSSESSION OR USE OF THIS DOCUMENT, EVEN IF CSA GROUP HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES,INJURY, LOSS, COSTS, OR EXPENSES.

In publishing and making this document available, CSA Group is not undertaking to render professional or other services for or on behalf of any person or entity or to perform any duty owed by any person or entity to another person or entity. The information in this document is directed to those who have the appropriate degree of experience to use and apply its contents, and CSA Group accepts no responsibility whatsoever arising in any way from any and all use of or reliance on the information contained in this document.

Intellectual property rights and ownership
As between CSA Group and the users of this document (whether it be in printed or electronic form), CSA Group is the owner, or the authorized licensee, of all works contained herein that are protected by copyright, all trade-marks (except as otherwise noted to the contrary), and all inventions and trade secrets that may be contained in this document, whether or not such inventions and trade secrets are protected by patents and applications for patents. Without limitation, the unauthorized use, modification, copying, or disclosure of this document may violate laws that protect CSA Group's and/or others' intellectual property and may give rise to a right in CSA Group and/or others to seek legal redress for such use, modification, copying, or disclosure. To the extent permitted by licence or by law, CSA Group reserves all intellectual property rights in this document.

Patent rights
Attention is drawn to the possibility that some of the elements of this document may be the subject of patent rights. CSA Group shall not be held responsible for identifying any or all such patent rights. Users of this document are expressly advised that determination of the validity of any such patent rights is entirely their own responsibility.

Use of this document
This document is being provided by CSA Group for informational and non-commercial use only. If you do not agree with any of the terms and conditions contained in this Legal Notice, you may not use this document. Use of this document constitutes your acceptance of the terms and conditions of this Legal Notice.



Executive Summary

1.1 Background

In Canada, approximately 425,000 adults live in Long-term care (LTC) or in assisted living (AL) settings, and this population is growing rapidly (Clarke, 2021[1]). Mental health and well-being are integral to a good quality of life for all Canadians, including residents in these settings. Two national standards of Canada have been published to address the safety, needs, and quality of life of residents in LTC settings: CSA Z8004:2022, *Long-term care home operations and infection prevention and control,* and HSO 21001:2023 *Long-Term Care Services*. A new Standard CSA Z2004, *Mental health and well-being in LTC and AL settings,* will complement the requirements and recommendations of these standards. Creating the conditions that support mental health needs is essential to all residents living in LTC and AL.

1.2 The public review and consultation sessions process

The CSA Z2004 draft Standard was made available for public review in both English and French from September 18 to November 17, 2023.

To support the public review of the Standard, CSA Group launched a series of five consultation and public review information sessions. These sessions engaged workers, management, residents, families, and care partners, Indigenous community members, and younger residents (ages 18-64); and were aimed at collecting feedback and information to further inform the content of the CSA Z2004 Standard. They also provided an opportunity for CSA Group to hear from persons with technical expertise and lived experience on the topics covered by the CSA Z2004 Standard. The sessions highlighted key sections of the CSA Z2004 draft to help public review participants navigate the standard and provide their input. The sessions reached interested parties from across the country and engaged technical experts and specific target audiences.

CSA Group also participated in a workshop of the Canadian Academy of Geriatric Psychiatry (CAGP) and Canadian Coalition for Seniors' Mental Health (CCSMH) Annual Scientific Meeting to gather comments from mental health experts.

These consultations and the public review process reached more than 450 interested individuals and organizations, and close to 750 comments were submitted. All feedback received from the consultation sessions and the public review process have been submitted to the Technical Committee and will be considered for implementation in the final version of the Standard.

