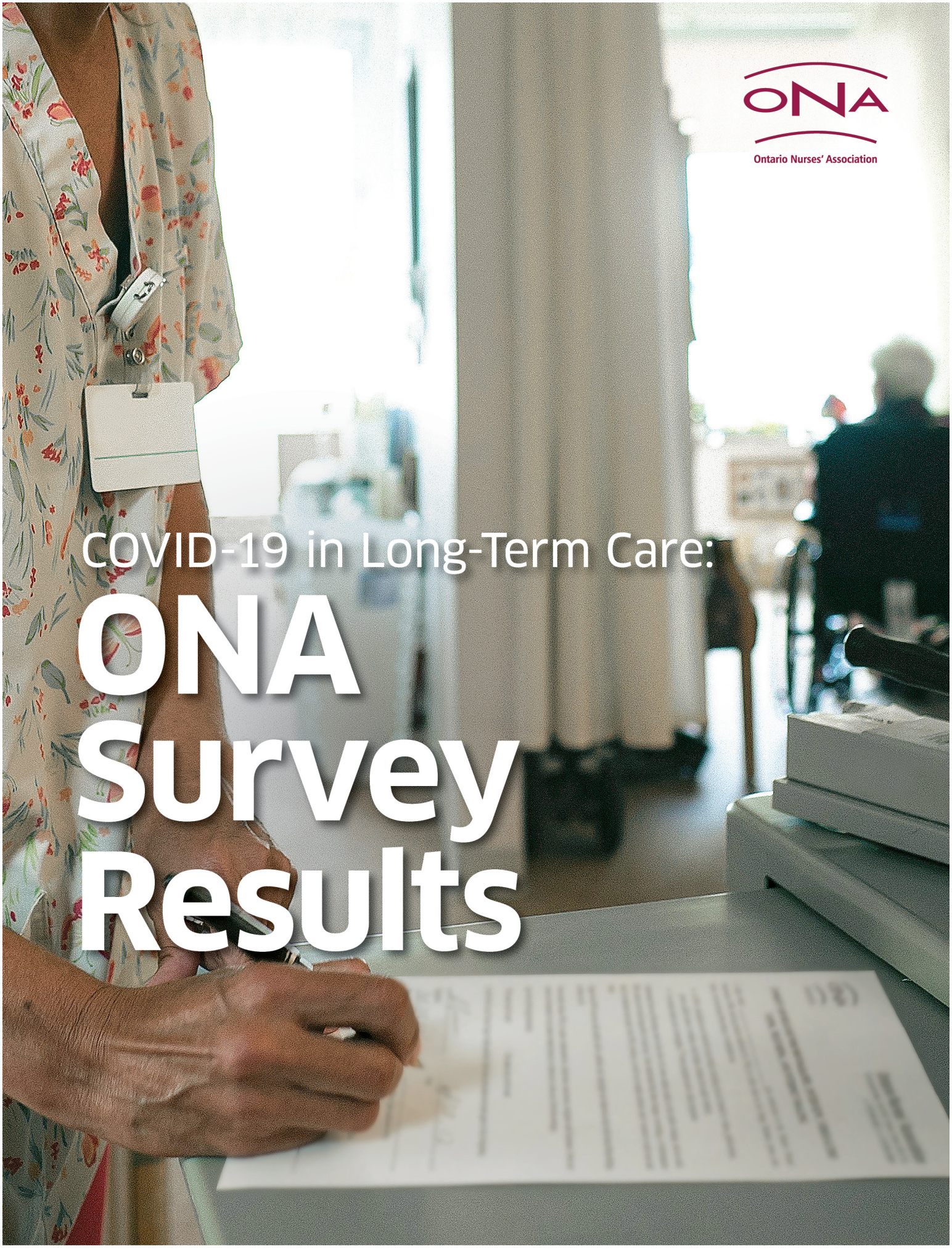

ONA
Ontario Nurses' Association

COVID-19 in Long-Term Care:

ONA Survey Results

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INTRODUCTION

From September 12 to October 4, 2020, the Ontario Nurses' Association (ONA) conducted a survey of ONA members working in long-term care (LTC) homes about their experiences during the COVID-19 pandemic, from its onset in March 2020. Survey respondents were asked to provide demographic information, as well as information about what it was like to work during the first wave of the COVID-19 pandemic in the spring and summer of 2020.

The questions asked in the survey have the overall purpose of providing input to the Long-Term Care Commission in order to assist with its mandate to:

- Investigate the spread of COVID-19 in LTC homes, and how residents, staff, and families were impacted, as well as the adequacy of measures taken by the province and other parties to prevent, isolate, and contain the spread.

- Provide the government with guidance and recommendations on how to better protect long-term care home residents and staff from any outbreaks in the future.

The statistics provided in this report are supplemented by over 1,000 written responses that contribute to understanding the experience of registered nurses (RNs) during the first wave.

The survey focused on four main themes: personal protective equipment (PPE), workload, management, and personal impact. The first three themes deal with key issues that the survey respondents faced while providing care through the pandemic. These include a lack of PPE, management restrictions on the use of PPE, short staffing, and inadequate Infection Prevention and Control (IPAC) measures. The last theme addresses the health and financial impact of the pandemic on the participating nurses. This theme includes whether the respondent tested positive for COVID-19, whether they lost hours of work or income due to the pandemic, and if they felt like they were adequately protected on the job.

The survey was conducted by Mindsuite Inc. using the Question Pro survey and business analytics tool. Participants completed the survey online at a computer, tablet, or on an android phone, with the opportunity to complete in multiple visits. Participants had the option to choose not to answer some survey questions. As a result, the number of participants answering each question is not consistent.

The survey was sent to approximately 3,300 ONA members. About 3,000 regularly work in LTC, while approximately 300 are nurses who are regularly employed in other health-care sectors but were redeployed to LTC homes experiencing outbreaks. 1,185 ONA members answered at least part of the survey, and 766 members completed the survey.

Viewed	Started	Completed	Completion Rate	Drop Outs (after starting)	Average Time to Complete
2,173	1,185	766	64.64%	416	37 Minutes

The questions asked are both analytical and anecdotal, with the goal of capturing information and stories, both positive and negative, to help identify what changes and innovations could be in practice today that would provide enhanced experiences for residents, staff, and the system at large.

The survey platform allowed ONA to segment the data based on the response of any question. Breakdowns of the data based on some of the segmentations will appear throughout the report.

We selected the segmentations based on some of the key issues we believe shed light on the LTC sector. The segmentations appearing in this report include:

- LTC home type: for-profit and not for profit
- outbreak status (outbreak or no outbreak)
- extent of outbreak (homes with five or less residents who tested positive for COVID-19 versus those with greater than five positive residents)[1]
- racial identity of the respondents.

A clear pattern emerges when comparing the survey responses from homes where an outbreak occurred to those where it did not, as well as responses from homes where the outbreak was contained to a small number of residents to those where the virus spread more widely. The experience of the nurses relayed through the survey show that homes that experienced outbreaks, especially medium and large outbreaks, were associated with problematic PPE use, heavy and inappropriate workloads, poor management decisions around the health and safety of residents and staff, and a heavy toll on nurses. It is also clear that the issues that plagued the "outbreak homes" were also more likely to exist in for-profit LTC homes. And while the personal toll on nurses was great, it was especially so for racialized nurses.

[1] For this report, we are calling an outbreak affecting five or fewer residents a "small" outbreak, and outbreaks affecting six or more a "medium/large" outbreak.

Executive Summary

The survey responses reveal significant trends around the key themes of PPE, workload, and leadership. Homes with no outbreak performed better in all aspects of these themes than those with an outbreak. The data is even more telling when homes that were able to contain an outbreak compared to those that could not: homes that had contained outbreaks had better supply of PPE, imposed less restrictions on its use, had better staffing levels, and had leaders who were proactive in preparing the home and the staff and in acting swiftly to isolate and cohort residents in order to contain the spread.

Another stark difference was in the performance of homes in the not-for-profit sector compared to the for-profit sector. It is well documented that the not-for-profit sector experienced significantly fewer outbreaks, cases of COVID-19, and resident deaths from COVID-19. We believe our survey sheds some light on why: on nearly every question we asked, the not-for-profit sector performed better.

A final issue to note is the disproportionate impact the pandemic has had on racialized staff. Respondents who identified as racialized are more likely to work in the for-profit sector, and more likely to work multiple jobs. They are over-represented in the homes that experienced outbreaks, and they were more likely to contract COVID-19 themselves.

PPE

The survey asked a range of questions about the ability of the respondents to access proper PPE. Questions about the consistency of supply and any restrictions on use were asked about each main type of PPE: N95 respirators, gloves, impermeable gowns, goggles, face shields, and surgical masks. Respondents were asked to select all the supply issues they faced, if any, based on the number of days and number of times in which there were no supplies. A list of forms of restrictions, such as requiring reusing or permission to access, was given, and respondents were instructed to choose all that applied.

Respondents were also asked about whether specific requirements were made of them, including whether they had to wear the same mask when treating healthy and sick residents, and if they had been discouraged from using PPE.

	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For Profit
Count	766	436	434	204	174	415	585
PPE	%	%	%	%	%	%	%
Experienced supply issues with N95s	41	30	49	37	65	36	44
Experienced restrictions on use of N95s	77	70	81	76	88	71	79
Told to wear same mask with healthy and sick residents	35	26	38	31	50	24	42
Discouraged from using PPE	20	16	24	20	31	16	22

Overall, 59% of participants indicated they had experienced no supply issues with N95s. In homes without outbreaks, 70% indicated no supply issues with N95s, while only 51% of those in outbreaks said the same. Of those outbreak homes, 63% of respondents working in contained outbreaks reported no N95 supply issues, while only 35% of those working in homes with

uncontained outbreaks said the same. Outbreaks, and especially uncontained outbreaks of more than five residents, were associated with higher rates of supply issues with N95 masks. This same pattern was found in each of the other types of PPE as well, with more supply issues linked to outbreaks, and particularly outbreaks of more than five residents.

Workload

The survey data confirms that staffing issues were a serious and widespread problem during the pandemic. Half of all respondents said the staffing levels in their homes decreased during the pandemic. Nearly a third of all respondents indicated that both RNs and registered practical nurses (RPNs) were short-staffed often, defined in the survey as several times a week. Two-thirds of respondents said personal support workers (PSWs) often worked short-staffed. Of course, fewer staff translates into more work for those left, and/or work getting missed.

A significant percentage of LTC homes also relied on temporary, or agency, staff. More than a quarter of all respondents indicated their home used agency RNs during the pandemic, with more than one in eight saying agency RNs were employed often, defined as several times a week. The reliance on temporary staff was even more pronounced for RPNs, with a third of respondents indicated they were used during the pandemic and more than one in six saying the usage was often. For PSWs, more than a quarter of the survey respondents indicated their LTC home used agency staff often.

Reports of short-staffing and usage of agency nurses was more pronounced in LTC homes that had COVID-19 outbreaks, and especially uncontained outbreaks of more than five residents. For instance, 40% of respondents working in outbreak homes indicated RNs were often short-staffed, and among outbreak homes with more than five resident cases, this figure was 45%. An exception to this pattern was found in the responses to the short staffing of PSWs, where the exceptionally high responses were roughly similar across the segmentations.

	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For Profit
Count	766	436	434	204	174	415	585
WORKLOAD	%	%	%	%	%	%	%
Staffing decreased during pandemic	50	48	53	50	59	44	54
Often work short staffed for RNs	32	26	40	37	45	32	33
Often work short staffed for PSWs	67	70	66	68	65	63	70
Often used agency RNs during outbreak	13	11	17	12	26	10	16
Often used agency PSWs during outbreak	28	23	36	27	48	16	37

Leadership

Management decisions were crucial to how LTC homes navigated the pandemic. Respondents were asked how their home made key decisions, such as if and how residents would be separated to prevent and contain the virus's spread. In homes that experienced outbreaks, respondents were much more likely to indicate there were delays in either isolating residents showing symptoms (moving them to a private room) or grouping them (moving them to a room with other symptomatic residents). This pattern also applied to the grouping of staff, where staff are assigned to work with either ill residents or well residents. In homes where outbreaks involved more than five residents, these responses were particularly stark, with 40% of respondents indicating there

was a delay in isolating residents. 33% saying there was a delay in grouping residents, and 35% saying there was a delay in grouping staff.

Respondents were also asked how they felt about the level of cleaning in the home and the general leadership of the administration. Respondents who worked in homes that experienced outbreaks, and particularly uncontained outbreaks, were much more likely to think that the cleaning in the home was insufficient to prevent and contain the spread of the virus, and that the leadership in the home was unsatisfactory.

	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For Profit
Count*	766	436	434	204	174	415	585
MANAGEMENT	%	%	%	%	%	%	%
Delay in isolating residents**	13	3	24	13	40	11	15
Delay in grouping residents**	11	4	18	7	33	8	13
Delay in grouping staff*	14	4	24	15	35	11	15
Cleaning was inadequate	23	18	25	20	30	14	30
Not satisfied with leadership	31	26	32	24	42	25	34

* there were slight variations in the total response count for each question as respondents were allowed to skip questions
**includes waiting until +ve test

Personal Impact

The survey shows that a sizeable portion of nurses felt that the pandemic impacted their health and finances. Nearly a third of respondents indicated they felt inadequately protected because either management took no measures to protect staff from exposure to the virus, or the measures taken were either insufficient or implemented too late. Feelings of inadequate protection were especially reported in homes that had outbreaks, and even more so in the sub-group of homes where outbreaks involved more than five residents. At the same time, a fifth of respondents reported losing hours or income due to being quarantined or isolated.

	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For Profit
Count*	766	436	434	204	174	415	585
PERSONAL IMPACT	%	%	%	%	%	%	%
Tested +ve	5	1	9	2	16	1	6
Felt inadequately protected**	31	18	44	28	63	22	38
Lost hours or income	21	15	27	21	33	17	25

*there were slight variations in the total response count for each question as respondents were allowed to skip questions
** includes no measures, measures considered insufficient and measures considered too late

Section 1: Basic Information

Section one of the survey asked ONA members basic information about their primary and secondary workplaces. For those who work in LTC, they were asked questions about the size, age and ownership of the primary home where they worked.

All survey respondents were able to complete this section.

1. Primary sector of employment

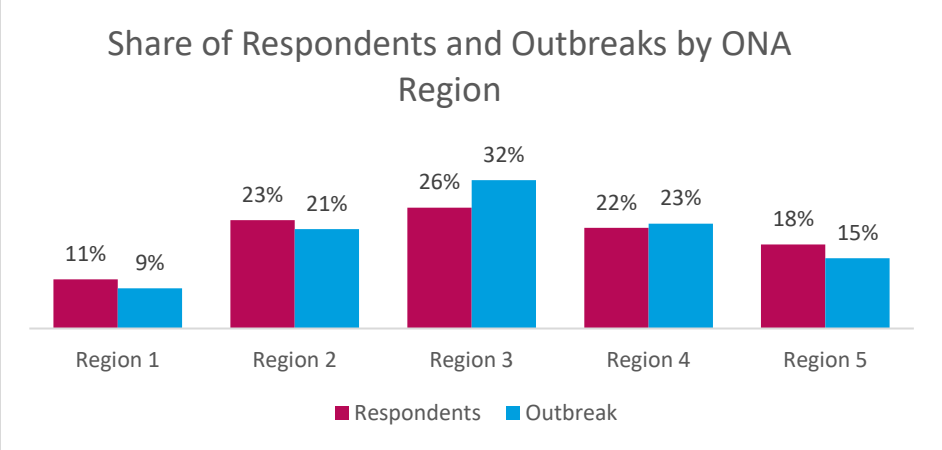
960 of 1,110 respondents indicated they worked primarily in LTC, with the remainder working primarily in hospitals, local health integration networks (LHINs), public health, or other health-care settings.