1 Clarke, J. 2021. *Impacts of the COVID-19 pandemic in nursing and residential care facilities in Canada. Statistics Canada.*

2. What we heard

2.1 Who we heard from

Over 280 interested parties attended the consultation and public review information sessions and submitted more than 425 comments. This enhanced engagement activity contributed to over 170 interested parties accessing the CSA Z2004 Public Review Draft and providing approximately 325 online comments. Feedback was received from various interested parties, including but not limited to:

- Administrators
- Care partners and family members
- Family councils
- Government ministries and health authorities
- Health service organizations
- Managers
- Members of related organizations, such as Recreation Therapists Organizations, MS Canada, etc.
- Residents
- Workers
- Worker unions

More details on the geographical representation and categories of participants of the consultation sessions are included in Annex A and Annex B.

2.2 What we heard

This report summarizes what we heard during the public review process. We heard about the positive aspects of the Standard and received suggested improvements.

CSA Group received several comments concerning the operations of LTC homes and the delivery of LTC services; however, these topics are outside the scope of CSA Z2004. Operations of LTC are addressed by the complementary CSA Z8004 standard, and LTC services are addressed by the HSO 21001 standard.

Another set of public review comments highlighted the importance of adequate funding and regulation needed to implement changes in LTC and AL (e.g., hiring additional staff) to achieve the care outlined in the Standard. As these are not technical requirements and they fall within the purview of authorities having jurisdiction, they are not incorporated into the National Standards of Canada.

The majority of feedback received related to the following Clauses:

- **Clause 3:** Definitions – 6%
- **Clause 4:** Guiding principles – 8 %
- **Clause 5:** Organizational commitment to mental health and well-being – 7%
- **Clause 7:** Workforce – 19 %
- **Clause 8:** Design of the LTC and AL setting (including Annex A Lighting levels to promote mental health and well-being) – 12 %
- **Clause 9:** Recreational therapy programs and activities to foster social connectedness, mental health, and well-being (including Annex B Examples of activities that may be offered within a therapeutic recreational therapy program) – 23%
- **Clause 10:** Optimizing mental health and well-being through relationships within LTC and AL settings – 6%
- **Clause 11:** Support for residents with mental health conditions (including Annex C Non-pharmacological treatment options for dementia, delirium, and depression) – 7 %

Comments received for these sections are described in Sections 2.3 to 2.10.

> "I found the session very informative and extremely well-organized, making everything easy to follow. I also really enjoyed hearing various viewpoints and learning from them. On behalf of me and my loved-one in LTC, thank you kindly for all CSA is doing in the hopes of enhancing the quality of life for all Canadians in LTC and AL. This journey isn't easy, but there are certainly things that can change and be implemented to help make it a bit easier for all."[2]

2 Consultation Session Participant: Reproduced with their permission.



The remainder of the comments (12%) were directed at the other clauses of the draft Standard: Introduction, Scope, Reference Publications, Critical Incident Management, and Younger Residents. Annex C provides a breakdown of the feedback received on the various Clauses in the Draft Standard.

> "This document is excellent. I'm impressed with the breadth and depth. I have reviewed and done a lot of research in the area of whole person - whole environment for dementia, and I am so impressed that some of the less known literature was cited in this draft."[3]

2.3 Definitions

Positive feedback and confirmation from reviewers were received about the use of terms that respected person-centred care principles (i.e., care partners). A large majority of participants were in favor of the use of the term "residents." Participants identified the correct terminology for health care professionals, such as the use of the term "recreation therapists." The need to align terminology with other LTC standards as well as across federal, provincial, and territorial legislation was also highlighted. A comment suggested updating Person Centred Care (PCC) to reflect the evidence of Person and Family Centred Care (PFCC).

2.4 Guiding principles

We heard that residents should be treated as individuals, not as a set of diagnoses. It was noted that trauma and violence have lasting effects on mental and emotional health and that trauma-informed care should cover both past and current trauma. We received comments that the wording around residents' physical, mental, social, and spiritual needs should be strengthened. We heard that input and preferences from the resident, family, and care partner needs to be integral to the care plan. One participant mentioned the need for supportive environments that not only acknowledge but also adapt to the varying cognitive abilities and communication styles of residents and that are flexible to changes in these abilities. Another person reminded us that the simple act of listening to the patient is often overlooked.

In the human rights subclause, we were asked to include that persons should not be discriminated against based on their socio-economic status. We received comments on the stigma subclause, reminding us of the reality and constraints that certain settings face in terms of financial resources, knowledge, and capability to manage residents with complex mental health needs.

3 Public reviewer of CSA Z2004



"Feedback on the cultural safety and humility subclause addressed the importance of capturing the rich diversity of cultural groups in Canada by including all Indigenous groups, including Inuit, Métis, and First Nations people. "

Feedback on the cultural safety and humility subclause addressed the importance of capturing the rich diversity of cultural groups in Canada by including all Indigenous groups, including Inuit, Métis, and First Nations people. We heard about the need to create a safe space where individuals from cultural communities can come in and offer spiritual and cultural support to residents. The need to address the ongoing and impactful traumatic experiences that some cultural groups continue to face in the country was also mentioned. It was suggested that systemic barriers and biases in health care be recognized and addressed to help ensure equitable and inclusive care for all residents. Finally, comments were submitted surrounding the need to prioritize and improve access to culturally appropriate and safe programs and resources that respect Indigenous residents' knowledge systems and ways of being.

2.5 Organizational commitment to mental health and well-being

Participants identified the importance of leadership having access to continuing education, particularly on mental health issues, to provide the most current and highest quality of care.

We heard that the integration of the requirements of this clause within the mission, vision, and values may be problematic for some organizations as most visions and missions go beyond these elements and cannot be adjusted in this regard.

Many comments were received on the policies for respectful treatment of residents and consequences for abuse and neglect, including the need for violence prevention policies, education, and training of workers, implementing reporting mechanisms, conducting regular audits, and responding swiftly to concerns. Participants asked for more detailed requirements for the safety risk assessment, including the frequency and by whom it should be conducted. Finally, we were asked to clarify what is meant by "least restraint."

> "CSA standards should reflect the ideals which we are to work towards, and I believe this standard has excellently covered organizational commitments. Can organizations attain these standards with the resources available? Not all the time, but the standards are to be worked towards, and for that reason, I believe the clause on organizational commitment has been drafted over and beyond. It's great work, in my opinion."[4]

2.6 Workforce

We received several comments concerning the well-being and conditions of workers in LTC and AL; however, these topics are outside the scope of CSA Z2004. The topic of enabling a healthy and competent workforce is covered in the complementary HSO 21001 standard.

Many comments highlighted the need to clarify if this standard was for workers' or for residents' mental health and well-being and to stress the fundamental 'reciprocity' between the well-being of residents and those who care for them.

Participants commented on the 'continuity of care' subclause. Concerns were voiced about having consistent worker assignments, such as the fact that certain residents are very difficult and the need to rotate staff between assignments to prevent burn-out. Participants suggested envisioning the care of these residents more from a team effort and perspective.

Voices were heard concerning the question of minimizing external staff, noting that travelling professionals bring new, fresh, and good ideas to permanent staff through peer-to-peer interaction and information sharing. We heard that agency staff needs to be utilized in a way that is appropriate, safe, and equitable, with a focus on continuity of care, as travelling nurses can also be called to work with the same resident over time.

4 Participant in worker consultation session

2.7 Design of the LTC and AL setting

We received some comments that provided detailed suggestions regarding design considerations for LTC and AL. While CSA Z2004 covers the design of LTC and AL as it relates to the mental health and well-being of residents, the general requirements for the physical design of LTC homes are covered in the CSA Z8004 standard. The feedback received regarding the general design of LTC homes will be shared with the Technical Subcommittee responsible for CSA Z8004 for their review and consideration for the next edition of the Standard.

> "The general design of long-term care settings, including any planned renovations (both inside and outside the setting), should consider dementia design because it supports residents to cope with the cognitive and functional challenges they face, reduces symptoms associated with dementia, and promotes mental health and well-being."[5]

We heard that the Standard should accommodate the religious and cultural practice needs of the residents as a community. This should be done through assessing residents' needs while balancing health, safety, and practical considerations, both for existing and new builds.