2. ONA members from across Ontario responded to the survey.

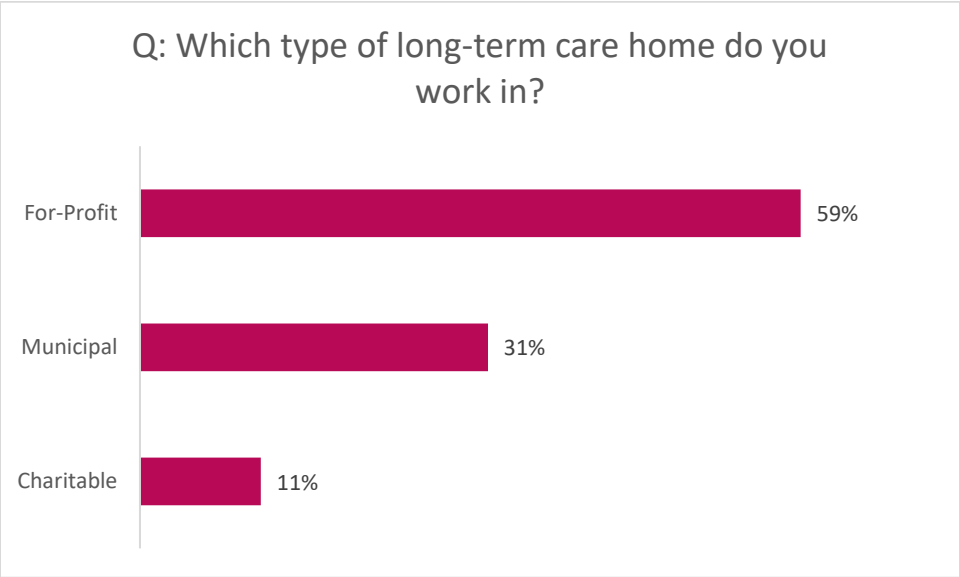
Q: Please identify your ONA region

Answer	Count	%
Region 1: Districts of Kenora, Rainy River, Thunder Bay, Algoma, Temiskaming, Nipissing, Cochrane, Manitoulin, City of Greater Sudbury	107	11%
Region 2: Counties of Prescott, Russell, Glengarry, Renfrew, Lanark, Grenville, Leeds, Dundas, Stormont, Frontenac, Hastings, Prince Edward, Lennox, Addington, Haliburton, Victoria, Peterborough, Northumberland, Regional Municipalities of Ottawa Carlton and Kingston	236	23%
Region 3: Regional Municipality of Durham, Municipalities of York, Peel and Toronto	263	26%
Region 4: Counties of Simcoe, Brant, Wellington, Dufferin, Haldimand, Norfolk, Regional Municipalities of Waterloo, Hamilton-Wentworth, Niagara, Halton, District Municipality of Muskoka and District of Parry Sound	219	22%
Region 5: Counties of Bruce, Grey, Huron, Perth, Oxford, Middlesex, Lambton, Elgin, Kent and Essex	183	18%
Total	1,008	100%

Region 3 experienced the highest percentage of outbreaks among survey respondents.



Most respondents (58%) worked in the for-profit sector, with 42% working in the not-for-profit sector, which is comprised of charitable and municipal LTC homes.



3. Number of employers and employment status

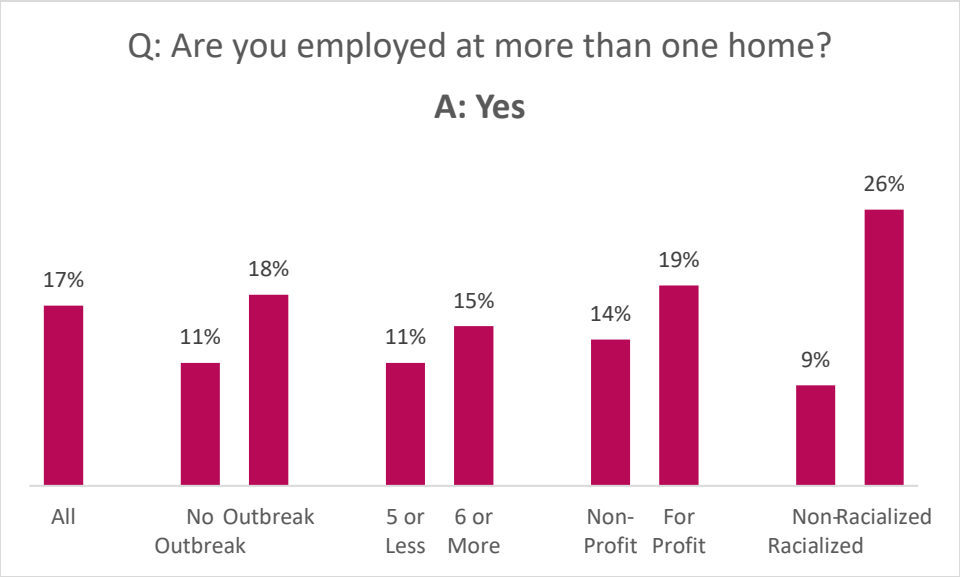
Respondents were asked a series of questions about how many positions they held, their status at their primary and secondary positions, and whether they would prefer full-time status. Of those who indicated that their status at the LTC home was not full time, 40% indicated a preference for full-time work.

All survey respondents were able to complete this section.

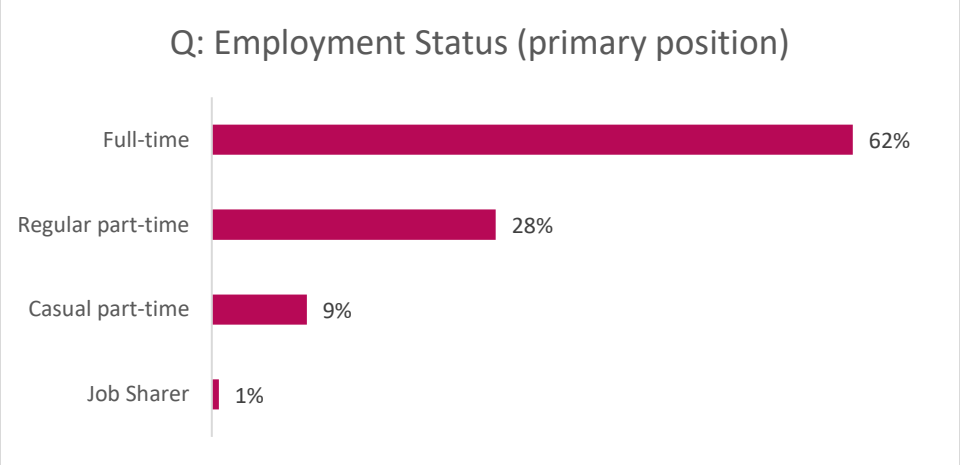
By segmenting the data, we are able to discern some interesting details:

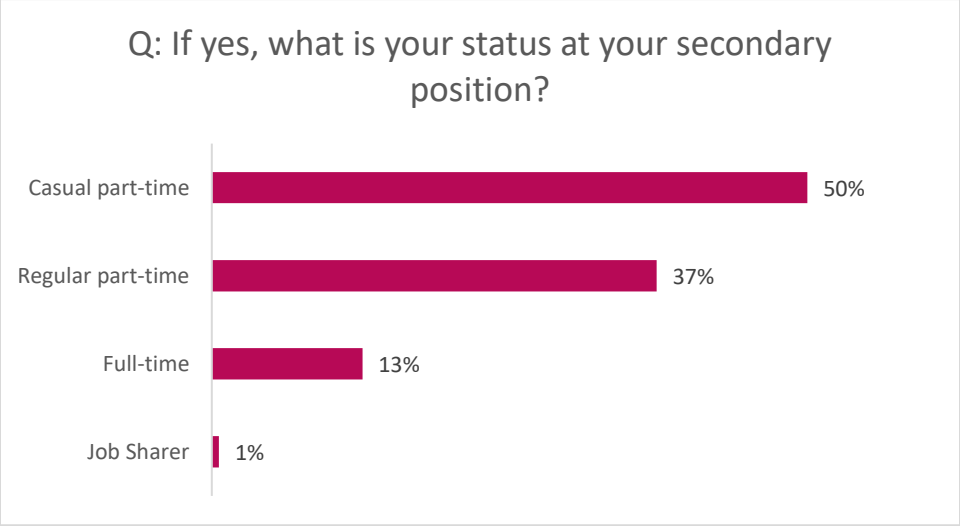
- Respondents who worked in more than one home are more likely to work in a for-profit home as their primary position;
- Respondents who worked in more than one home were more likely to work in a home that experienced an outbreak in the first wave; and
- Many outbreaks in the first wave started before the Chief Medical Officer of Health (CMOH) Directive, issued April 16, that required LTC staff to choose a single employer.

These findings together could suggest that the prevalence of workers holding more than one position in this sector may have been a factor in the early spread of COVID-19. Had the government limited health-care workers to one home earlier, like in British Columbia, which implemented the restriction on March 26, 2020, the spread of COVID-19 in the first wave may have been checked.



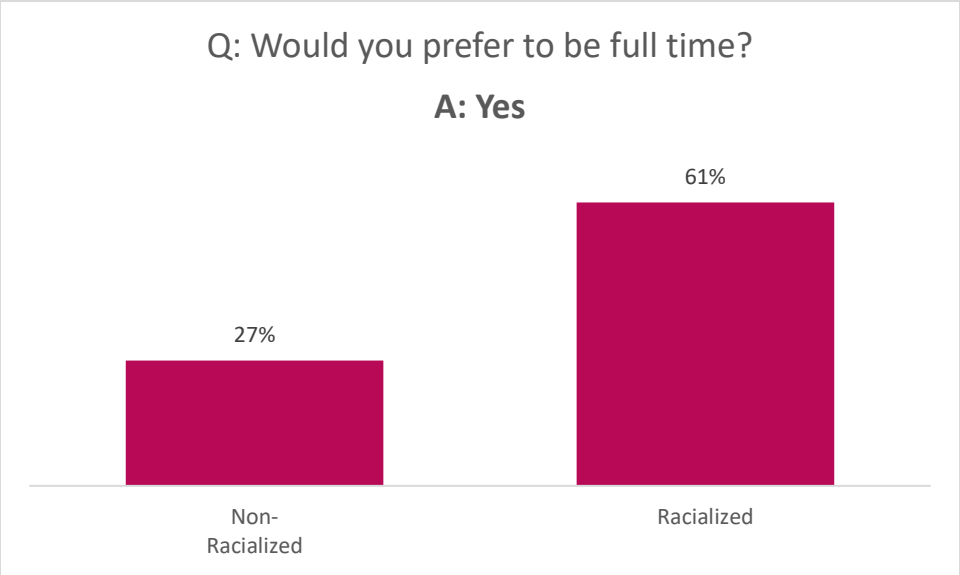
Members who answered that they were employed at more than one home were asked about their status at their primary and secondary positions. The majority held a full-time position at their primary job, but over a quarter (28%) held a part-time job at their primary job.





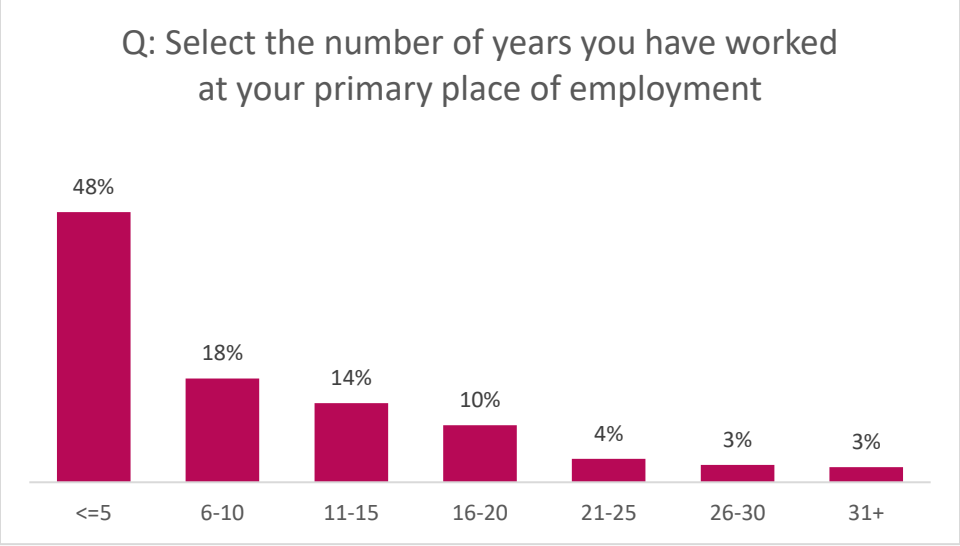
Respondents in homes with outbreaks were more likely to indicate a preference for full-time work, with the percentage increasing in homes that experienced medium and large outbreaks. We are not able to segment the data in a way that would know if the respondents expressing a desire for full-time work also hold more than one job. If this hypothesis were true, it could explain the correlation between desire for full-time work and likelihood of working in a home with an outbreak. As noted above, many first wave outbreaks started before the government directive requiring staff to work in only one facility.

Members who identified as racialized were significantly more likely to work at more than one home, and were more likely to indicate a preference for full-time work.



4. Most respondents had limited years at their primary place of employment.

The majority of respondents indicated that they had worked at their primary place of employment for five years or less. This is consistent with the well-known evidence that LTC is a sector with chronic issues of recruiting and retaining staff.

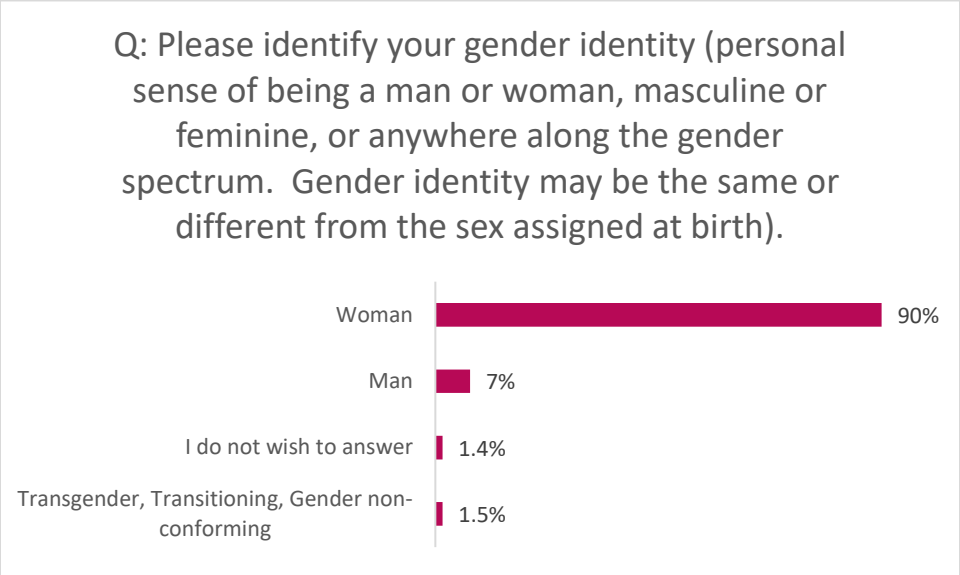


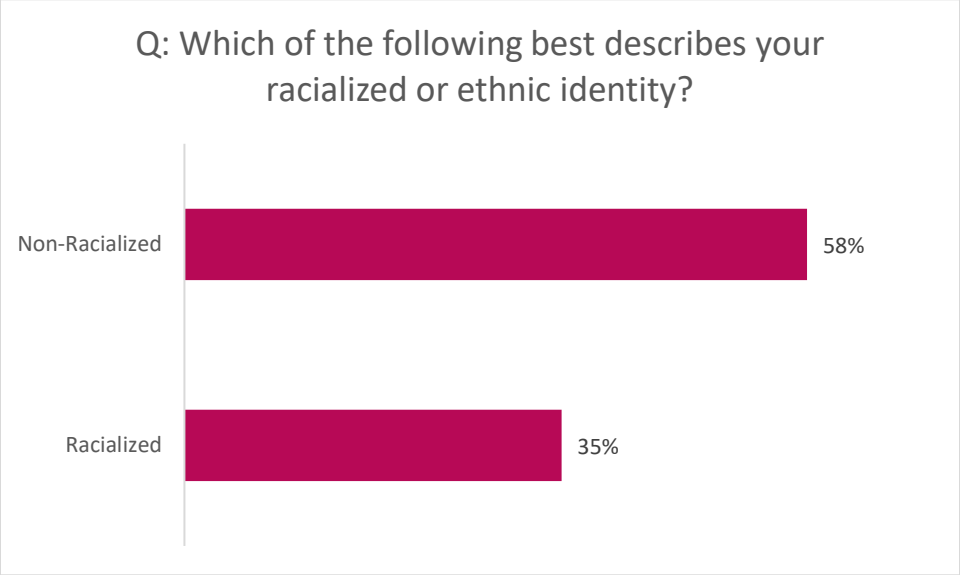
Section 2: About You

In section two, ONA members were asked a series of demographic questions. All survey respondents were able to complete this section.

1. The LTC workforce is heavily female dominated and racially diverse.

The survey responses illustrate that LTC is a heavily female-dominated workforce, and very racially diverse. [23]





[2] For the purpose of illustrating the data, the categories cis-man and cis-woman have been combined, and the categories trans man, trans woman, gender non-conforming non-binary, transitioning, two-spirit, not applicable and other have been combined.
[3] For the purpose of illustrating the data, the categories Arab (0.1%), Black (8.3%), Indigenous (0.89%), Chinese (3.06%), Filipino (8.2%), Japanese (0.2%), Korean (0.79%), Latin American (0.59%), South Asian (9.78%), and West Asian (0.99) have been combined.

Section 3, Part A: Impact of COVID-19 Pandemic on your LTC Home

Only survey respondents who normally work in LTC were able to answer questions in this section (i.e., those who were redeployed from hospitals did not answer).