One participant identified that currently, homes are designed to accommodate extroverts who enjoy being in the company of others and are happy to be in these common areas. Introverts, on the other hand, may not be able to find any place where they can have quiet time and low stimulation. They asked if there was a way to incorporate quiet common zones, so these residents did not have to stay in their rooms all the time to enjoy quiet time.

Interested parties advised that the Standard could benefit from further attention to inclusivity in the selection of artwork, especially in acknowledging the potential impact on individuals from diverse cultural groups and the 2SLGBTQI+ community.

2.8 Recreational therapy programs and activities to foster social connectedness, mental health, and well-being

We received many comments regarding the terminology related to "recreation therapy programs", the legal landscape in Canada surrounding the work of recreation therapists, and the qualifications of those offering these services. There is a desire for qualified recreational therapy staff to be available in each home, but it was recognized that to achieve this, some flexibility will be required, including the increased use of technology.

It was noted that the availability and quality of recreational programs were improving for a time but appear to be in decline. Funding and staff shortages are cited as primary elements of these changes.

We heard that to optimize inclusion and participation, activities need to be offered not only on weekdays but also during weekends, holidays, and at different times of the day to accommodate the schedules and routines of residents.

We heard that residents need to feel a sense of purpose by contributing to their homes and communities. Participants advised on the importance of having a holistic view of activities, addressing the five domains (physical, social, emotional, psychological, and spiritual).

Participants mentioned the need to minimize barriers and accessibility issues for residents to take full advantage of external activities through adequate transportation options. Residents also need to be able to access translation devices to promote their participation in care, programs, and services. It was also mentioned that a stronger emphasis should be placed on collaboration with external partners to create and deliver supports.

5 Public reviewer of CSA Z2004.

2.9 Optimizing mental health and well-being through relationships within LTC and AL settings

We heard that there needs to be a personal connection between caregivers, health care professionals, residents, and family members, as they all contribute to the residents' life in the home. Participants noted that many families live far away and rely on the staff to be the main source of connection to their loved ones. Participants stressed the importance of partnerships with volunteers and unpaid workers and recommended that these partnerships should be highlighted in the Standard, as well as providing guidance on liaising with volunteers.

Participants also noted that residents' connections play a pivotal role in enhancing their overall well-being and mental health. Engaging with the community provides residents with a sense of belonging, purpose, and social support. Regular interactions, participation in local events, and involvement in community activities not only foster a vibrant social life, but also contribute to mental resilience.

We received numerous comments about the importance of having a resident and family council in every long-term care home across Canada so that they have a mechanism to share and bring forward ideas, support one another, and see advances through their own voice.

Participants also advised that families need support in managing the changes their loved ones are going through. Mental health support for families is important, as well as having staff with the awareness of how to help families in these difficult times. Additionally, the need for ensuring respect between residents was highlighted.

Finally, participants recommended giving residents more information to help them identify who is who, e.g., doctor, care person, nurse, cleaning person. Sometimes, staff members wear name tags, but this does not specify their roles.

2.10 Support for residents with mental health conditions

Participants highlighted the importance of considerations related to continuity of care across a person's home, acute care, AL, and LTC, with an established process for the transfer of information among the levels of care. Interested parties explained that people may have mental health support prior to coming into long-term care, but once they are admitted to a home, these services are often withdrawn as the assumption is that the home will manage it, but this is often not the case.

We received many comments suggesting the Standard should include mental health and addictions as there is often concurrent substance use disorder. As addictions are now understood to be a component of mental health, participants believe it is important to treat these two issues as interrelated and to do so explicitly. Participants also recommended considering the addition of a commitment to recovery-oriented practices or services for residents with mental health disorders.

Participants stressed that while acknowledging the importance of specialized mental health workers as essential in situations requiring visitor restrictions, it is crucial to recognize the significant role family members can play in providing mental health support. Families often serve as a vital source of emotional and psychological well-being for residents.

In addition, participants noted that while it is important to assess medication in the event of new signs of dementia or delusion, it is equally important to help ensure that medication or other causes of cognitive decline (bladder infection, etc.) are identified and periodically reviewed. The importance of the review and incorporation of results of the *Resident Assessments Instrument (*RAI) into care planning was also highlighted. Finally, the need to provide talk therapy and grief counselling was mentioned.

Next steps

CSA Group and the Technical Subcommittee (TSC) for Mental Health and Well-being in LTC and AL settings are grateful for the extensive public participation and tremendous feedback received from workers, managers, mental health experts, residents, families, care partners, and other interested parties.

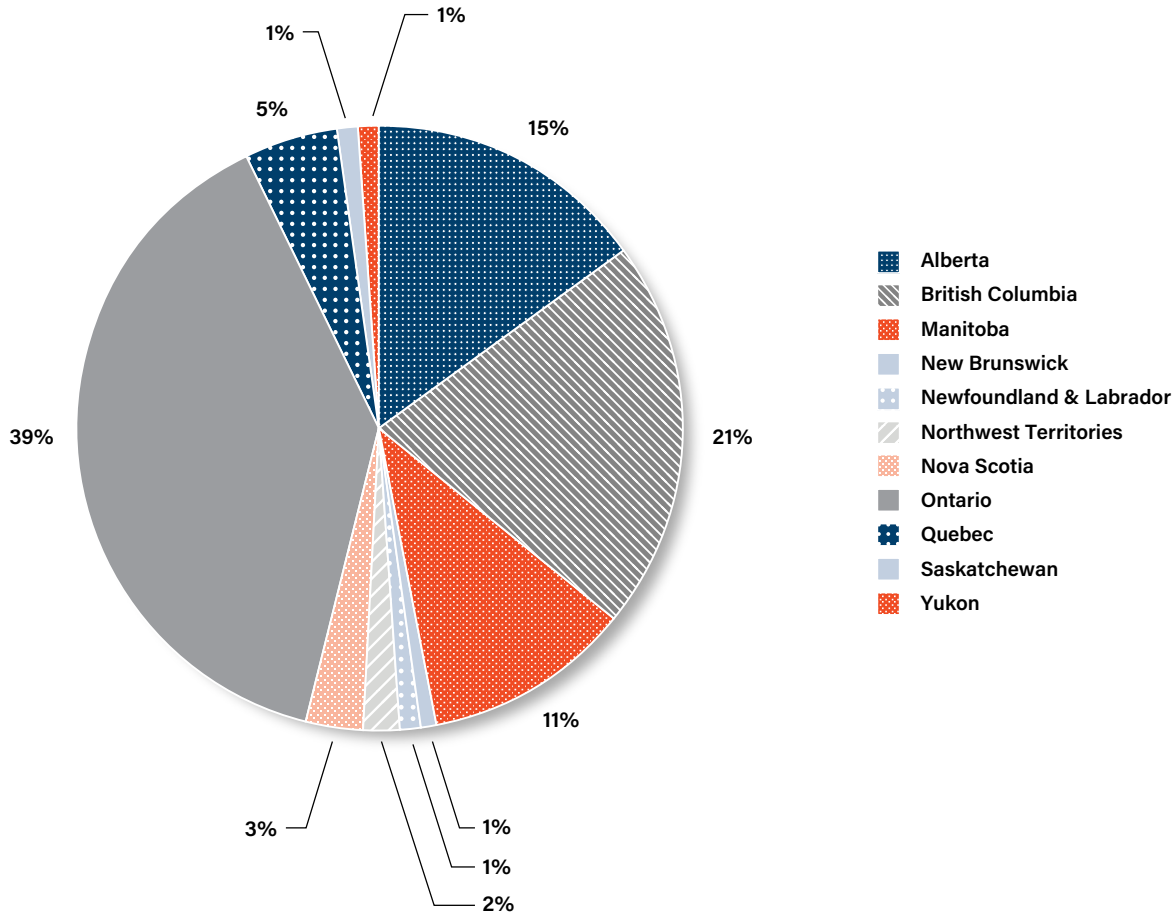
In accordance with CSA Group's accredited standards development process, all comments received during public review and the consultation sessions were reviewed by the TSC on Mental Health and Well-being in LTC and AL Settings. This review resulted in further revisions to the Draft Standard to improve its clarity and usability.