1. Outbreaks

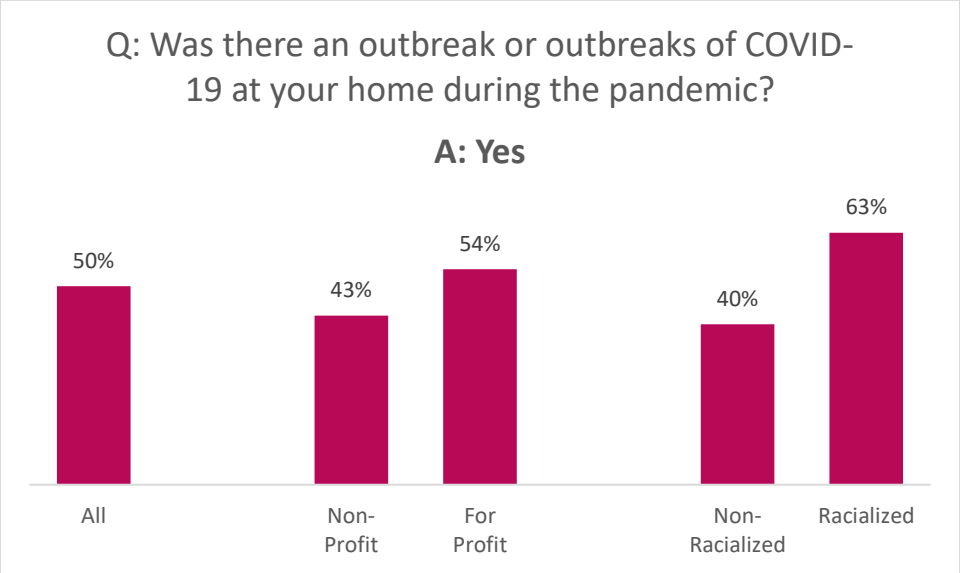
Respondents were asked whether their home experienced an outbreak. If they indicated yes, they were asked a follow up question about the extent of the outbreak.

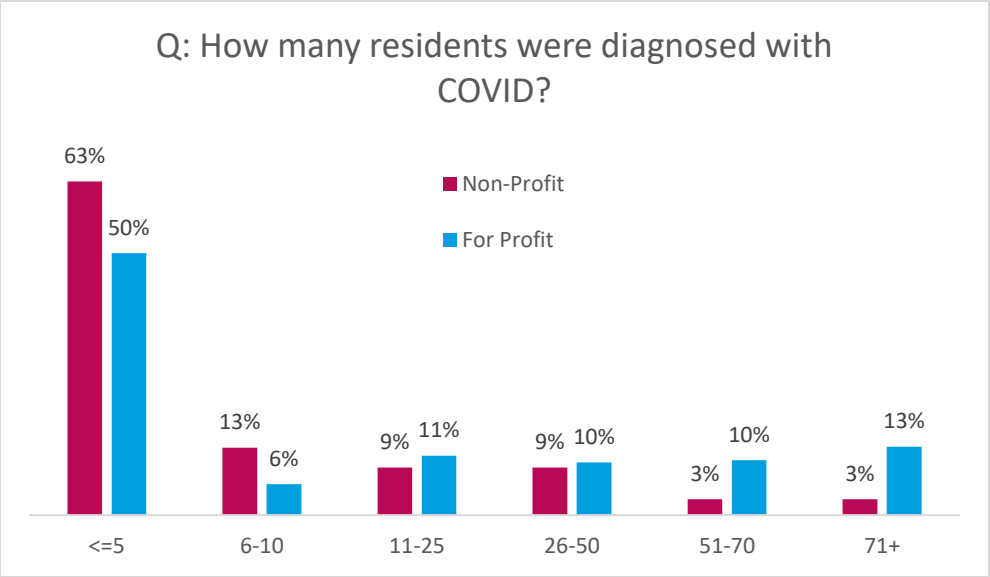
Approximately half of survey takers indicated that their LTC home had experienced an outbreak during the First Wave. We know from Provincial data that approximately 34% of all homes in Ontario experienced an outbreak in the First Wave. It is likely that ONA members who had worked through an outbreak were motivated to share their stories and therefore more likely to complete the survey.

When the data is segmented by home type, we see that 11.6% more respondents who said they had experienced an outbreak in their home worked at a for-profit home.

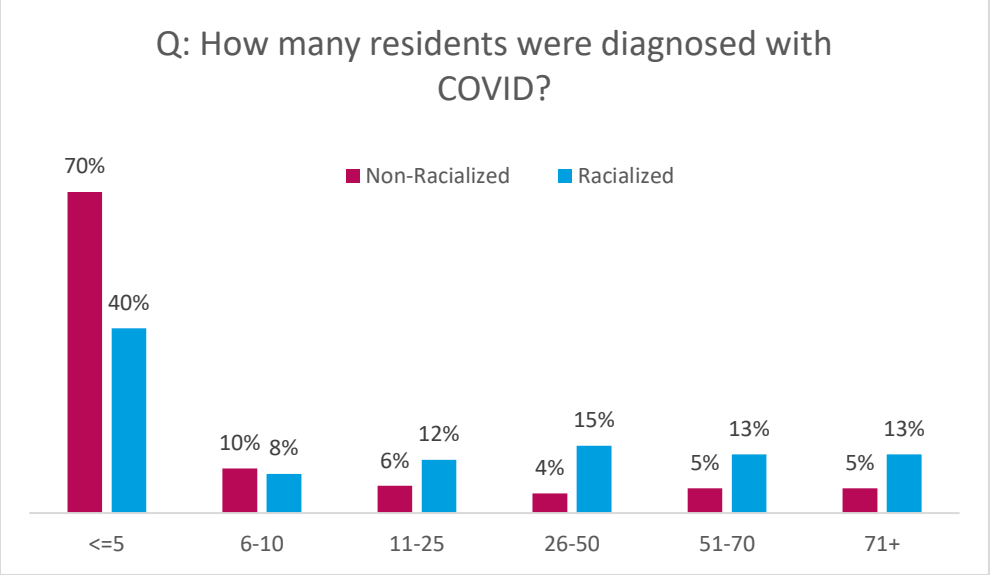
We also see that a significantly higher number (22.95%) of respondents who worked in a home with an outbreak identified as racialized.

With respect to the size of the outbreak, the segmented data shows that not-for profit homes were more likely to have smaller outbreaks, and for-profit homes were more likely to have larger outbreaks. In fact, the margins increase as the size of the outbreak increases: of outbreaks with 51-70 residents infected, 7.4% percent more are in for-profit homes, and of outbreaks where more than 70 residents were infected, 9.9% more are in for profit homes. Survey respondents who identified as racialized were also more likely to work in homes with larger outbreaks.





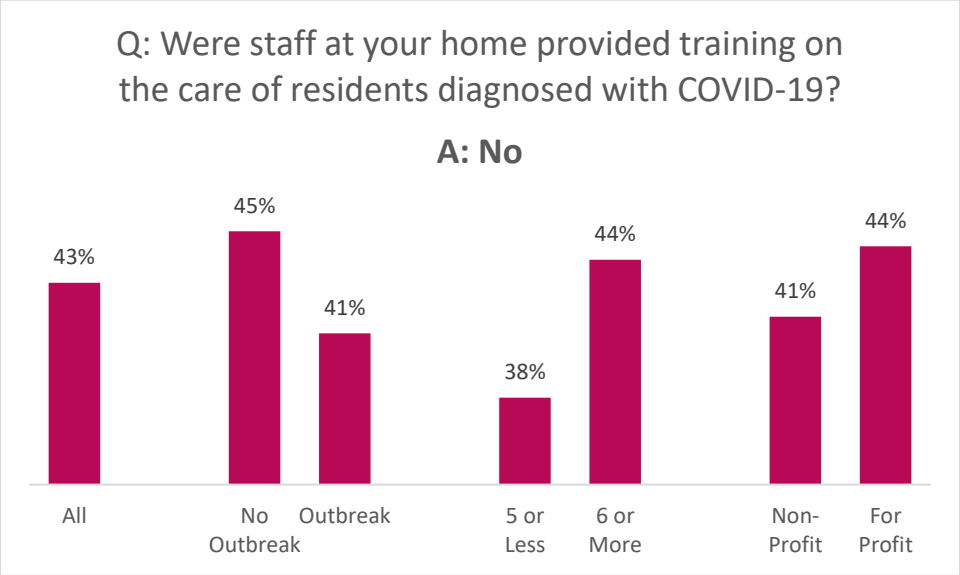
Respondents who identified as racialized were not only more likely to work in a home with an outbreak, they were also more likely to work in a home with a larger outbreak.



2. Training on care of positive residents

We asked respondents if they had been provided training on the care of residents diagnosed with COVID-19; 43% had not. The deaths in long-term care homes to date account for 70% of COVID-19 deaths in Ontario. Those that need to provide treatment must have the knowledge to identify the presentations and progressions of the illness in the geriatric population.

When data is broken down by outbreak size, homes with small outbreaks were more likely to provide training and education on caring for residents than homes with medium and large outbreaks.


Q: Were staff at your home provided training on the care of residents diagnosed with COVID-19?
A: No
43%
45%
41%
38%
44%
41%
44%
All
No Outbreak
Outbreak
5 or Less
6 or More
Non-Profit
For Profit

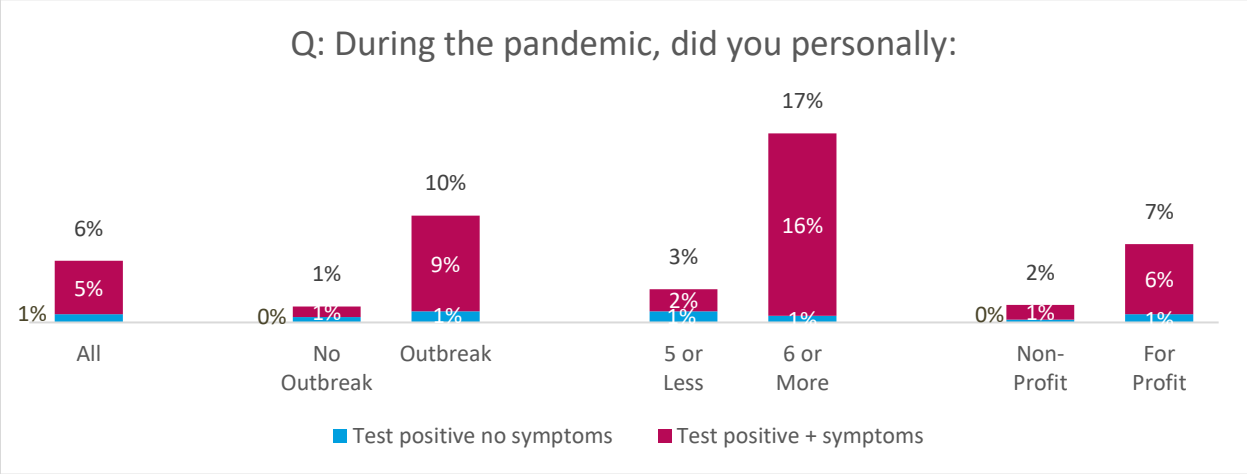
Section 3, Part B: Employee Experiences with COVID-19

This section asks respondents about whether they had personally contracted COVID-19 during the first wave. Respondents who answered yes were asked a series of follow-up questions about the severity of their illness, and about their experiences with return to work after their illness, as well as any investigations made by their employer or public health as to the potential source of their infection.

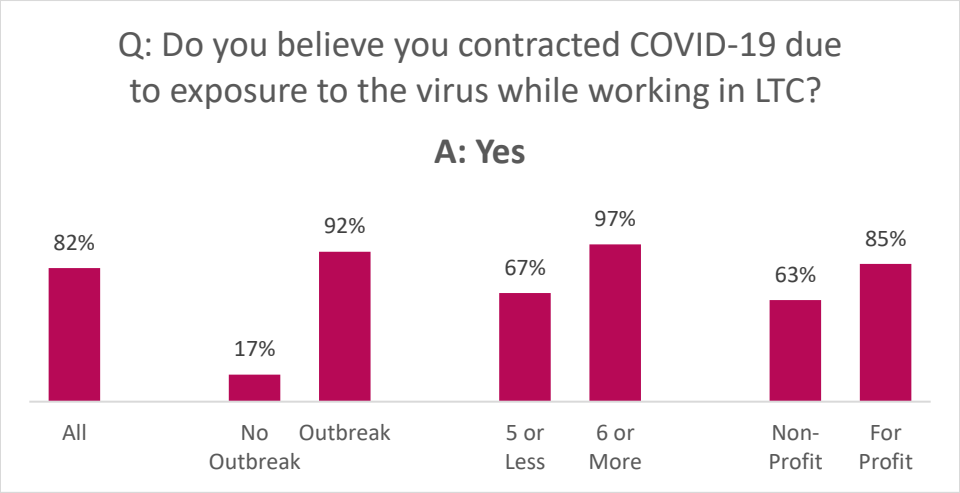
All survey respondents were able to complete this section.

1. COVID-19 infections

The majority of survey respondents neither tested positive for COVID-19 nor showed symptoms consistent with the disease. Respondents from homes with outbreaks in the first wave were more likely to test positive or show symptoms, and the percentages increase along with the size of the outbreak. Respondents in not-for-profit homes were less likely to contract COVID-19 or show symptoms than those in the for-profit sector. Members who identified as racialized were more likely to respond that they had tested positive or showed symptoms of the disease.

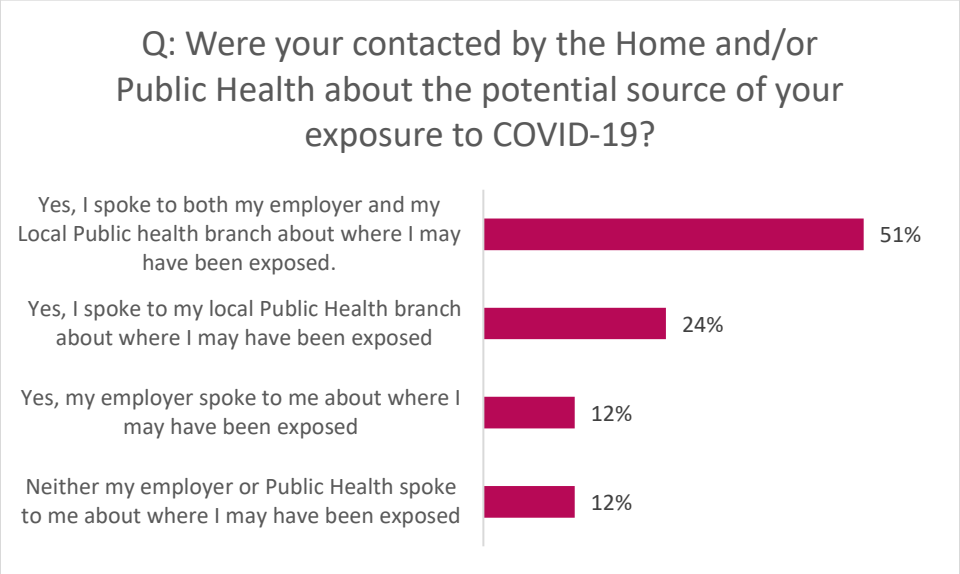


Of the respondents who tested positive, 82% responded that they believed they had been exposed to the virus while working in LTC. The percentage who believe they contracted the virus in their workplace was higher for those working in for-profit homes, and higher in homes with outbreaks.



2. Investigation and contact tracing

Of those who tested positive, the majority of respondents who contracted COVID-19 were contacted by both their employer and public about where they may have been exposed, a significant number (24.5%) were only contacted by public health, and 12.2% responded that neither their employer nor public health contacted them.



3. Medical attention

The majority of respondents who contracted COVID-19 did not require medical attention or received medical attention but were able to self-care at home. Three respondents were admitted to hospital, with two requiring care in an ICU. 17.4% of respondents had not recovered and returned to work at the time they responded to the survey, and 26.3% responded that they were still experiencing residual symptoms.

Q: What medical treatment did you receive for COVID-19?

Answer	Count	%
I did not require any medical attention.	20	43%
I received medical attention from my family doctor (or other health care practitioner) but was able to self-care at home.	21	46%
I required hospitalization.	1	2%
I required admittance to ICU.	2	4%
Prefer not to answer.	2	4%
Total	46	100%

Q: Have you recovered and returned to work?