The content of the revised CSA Z2004 Draft was approved by the Technical Committee for Home and Community Care and is now being prepared for publication. The CSA Z2004 Standard is expected to be published in English and French in the summer of 2024.

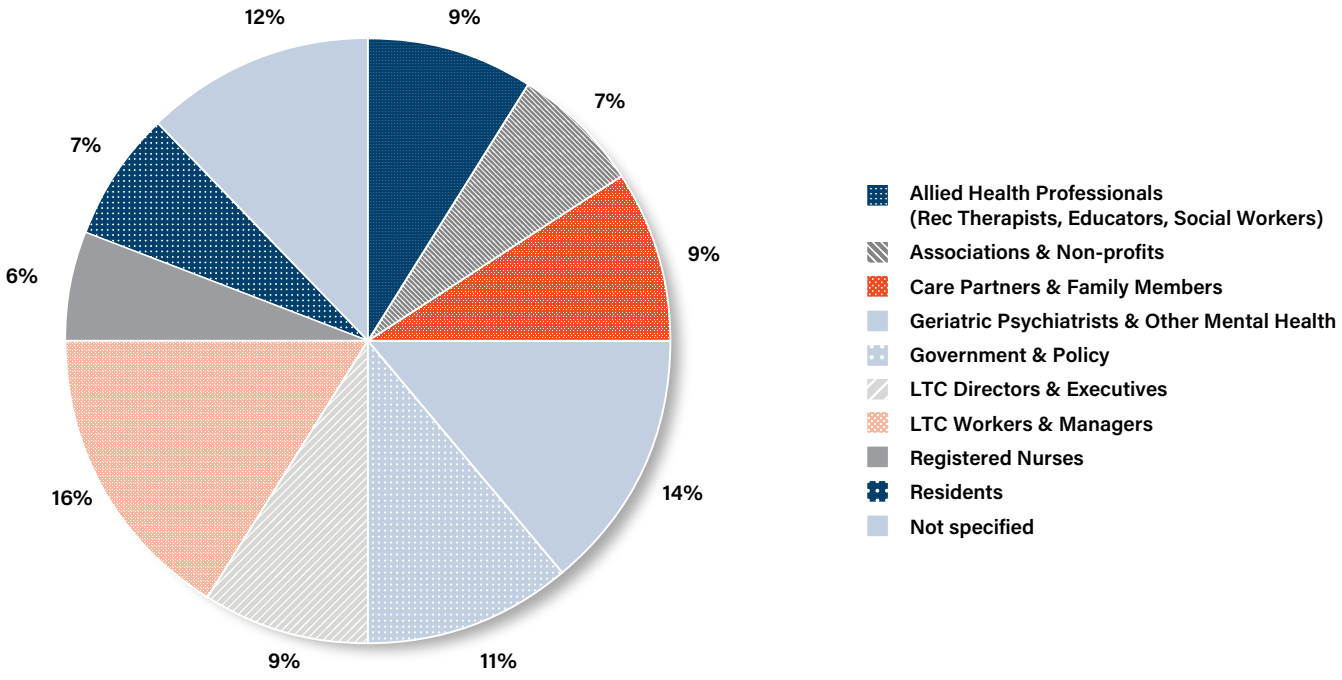
For more information, ongoing public updates on the development of CSA Z2004, and to participate in the discussion, please visit the CSA website on Long-term Care:

https://www.csagroup.org/standards/areas-of-focus/healthcare-and-well-being/standards-for-safer-long-term-care-homes/

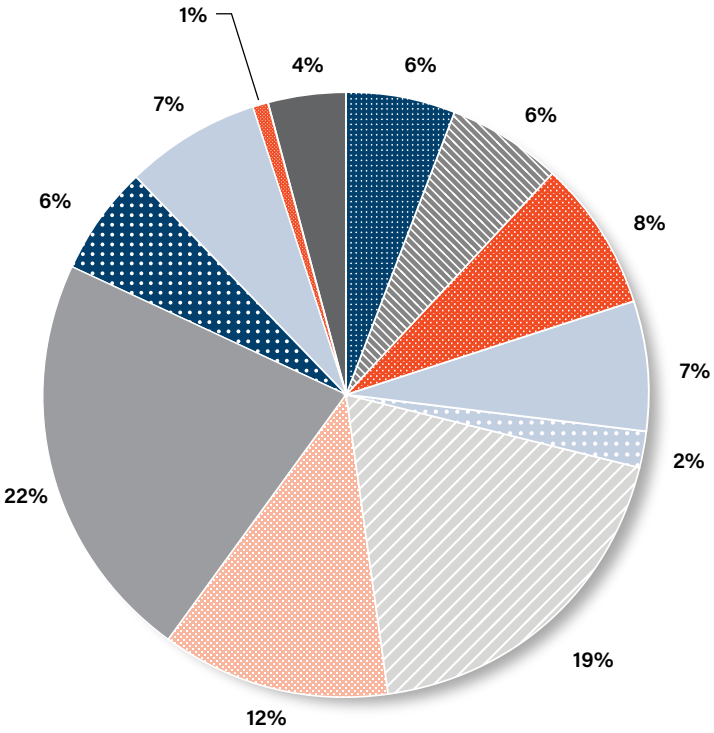
Annex A: Geographical breakdown of participants that attended consultation and public review information sessions



Annex B: Breakdown of participant categorization that attended consultation and public review information sessions



Annex C: Feedback on CSA Z2004 by clause



- **Clause 0-2:** General, preface, scope, proposed additions
- **Clause 3:** Definitions
- **Clause 4:** Guiding principles
- **Clause 5:** Organizational commitment to mental health and well-being
- **Clause 6:** Quality improvement
- **Clause 7:** Workforce
- **Clause 8:** Design of the LTC and AL setting (including Annex A Lighting levels to promote mental health and well-being)
- **Clause 9:** Recreational therapy programs and activities to foster social connectedness, mental health, and well-being (including Annex B Examples of activities that may be offered within a therapeutic recreational therapy program)
- **Clause 10:** Optimizing mental health and well-being through relationships within LTC and AL settings
- **Clause 11:** Support for residents with mental health conditions (including Annex C Non-pharmacological treatment options for dementia, delirium, and depression)
- **Clause 12:** Critical incident management
- **Clause 13:** LTC and AL considerations for younger residents (including Annex D Additional context on younger residents)

CSA Group

CSA Group is a global organization dedicated to safety, social good, and sustainability. We are a leader in Standards Development and in Testing, Inspection and Certification around the world, including Canada, the U.S., Europe, and Asia.

The mission of CSA Group's organization is to enhance the lives of Canadians through the advancement of standards in the public and private sectors. We are a leader in standards research, development, education, and advocacy.

CSA Disclaimer

This work has been produced and owned by Canadian Standards Association. It is designed to provide general information in regard to the subject matter covered. Canadian Standards Association is not responsible for any loss or damage which might occur as a result of your reliance or use of the content in this publication. The views or opinions expressed by the interviewees in this publication do not reflect the opinions of Canadian Standards Association or any of its staff members.

CSA GROUP™

© 2024 Canadian Standards Association. All Rights Reserved.