Answer	Count	%
Yes	38	83%
No	8	17%
Total	46	100%

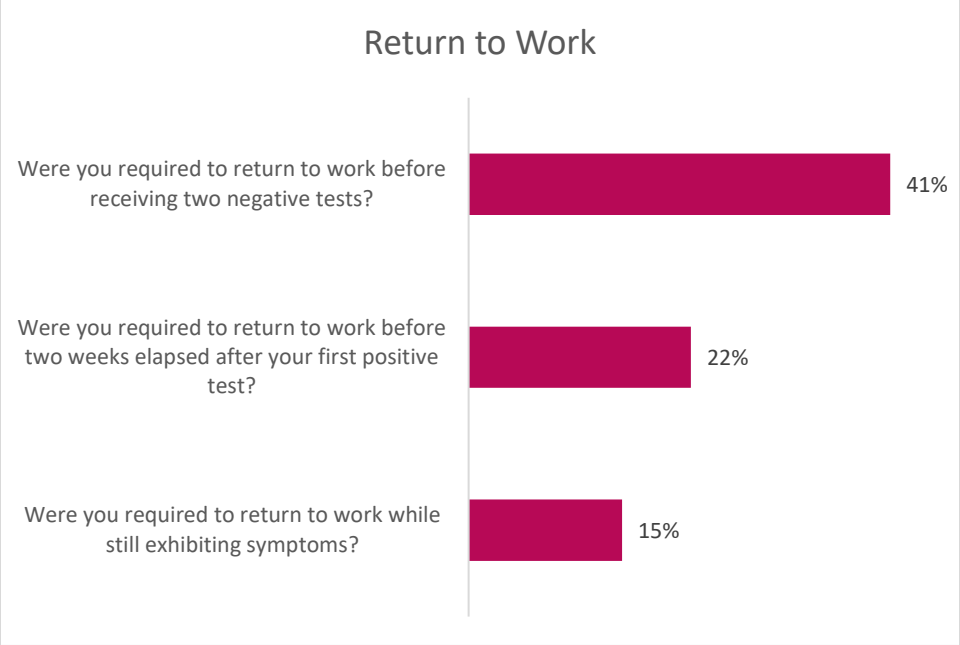
Q: Do you still experience any residual symptoms that you associate with contracting COVID-19?

Answer	Count	%
Yes	25	26%
No	70	74%
Total	95	100%

4. Return to Work

Significant numbers of respondents were required to return to work while they may have still been infectious: 14.9% responded they were required to return to work while still exhibiting symptoms; 41.1% were required to return to work before receiving two negative tests; and 21.7% were required to return to work before two weeks had elapsed since their first positive test.

The highest proportion of respondents that reported a COVID-19 infection worked at a home that experienced a medium/large of COVID-19. This is consistent with results that a larger proportion of respondents who worked in a home medium/large outbreak were reporting that they caught COVID-19 while at work. Findings also show that a higher proportion of workers that work in for-profit homes or are racialized reported being diagnosed with COVID-19.



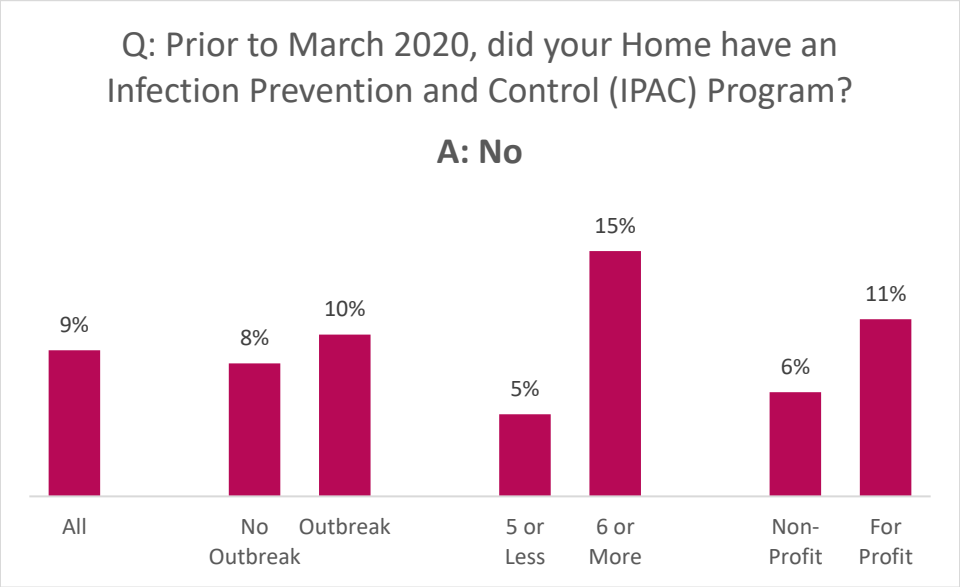
Section 4: IPAC and Health and Safety in LTC Homes Prior to the Pandemic

In this section, members were asked a series of questions about Infection Prevention and Control (IPAC) policies, procedures and training, as well as about fit-testing for N95 respirators.

Only members who normally work in LTC were able to complete this section.

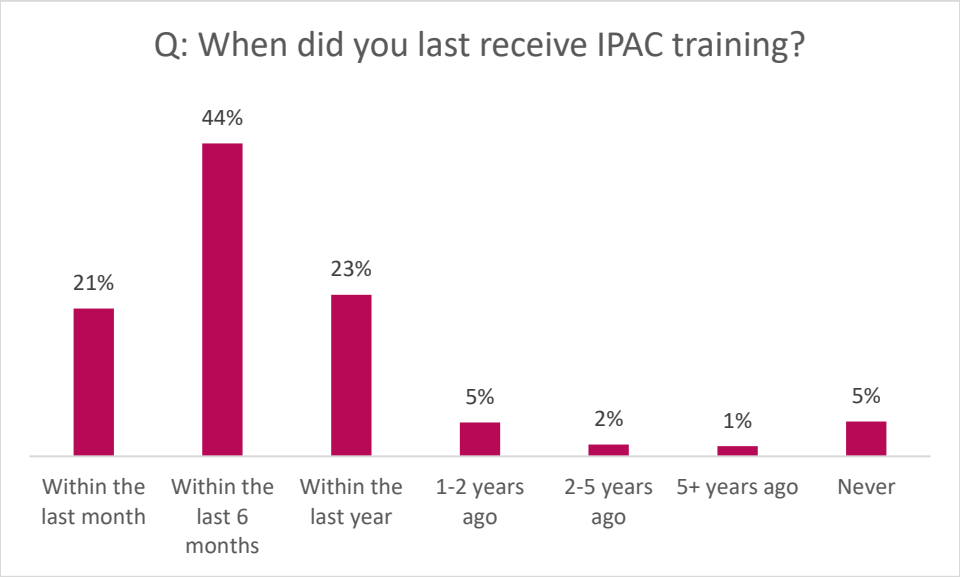
While the majority of homes did have an IPAC program prior to the pandemic, homes that experienced no outbreak and small outbreaks were more likely to have programs than homes with medium and large outbreaks.

1. IPAC programs and training

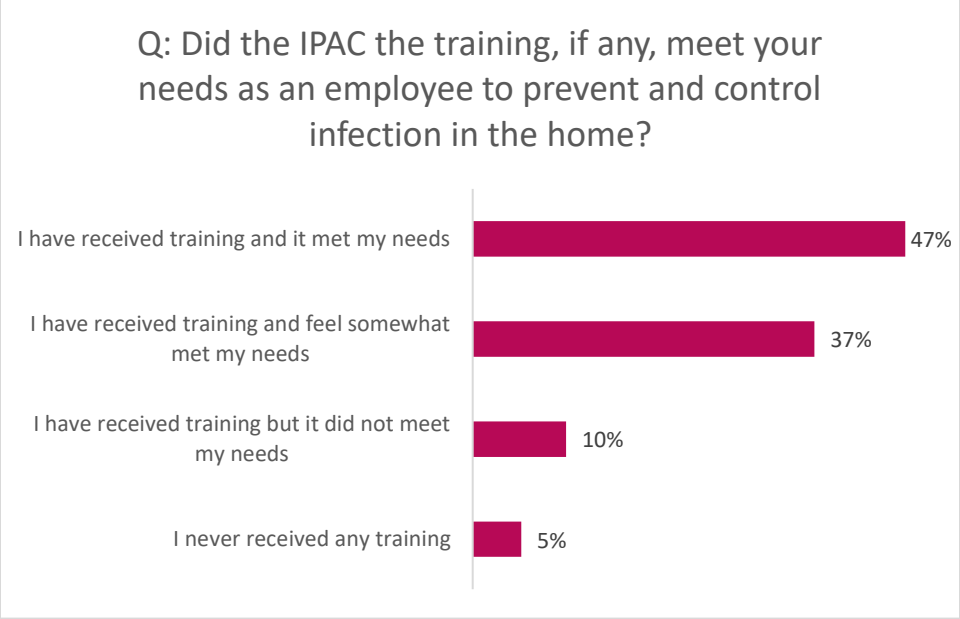


For most respondents, the training they had received had been either e-learning (33.2%) or they were provided a policy to review (29.6%). Only 21.3% said they had received in-person training, including practicing donning and doffing PPE, and 8.3% saying they had received in-person training without practice. 5.2% said they had received no training.

Survey results show that a significant number of respondents had not received IPAC training since the pandemic began. The majority of respondents did receive IPAC training in the past six months (43.9%), with 20.7% saying they had been last been trained in August/September. Shockingly, 22.7% responded that their last training had been within the last year rather than within six months or within the last month, meaning no updated IPAC training was provided since the pandemic began. Also concerning is that 7.9% selected either 1-2 years, 2-5 years or 5 plus years, and 4.9% responded that they had never received IPAC training.

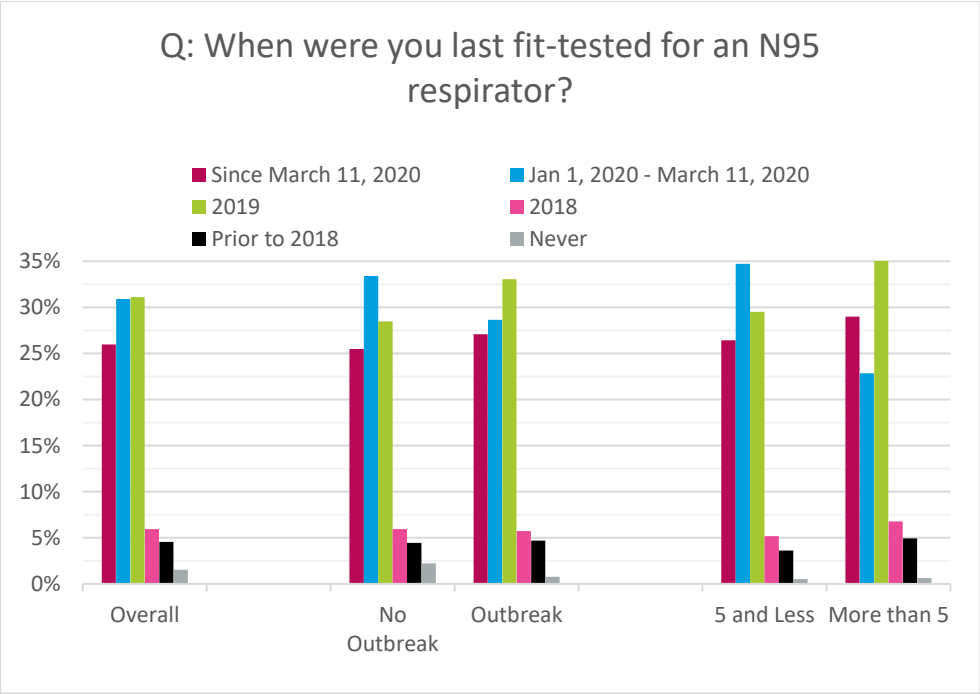


Less than half (47%) of respondents answered that the training they had received met their needs, with 37% saying the training somewhat met their needs and 10% saying the training did not meet their needs.



2. Fit-Testing for N95s

We asked respondents when they were last fit-tested for an N95 respirator. It is interesting that there appears to be a correlation between the timing of fit-testing and whether the home experienced an outbreak. Homes with no outbreaks and with small outbreaks were the most likely to fit-test in early 2020, when COVID-19 was a known threat but had not yet been declared a pandemic.



Section 5: Health and Safety Measures

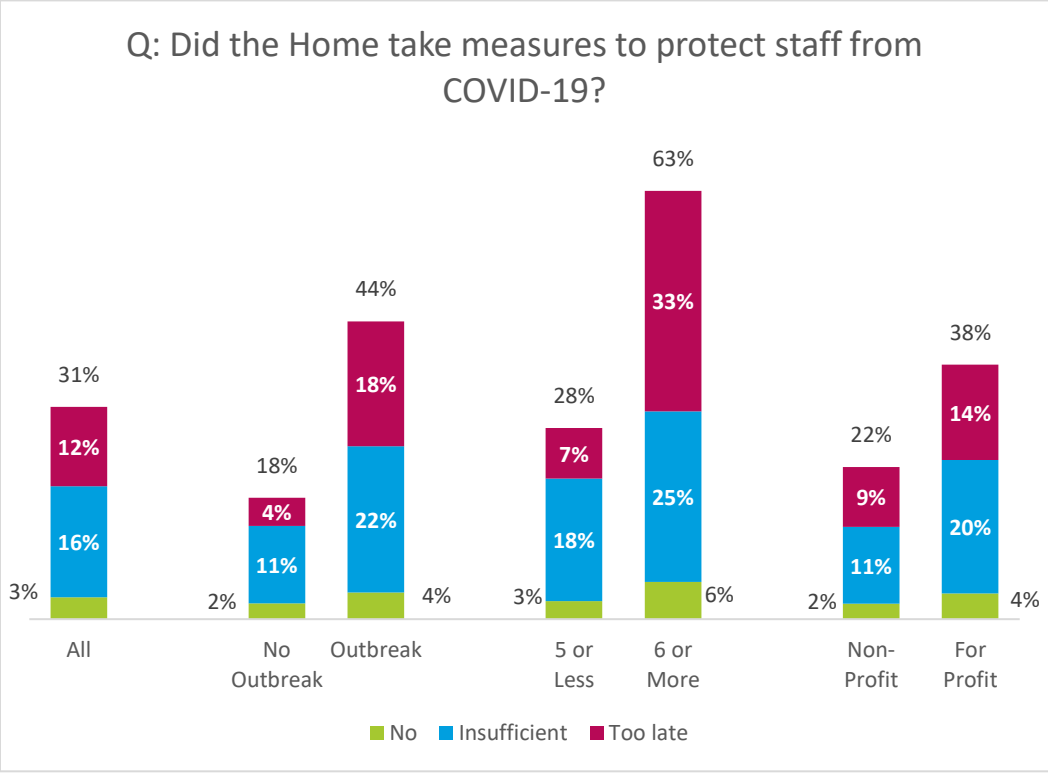
In this section, we asked respondents a series of questions about health and safety measures during the first wave of the pandemic, and whether respondents felt those measures were adequate.

All survey respondents were able to answer this section.

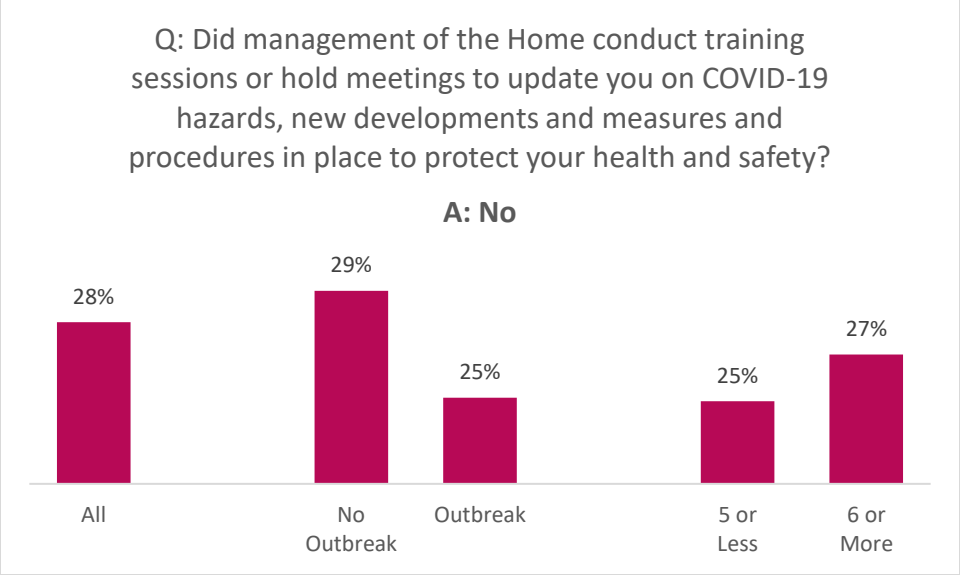
1. Health and safety measures to protect staff

While the majority of respondents (65.4%) felt their home had done either a good or adequate job of implementing measures to protect staff, over one-third indicated that their home had not implemented sufficient measures, implemented measures too late, or implemented no measures at all. Respondents from not-for-profit homes were much more likely (11.6%) to say their home had done a good job, and respondents from for-profit homes were more likely to say that their home had implemented insufficient measures (8.3%) or implemented measures too late (5.3%). Perhaps it is not surprising that in homes where there was no outbreak in the first wave, respondents were much more likely to characterize measures as "good" or "adequate." Respondents who identified as racialized were significantly less likely (12.05%) to characterize measures as good, which is consistent with the data showing that racialized members were more likely to work in a home with an outbreak.

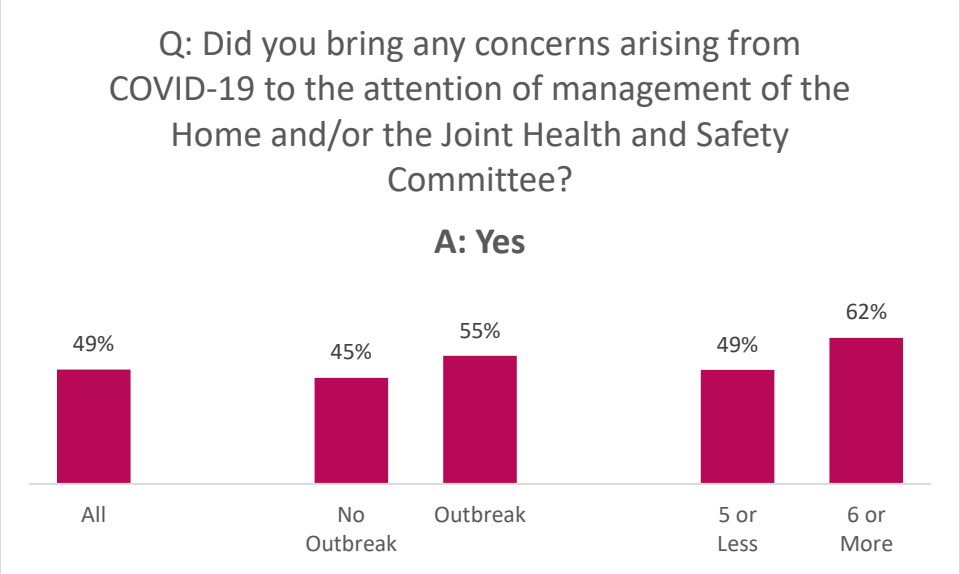
A significant number of respondents (442/865, or 49%) responded that they had raised concerns about COVID-19 with their management or the Joint Health and Safety Committee (JHSC) at their home.



Homes that did not experience outbreaks, and those that experienced small outbreaks, were more likely to conduct training sessions and meetings to update staff about COVID-19.



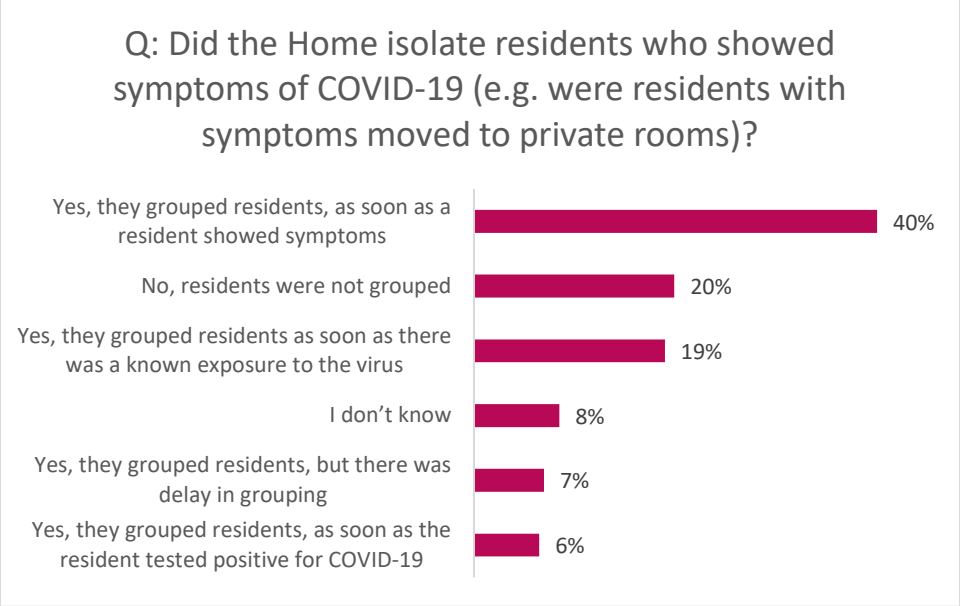
Respondents in homes with outbreaks, and particularly in those with medium and large outbreaks, were more likely to have concerns about COVID-19 that they raised with management or the JHSC.

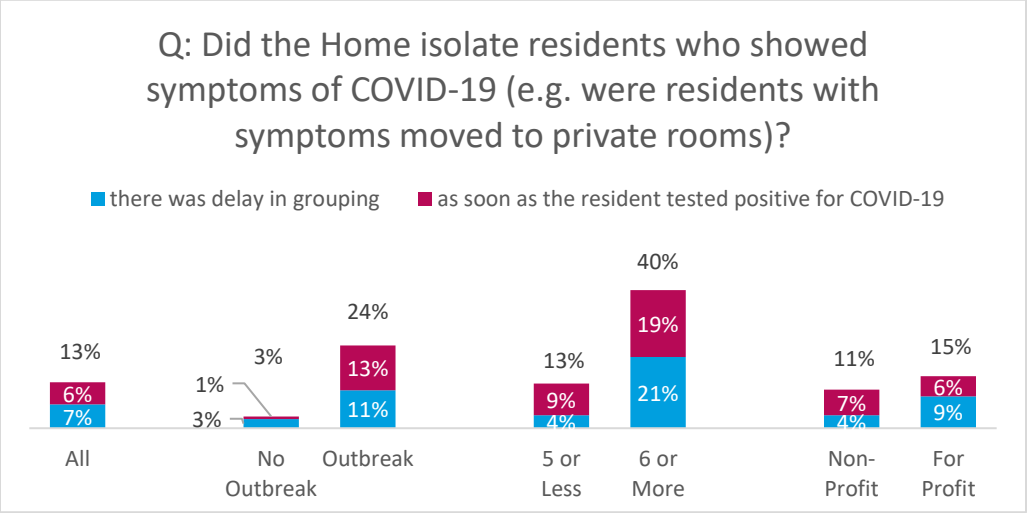


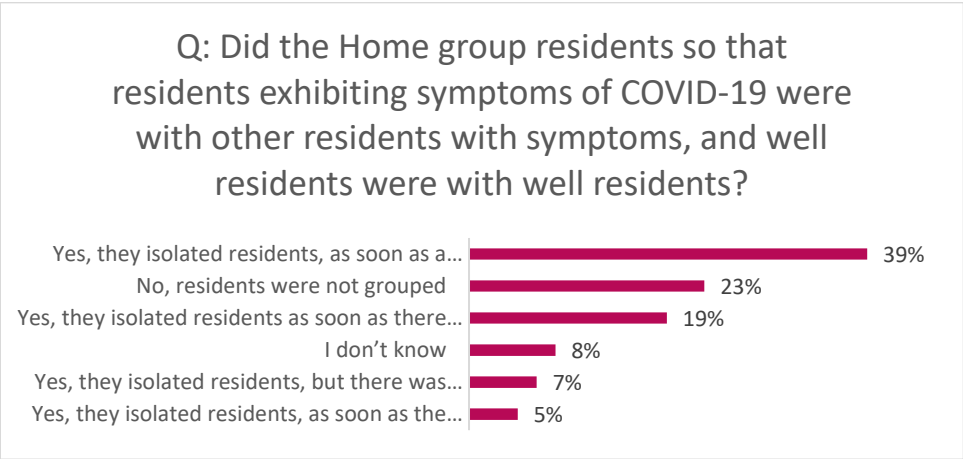
2. IPAC measures

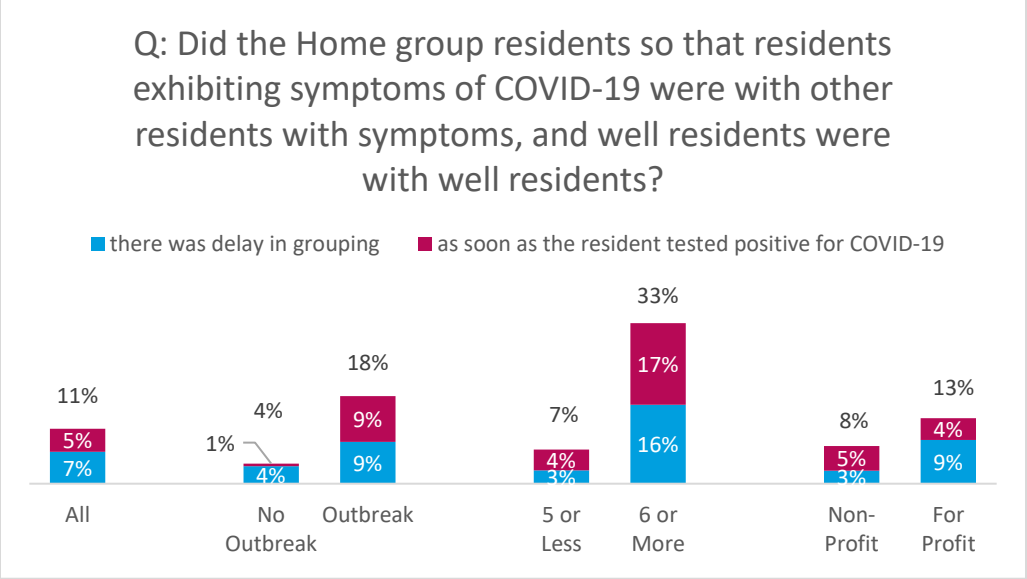
Isolating suspected/positive residents, cohorting residents positive for COVID-19, and cohorting the staff who care for those residents, are important IPAC measures. When respondents were asked about these measures, alarmingly high percentages responded these measures were not done, or were done too late. When the data is segmented by size of outbreak, homes with small outbreaks were more likely to isolate and cohort quickly (following exposure or symptoms) than homes with medium and large outbreaks. [4]

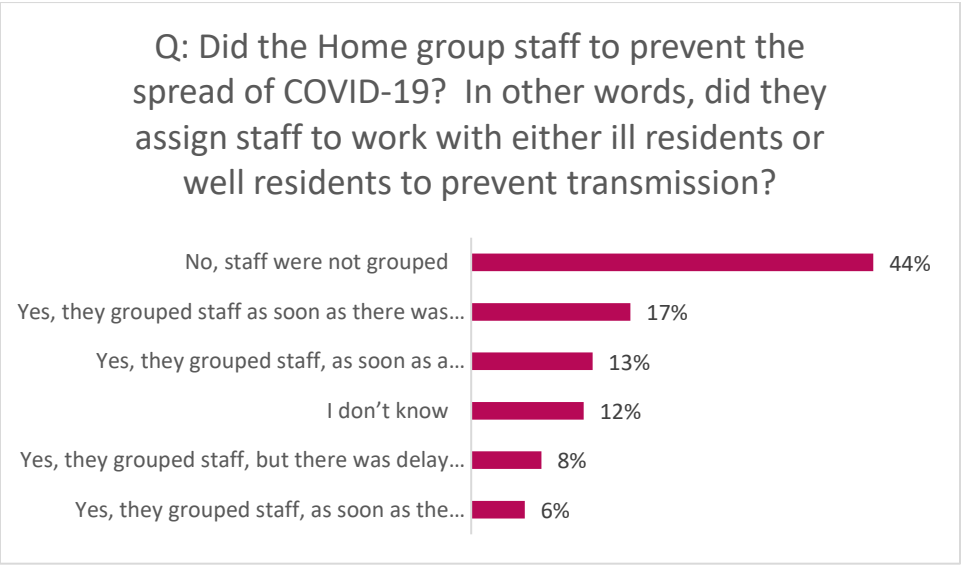
[4] For this questions on isolating and cohorting residents, an unfortunate typographical error appeared on the survey. While the question asks about isolation, the answers refer to grouping. The following question asks about grouping and the answers refer to isolation. As the responses show similar trends, we are reasonably confident the questions still provide information about the measures homes took to isolate and group symptomatic residents.

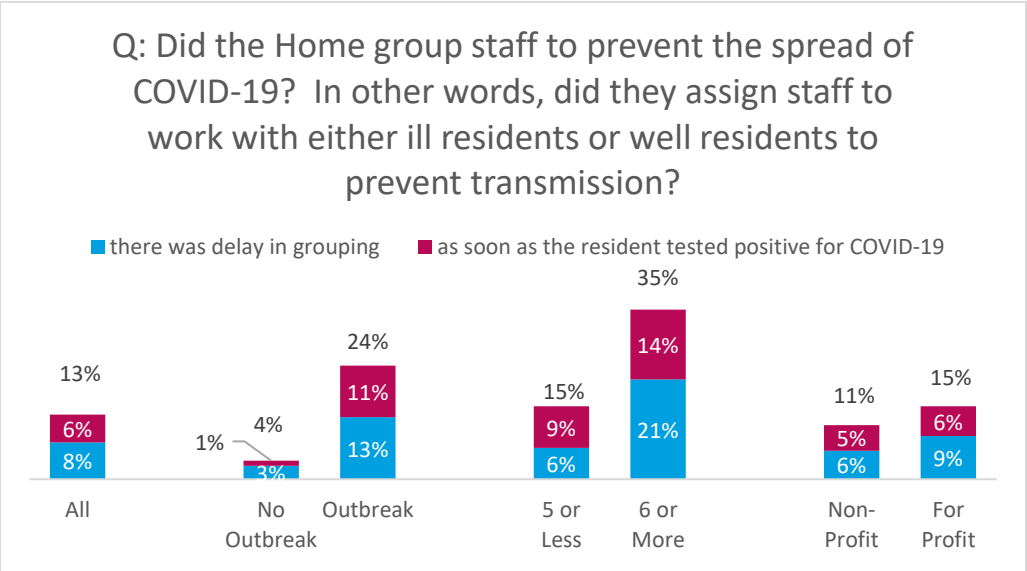

Q: Did the Home isolate residents who showed symptoms of COVID-19 (e.g. were residents with symptoms moved to private rooms)?
Yes, they grouped residents, as soon as a resident showed symptoms
40%
No, residents were not grouped
20%
Yes, they grouped residents as soon as there was a known exposure to the virus
19%
I don't know
8%
Yes, they grouped residents, but there was delay in grouping
7%
Yes, they grouped residents, as soon as the resident tested positive for COVID-19
6%


Q: Did the Home isolate residents who showed symptoms of COVID-19 (e.g. were residents with symptoms moved to private rooms)?
there was delay in grouping
as soon as the resident tested positive for COVID-19
13%
6%
7%
All
3%
1%
3%
No Outbreak
24%
13%
11%
Outbreak
13%
9%
4%
5 or Less
40%
19%
21%
6 or More
11%
7%
4%
Non-Profit
15%
6%
9%
For Profit

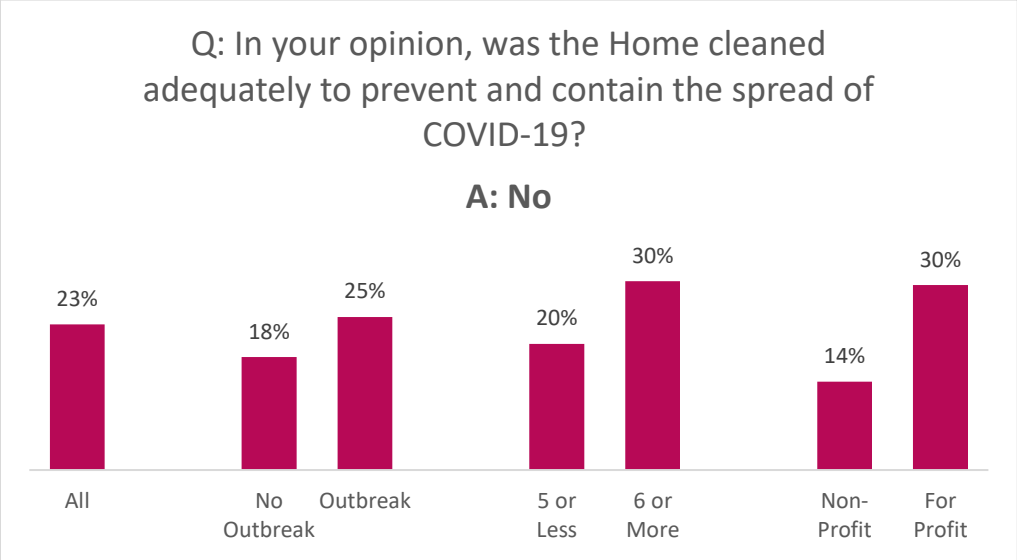

Q: Did the Home group residents so that residents exhibiting symptoms of COVID-19 were with other residents with symptoms, and well residents were with well residents?
Yes, they isolated residents, as soon as a...
39%
No, residents were not grouped
23%
Yes, they isolated residents as soon as there...
19%
I don't know
8%
Yes, they isolated residents, but there was...
7%
Yes, they isolated residents, as soon as the...
5%


Q: Did the Home group residents so that residents exhibiting symptoms of COVID-19 were with other residents with symptoms, and well residents were with well residents?
there was delay in grouping
as soon as the resident tested positive for COVID-19
11%
5%
7%
4%
1%
4%
18%
9%
9%
7%
4%
3%
33%
17%
16%
8%
5%
3%
13%
4%
9%
All
No Outbreak
Outbreak
5 or Less
6 or More
Non-Profit
For Profit


Q: Did the Home group staff to prevent the spread of COVID-19? In other words, did they assign staff to work with either ill residents or well residents to prevent transmission?
No, staff were not grouped
44%
Yes, they grouped staff as soon as there was...
17%
Yes, they grouped staff, as soon as a...
13%
I don't know
12%
Yes, they grouped staff, but there was delay...
8%
Yes, they grouped staff, as soon as the...
6%

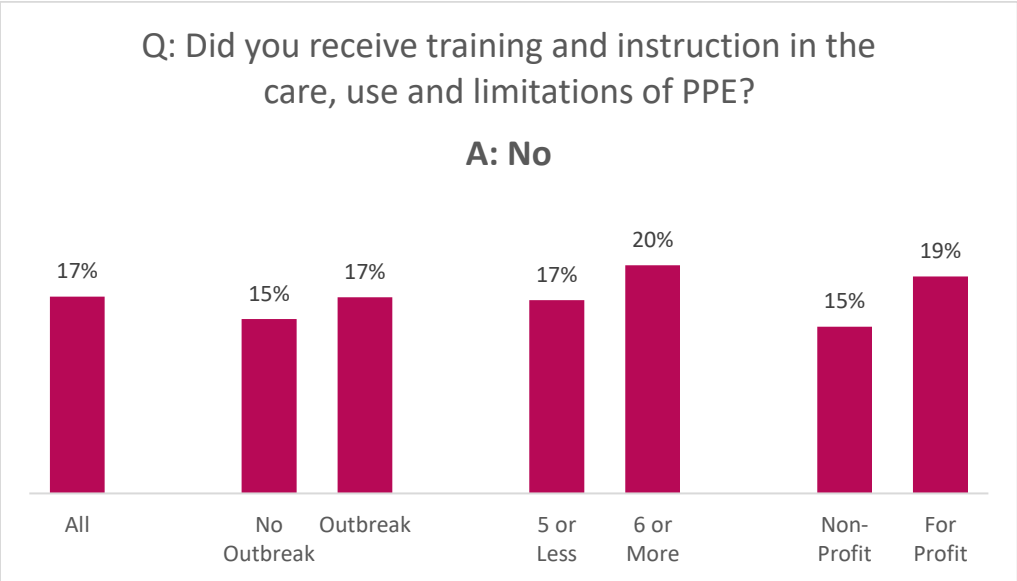

Q: Did the Home group staff to prevent the spread of COVID-19? In other words, did they assign staff to work with either ill residents or well residents to prevent transmission?
there was delay in grouping
as soon as the resident tested positive for COVID-19
13%
6%
8%
1%
4%
3%
24%
11%
13%
15%
9%
6%
35%
14%
21%
11%
5%
6%
15%
6%
9%
All
No Outbreak
Outbreak
5 or Less
6 or More
Non-Profit
For Profit

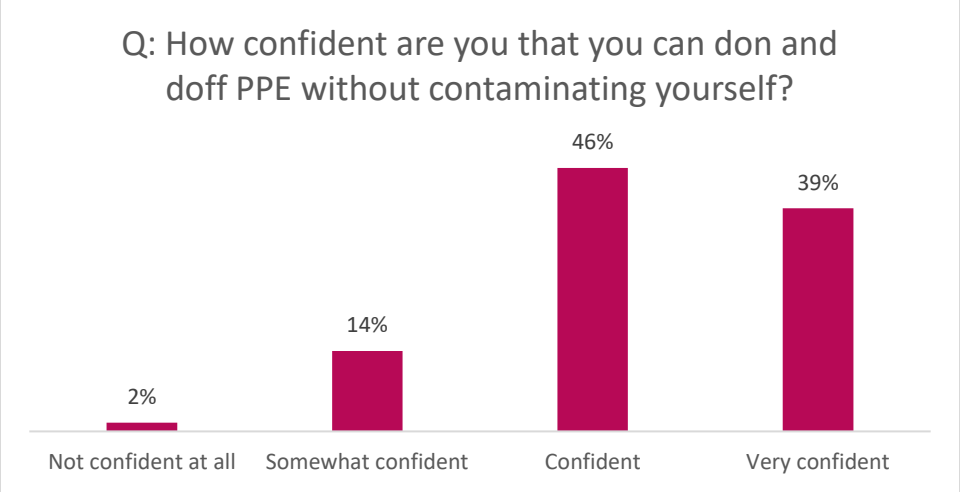
Overall, two thirds of respondents said their homes were cleaned adequately to prevent and contain the spread of COVID-19. However, significant discrepancies were noted in the answers of respondents in for-profit and not-for-profit homes, with 15.5% more respondents from for-profit homes saying their homes were not cleaned adequately.



Most respondents (79% overall) had received training and instruction in the care, use and limitation of PPE, and most were confident that they could don and doff PPE without contaminating themselves. Respondents in homes with small outbreaks were more likely to say they had training than homes with medium and large outbreaks.

The following question illustrates that most respondents felt confident or very confident that they could safely don and doff PPE. A substantial majority of the ONA members who responded to the survey are RNs who would have education and experience with PPE use. We can hypothesize that the correlation the answers show between training on PPE and size of outbreak may be because other classifications of workers in LTC, such as PSWs and cleaners, do not typically have education in PPE use, unless their employer provides it.



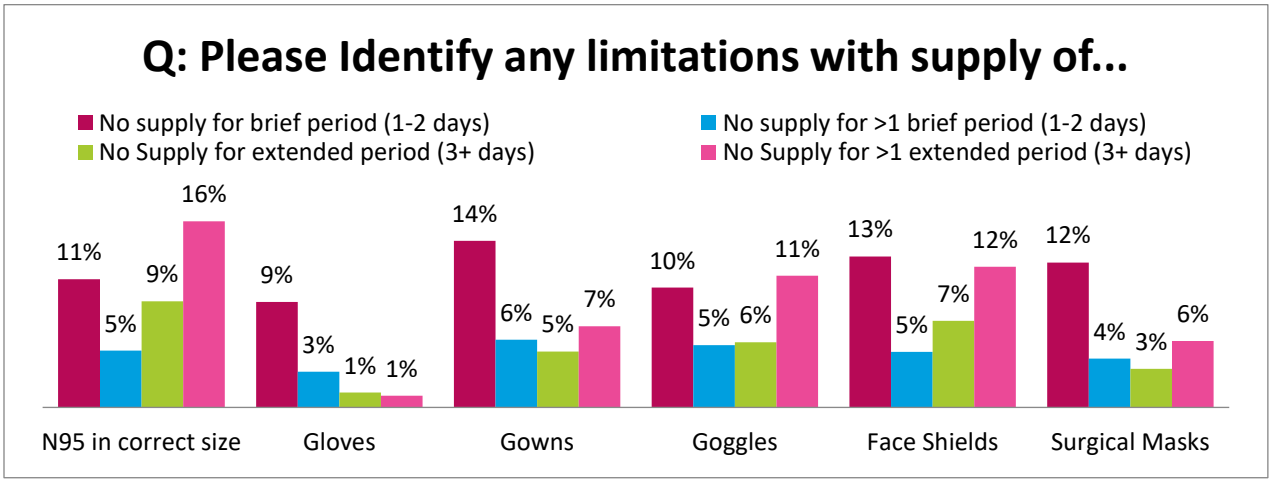


3. Supply and access to PPE

We asked the respondents a number of questions about the adequacy of PPE supply and any limitation on access.

When we look at the segmented data for homes that experienced an outbreak of COVID-19 during the first wave, the majority of respondents selected “no supply issue at any time” for each type of PPE, however, the percentage of respondents who indicated that their home experienced shortages are still significant. The worst shortages pertained to N95 respirators, with 49% of respondents selecting no supply for at least a brief time. While the percentages of respondents experiencing shortages of other types of PPE were lower, the results are still alarming:

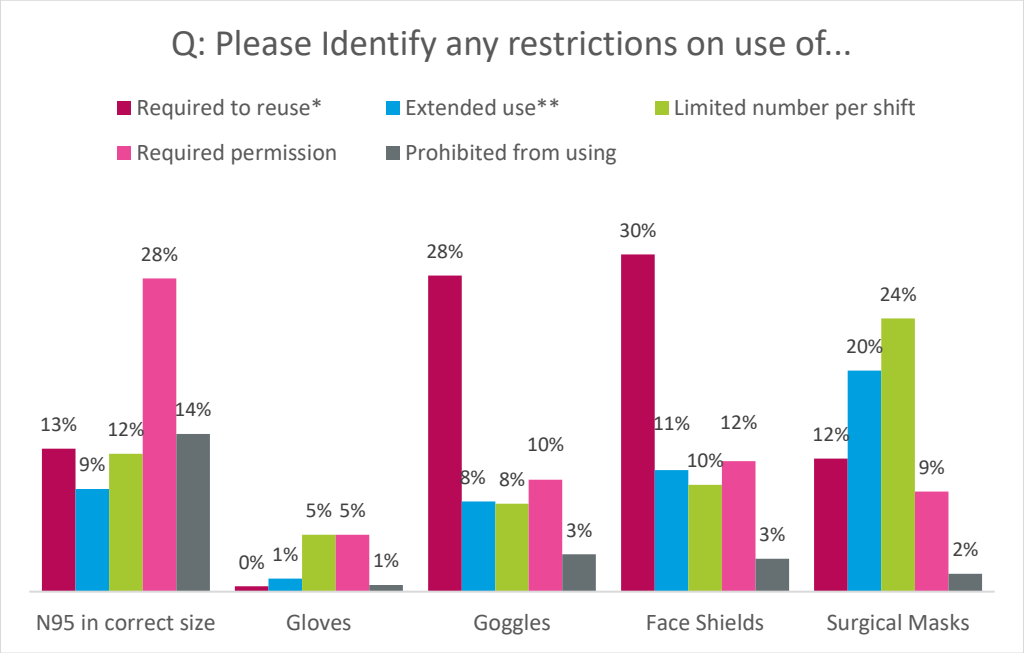
- 17.5% report no supply of gloves for a brief time or longer
- 35.6% report no supply of gowns for a brief time or longer
- 35.3% report no supply of goggles for a brief time or longer
- 39.3% report no supply of face shields for a brief time or longer
- 28.9% report no supply of surgical masks for a brief time or longer



For-profit homes were more likely to have supply issues for each type of PPE. There is also a correlation with supply issues and size of outbreak, with homes with medium and large outbreaks having more issues with supply.

No Supply For At Least 1 Extended Period (3+ days)	Overall	Outbreak Status		Outbreak Size		Home Type	
		No Outbreak	Outbreak	5 or Less	More than 5	Non-Profit	For Profit
Count	766	436	434	204	174	415	585
	%	%	%	%	%	%	%
N95 in correct size	25	18	31	21	43	20	28
Gloves	2	1	3	1	4	2	2
Gowns	12	12	11	7	16	10	13
Goggles	17	15	16	7	27	15	18
Face Shields	19	19	22	15	30	18	20
Surgical Masks	9	7	11	10	11	10	9

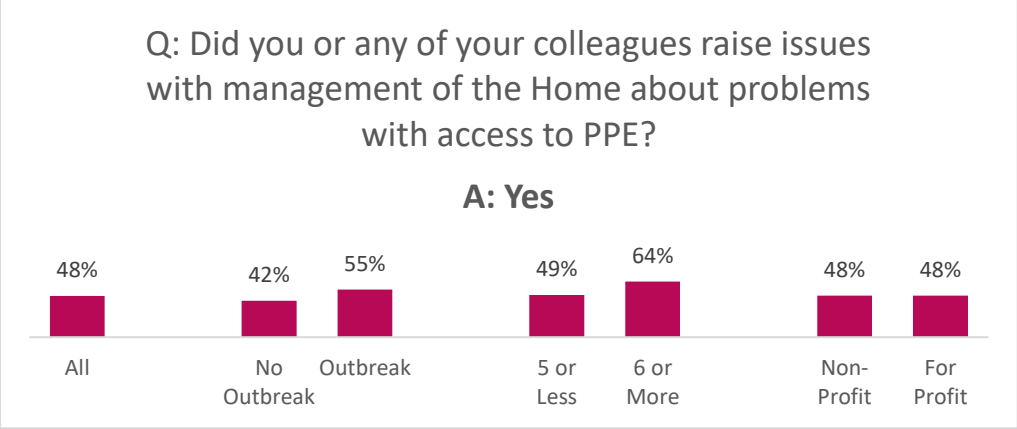
Respondents were asked similar questions about limitations to their access to PPE. N95 respirators were the type of PPE for which most respondents indicated limitations on access. Even for PPE required under the CMOH's Directive to use droplet and contact precautions, respondents in homes that experienced an outbreak report limitation on use. They report having to ask permission to use PPE or being required to reuse or extend the use of such items as gloves and surgical masks, which are intended as single-use items.



* Reuse was defined in the survey as being required to save PPE after doffing, and don again for future use

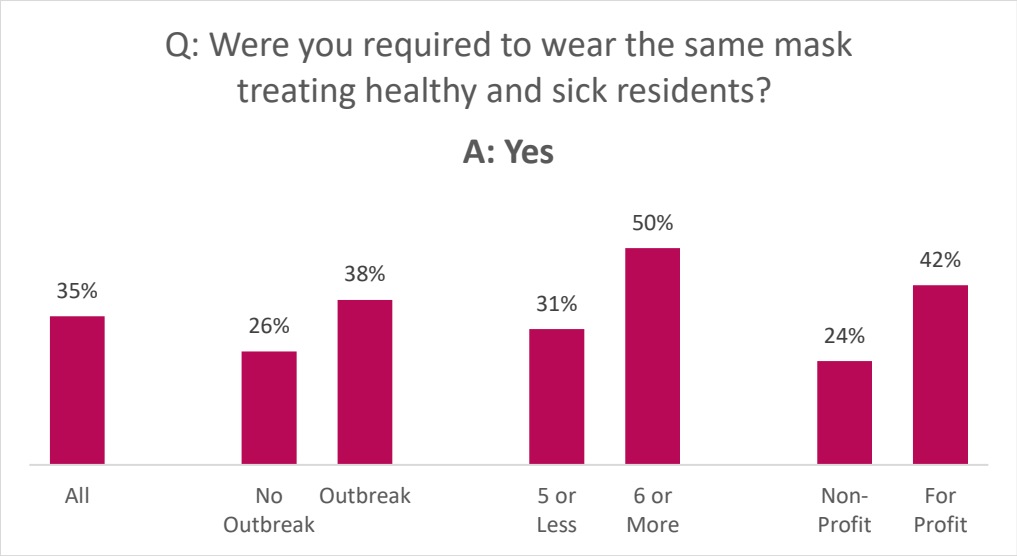
**Extended was defined in the survey to mean being required to wear PPE for longer than normal use, but not required to doff and re-don the PPE

47.8% of respondents indicated that they or their colleagues raised concerns with management of the home about problems with access to PPE, with this number rising to 55.3% in homes that experienced an outbreak in the first wave.



Note: "I don't know" was also an option, which has not been included on the chart, so the totals do not add up to 100%

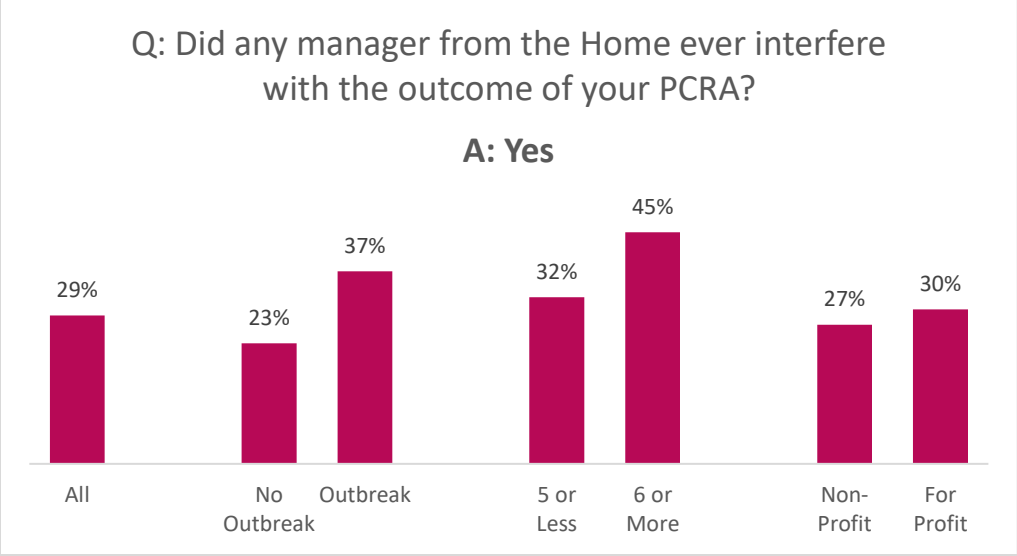
In homes with an outbreak, a significant number of respondents were required to wear the same mask while treating sick and healthy residents. This is inconsistent with basic IPAC practices. These statistics are consistent with the findings, with survey results showing insufficient IPAC training and limits to use of surgical masks and N95 respirators. Where staff were not cohorted to a particular unit of the home, failing to change masks between healthy and sick residents can present as a significant source of spread throughout a home.



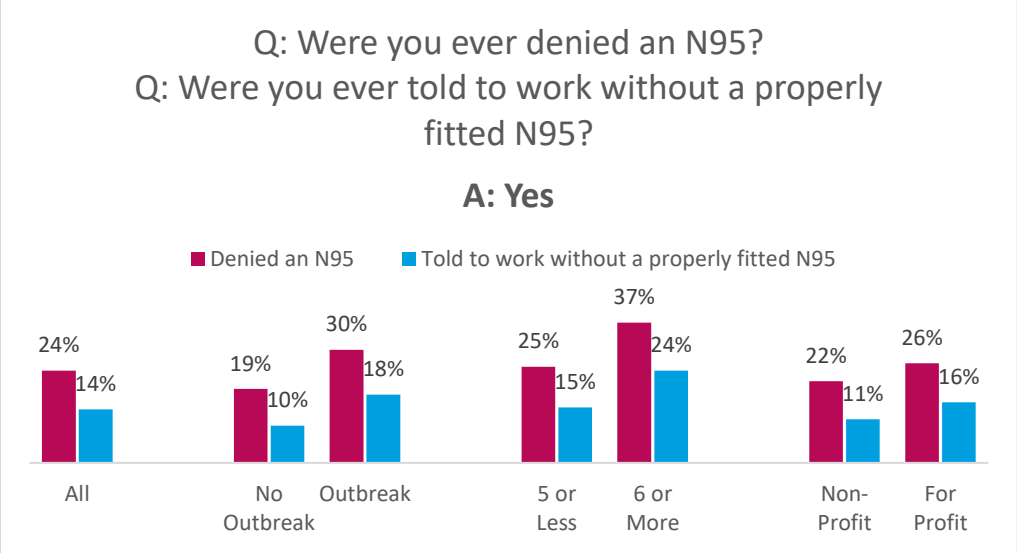
4. N95 respirators

In March, the CMOH issued Directive 5, which ordered employers to provide PPE to nurses based on a point-of-care risk assessment (PCRA). The purpose of the PCRA is for nurses to apply their own clinical judgment to determine what level of PPE is necessary to protect themselves. A significant number of respondents indicated that a manager from their home had interfered with the outcome of their PCRA.

The percentage was higher in homes with outbreaks during the first wave. This is extremely concerning given that nurses' clinical judgment with respect to appropriate PPE was being ignored in homes that were unable to contain the spread of COVID-19.



Nearly a quarter (24.3%) of all respondents report that they were denied an N95, with the percentage increasing homes that had outbreaks, with the most denials reported in homes that had medium and large outbreaks.

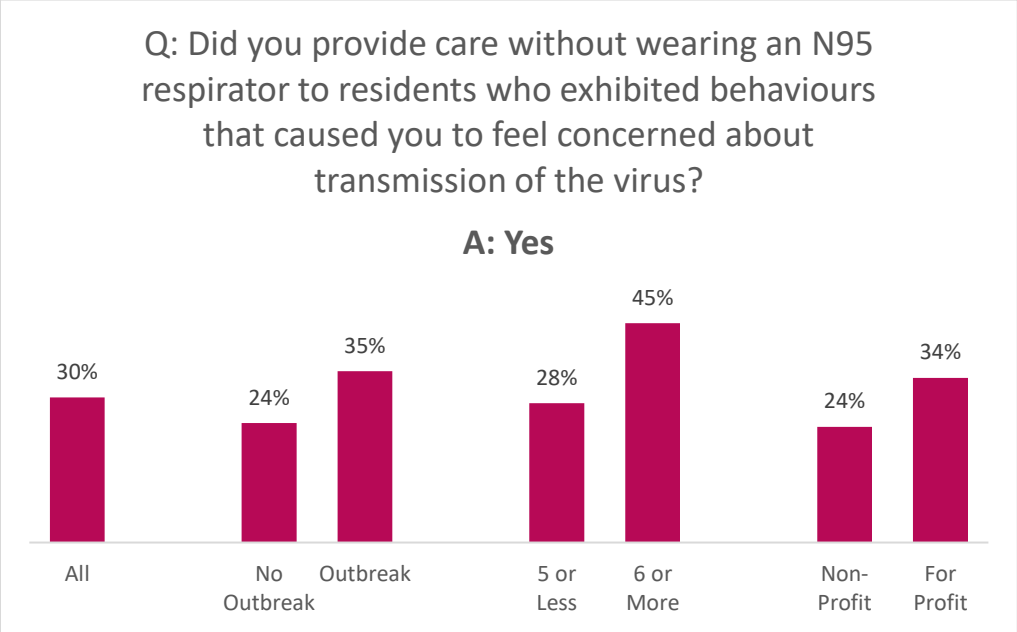


Under Directive 5, health-care workers must wear N95s when performing aerosol generating medical procedures (AGMPs). The survey data showed 22.6% of all respondents, and 26.7% of respondents who worked in a home that had experienced an outbreak, reported performing AGMPs.

The supply shortages and restrictions on use of N95s reported by respondents merits further investigation, given the extent to which nurses report performing AGMPs in LTC.

Answer	Count	%
Intubation and related procedures (e.g., manual ventilation, open endotracheal suctioning)	5	2%
Cardio-pulmonary resuscitation during airway management	16	7%
Bronchoscopy	2	1%
Sputum induction	7	3%
Non-invasive ventilation (i.e., BiPAP)	39	17%
Open respiratory/airway suctioning	56	25%
High frequency oscillatory ventilation	2	1%
Tracheostomy care	3	1%
Nebulized therapy/aerosolized medication administration	59	26%
High flow heated oxygen therapy devices (e.g., ARVO, optiflow)	10	4%
Autopsy	0	0%
Other (Please Specify)	28	12%
Total	227	100%

Since the first wave, mounting scientific evidence confirms ONA's concerns from the beginning of the pandemic that COVID-19 is aerosolized. ONA has supported members seeking to access N95 respirators when they determine it is necessary in their professional judgement, including where a person is engaging in "aerosol generating *behaviours,*" such as coughing, sneezing or shouting. When respondents were asked whether they provided care without an N95 to residents exhibiting such symptoms, almost one-third of all respondents reported "yes," with the number increasing in homes with outbreaks during the first wave.



A significant number of respondents indicated that managers from their homes told them things which discouraged PPE use.

Answer	Count	%
The cost of PPE was an issue	141	20%
Supply of PPE was an issue	412	57%
Your use of PPE was wasteful	80	11%
Use of PPE would scare residents and/or family members	85	12%
Total	718	100%

Overall, the segmented data on homes with large outbreaks provides significant insight into how COVID-19 spreads. The results show that during the first wave:

- Homes with large outbreaks were less likely to receive training on the care of residents diagnosed with COVID-19;
- Homes with medium/large outbreaks were less likely to provide training on PPE care, use and limitations;
- Respondents who experienced a medium/large outbreak were less likely to bring concerns arising from COVID-19 to management and/or JHSC;
- Respondents from homes with medium/large outbreaks were much more likely to report that colleagues had raised issues with management about access to PPE;
- Respondents from homes with medium/large outbreaks were more likely to be denied an N95;
- Respondents working in a home with an outbreak were more likely to provide care to residents that were coughing, sneezing and spitting, without an N95.
- Almost 20% of respondents stated that the home expressed that the cost of PPE was an issue; and
- A larger percentage of respondents who have experienced medium/large outbreaks expressed dissatisfaction with the home's measures to protect staff from COVID-19.

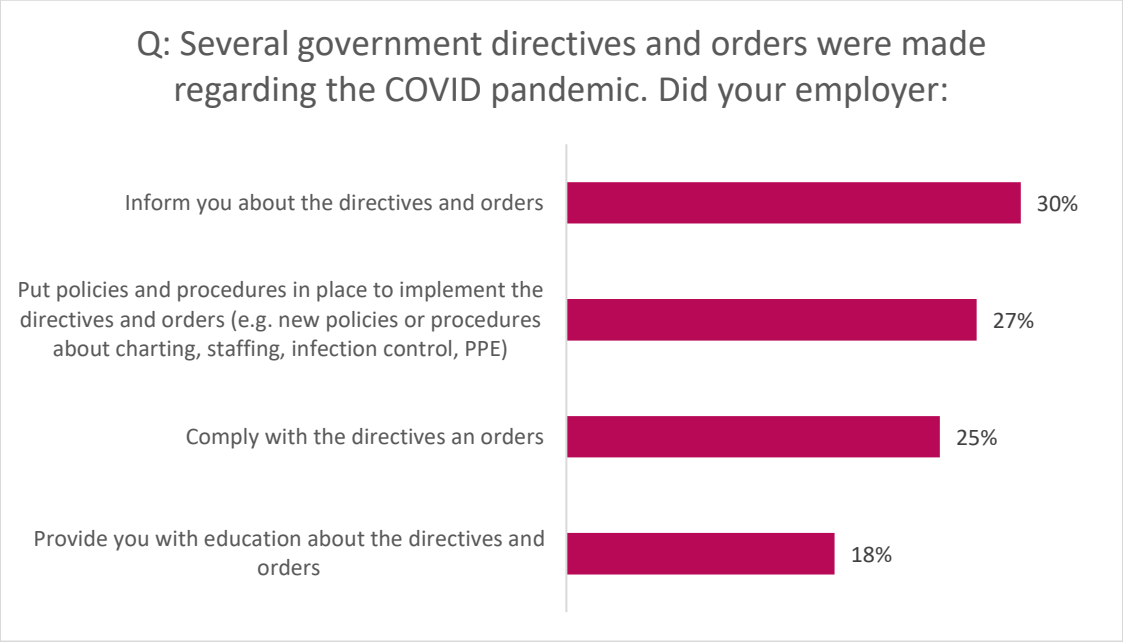
Generally, these findings offer evidence that medium/large outbreaks are associated with poor IPAC and PPE practices in long-term care.

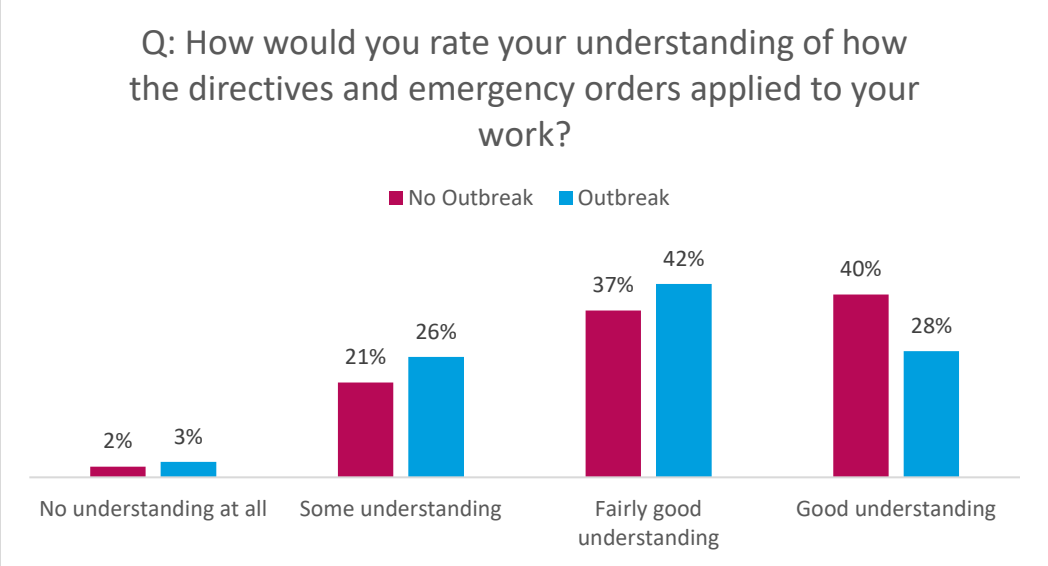
Section 6: Government Directives and Emergency Orders

In this section, we asked questions about the extent to which Government Directives and Emergency Orders were communicated to staff in LTC homes, and the extent to which the homes complied with these orders. We also asked about the respondents' understanding of the Directives and Orders, and their opinions on their effectiveness.

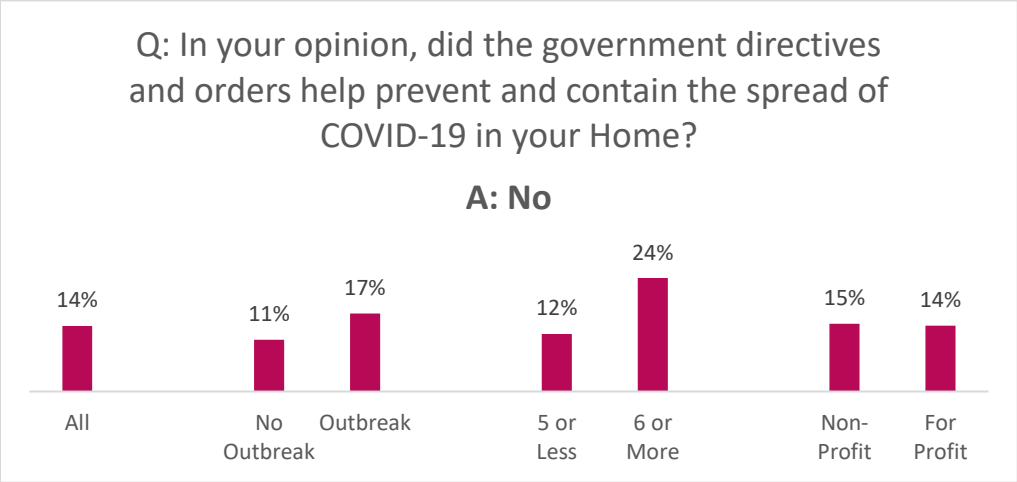
Only members who normally work in LTC were able to complete this section.

The responses show limited information, education and compliance with the Orders and Directives. Only 34% of respondents indicated a good understanding of how the Directives and Orders applied to their work. In homes that experienced an outbreak during the first wave, respondents were actually less likely to rate their understanding as "good" than in homes with no outbreak. Respondents in not-for-profit homes were also 8.4% more likely to rate their understanding as good than respondents working in for-profit homes.

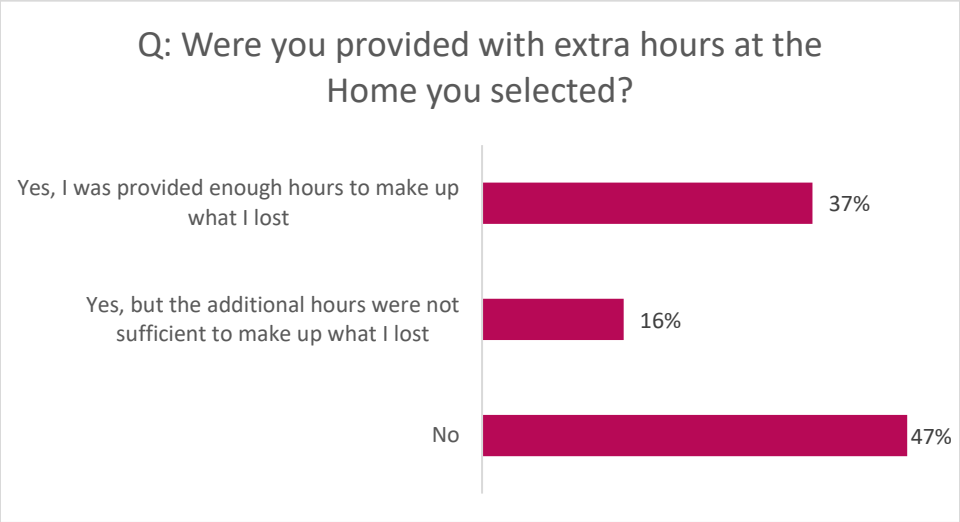




There appears to be a strong correlation between the experience of working in a home that had an outbreak in the first wave, and the respondent's opinions about the effectiveness of Government Directives and Orders. Overall, 68.5% of respondents felt the Directives and Orders were effective in preventing and containing the spread of COVID-19. In homes that experienced an outbreak, the percentage drops to 63%. In homes that experienced an outbreak affecting five or more residents, the percentage drops to 51.2%.



For respondents who normally work at more than one facility, the largest number of respondents (47.4%) indicated they were not provided with the opportunity to work extra hours at the home they selected. This is a surprising result, given the documentation of staffing shortages during the pandemic. In homes that experienced an outbreak, there was little change in this result (47.1% said they were not provided extra hours), and in homes with large outbreaks (six or more residents), the result response was 50%.



Respondents who worked in an outbreak were more likely to express dissatisfaction with government directives to prevent outbreaks. At the same time, those who worked in an outbreak also reported they were less likely to have a good understanding of the government directives.

These statistics are consistent with the survey data identifying significant delays in training staff on IPAC procedures and policies.

Section 7: Staffing During the Pandemic

Only members who normally work in LTC were able to complete this section.

In this section respondents were asked question about staffing in their home during the pandemic. Respondents were asked to answer these questions base on the period from mid-March 2020 to the time they completed the survey.

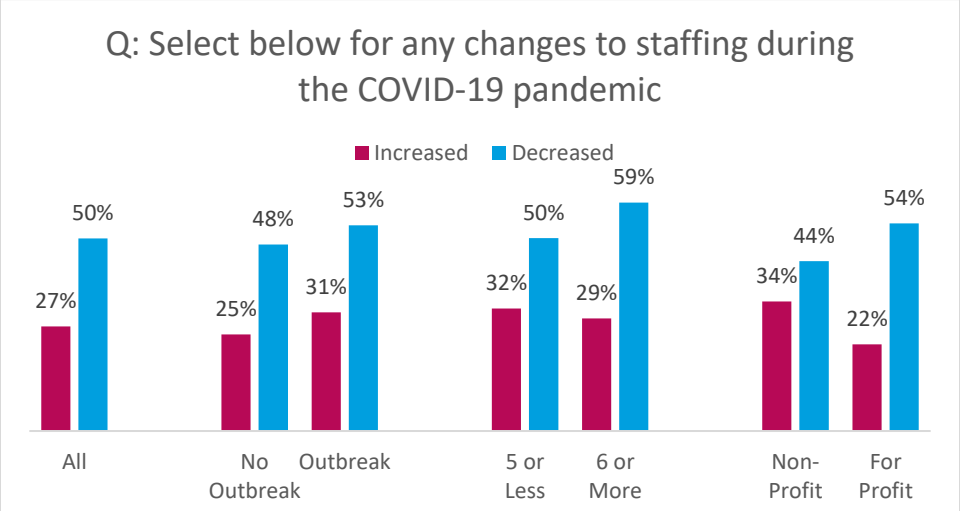
Our questions pertained to the regular staff in the home, as well as the presence or absence of personnel from external organizations (coroners, the military, hospital).

The survey data supports the anecdotal evidence that during the first wave, staffing levels in LTC reached crisis levels. While staffing levels decreased the most in the homes with large outbreaks, staffing levels decreased among all front-line health-care workers. Not-for-profit homes were the least likely group from the segmented data to experience a staffing shortage, with approximately a third of respondents in this category answering that staffing levels increased.

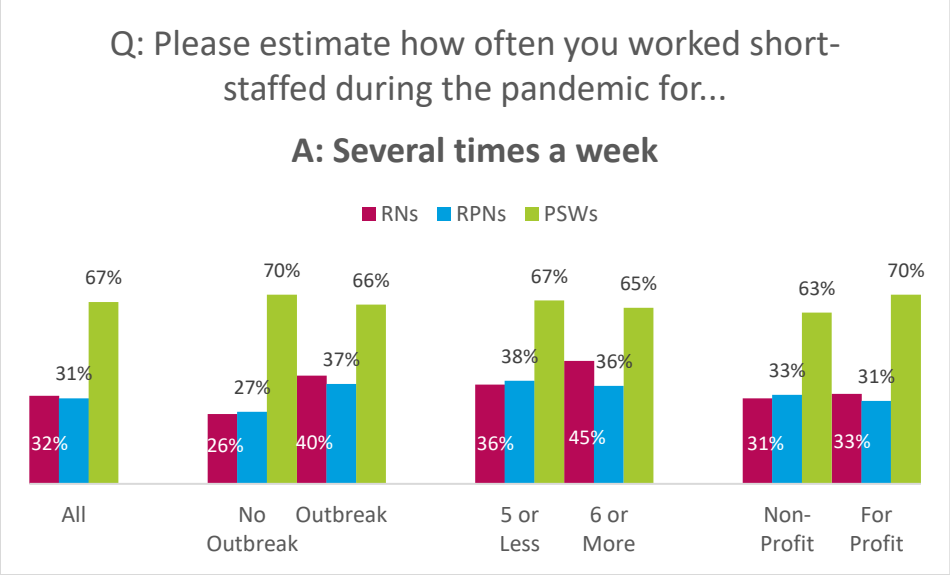
A number of survey respondents worked in homes where the military, hospitals and other organizations assisted, with more of these external personnel present in homes with large outbreaks.

1. Staffing shortages involving regular staff of the home

When asked whether staffing increased, decreased or stayed the same during the pandemic, 49.9% of respondents overall said staffing decreased. When the segmented data is considered, 9.8% more respondents in for-profit homes said staffing decreased, compared to not-for-profit; 5% more respondents in homes with an outbreak said staffing decreased, compared to homes with no outbreak; and 9.2% respondents from homes with a large outbreak said staffing decreased, compared to homes with a small outbreak.

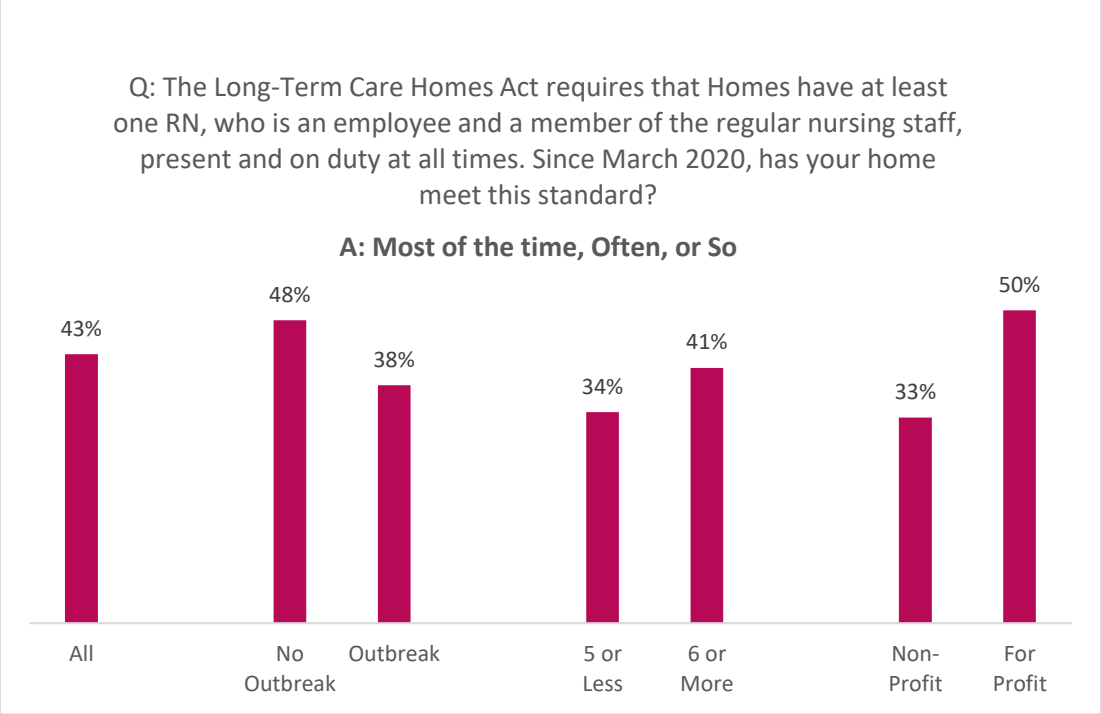


A similar trend is seen when we examine the responses to questions about working short for RNs, RPNs and PSWs. For each type of staff, “often-several times a week” was the most selected option from the overall responses. In the segmented data, the percentage of respondents who selected that they worked short “often” is higher in for-profit homes v. not-for-profit, in homes with outbreaks v. homes with no outbreak, and in homes with large outbreaks v. small outbreaks.



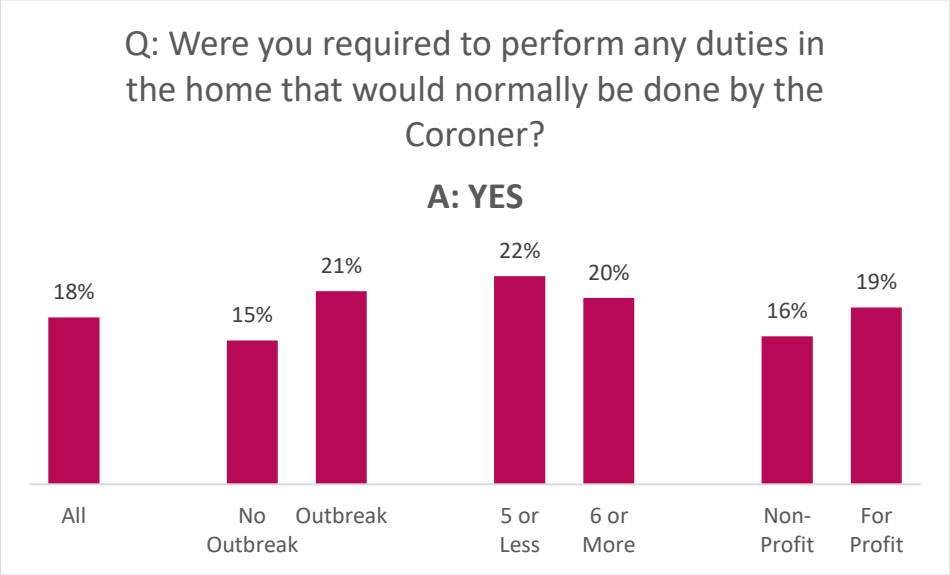
Respondents were asked about the requirement under the *Long-Term Care Homes Act* that an RN who is an employee of the home and a member of the regular staff be present and on duty at all times. Although Order 95/20 under the *Emergency Management Act* relieved LTC homes from this legislative requirement during the state of emergency, we felt it was worth asking about the standard, given the important role of the RN in LTC. 42.98% of all respondents indicated that their home was not meeting this standard all of the time, with 23.64% indicating that the standard was not met more than once a month, and 11.46% indicating the standard was not met four or more times per month.

Homes that experienced an outbreak in the first wave actually performed better than homes that did not, with 62% of respondents from homes with an outbreak answering that their home always met the standard during the pandemic. For-profit homes were significantly less likely to meet the standard, with only 50% of respondents from for-profit homes answering that their home always met the standard during the pandemic, versus 67.1% from non-for-profit homes.



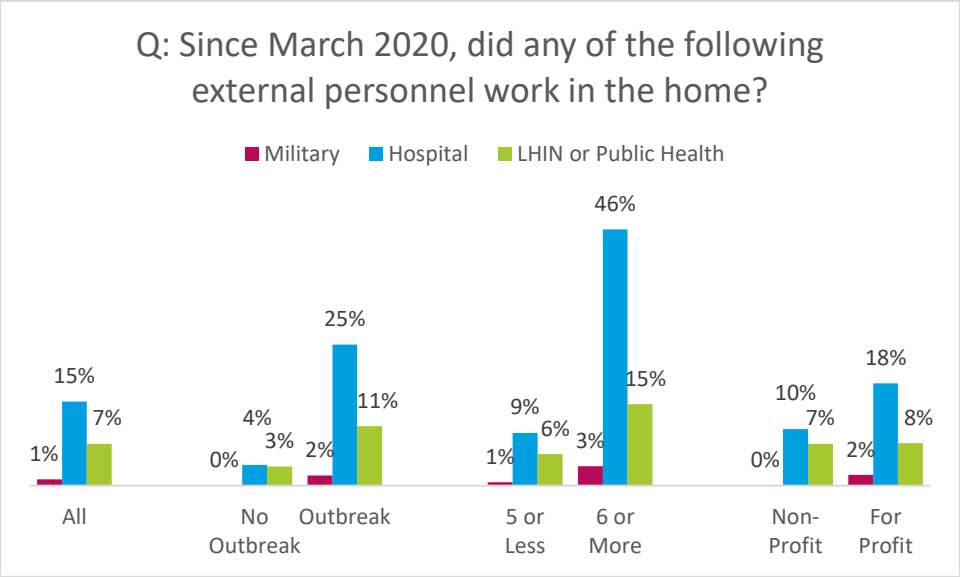
2. Staff from external organizations

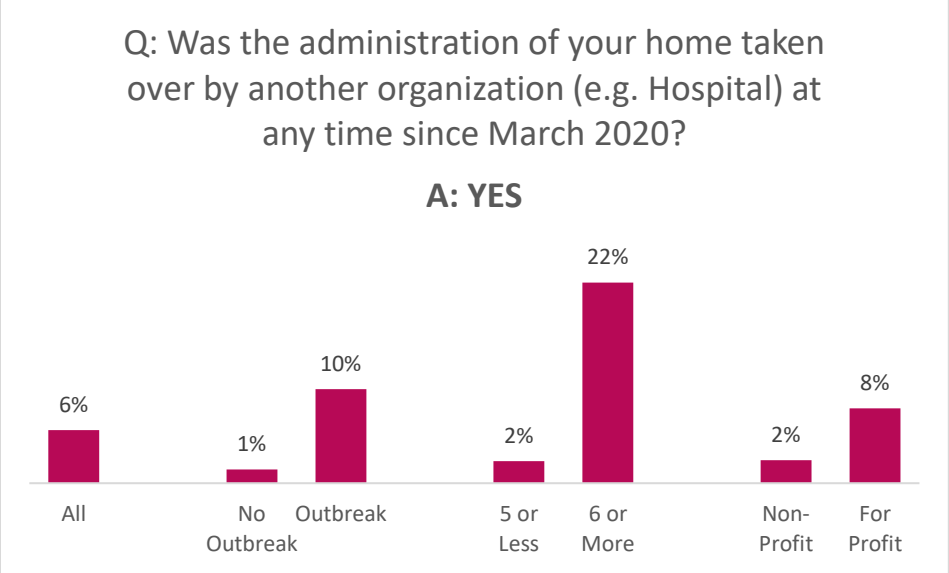
During the first wave, 17.9% of all respondents said they were required to perform duties normally performed by the coroner. This increased to 20.7% in homes with an outbreak, although there were no significant differences between the responses from homes with a large versus small outbreak.



Respondents from for-profit homes were more likely than not-for-profit homes to have had personnel from the military, hospital or health-care organizations assisting in their homes. This evidence is consistent with the widely-publicized data that for-profit homes experienced more outbreaks, more severe outbreaks, and higher resident mortality rates. For-profit homes were

much more likely to be among those where the administration of the home was taken over by another organization.





Overall, COVID-19 has had a negative impact on staffing levels in the long-term care sector. During the pandemic, respondents reported they were often working short RNs, RPNs, and PSWs.

Respondents reported that for-profit homes were less likely to have one RN staff on duty in the home 24/7 and more likely than not-for-profit to have other care providers (hospital personnel and military) to enter the home for support.

Section 8: Redeployment to LTC homes

ONA sent links to the survey to approximately 300 ONA members who were deployed to assist in LTC homes from other health-care employers (mainly hospitals, LHINs and public health) during the first wave. Only these respondents were asked the questions in Section 8, which are specific to their experience with the redeployment. Approximately 60 respondents answered the questions in this section.

Most of these respondents volunteered for the redeployment, however, some were reassigned or chosen through some other means.

Q: How were you selected to be redeployed to LTC?

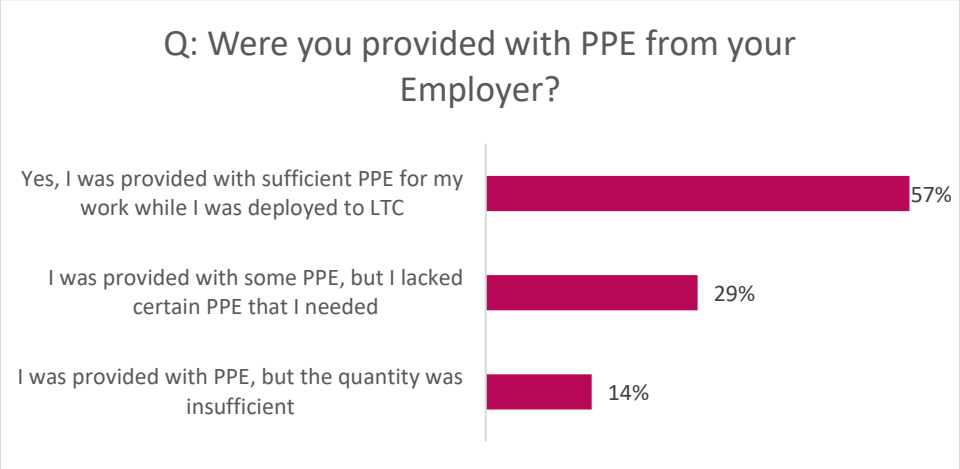
Answer	Count	%
Volunteer	41	67%
Reassigned	7	11%
Other	13	21%
Total	61	100%

1. Preparation for redeployment

The majority answered that they were provided information and training in advance of the redeployment, however, only slightly over half (53.45%) felt the information and training was sufficient to prepare them for the work.

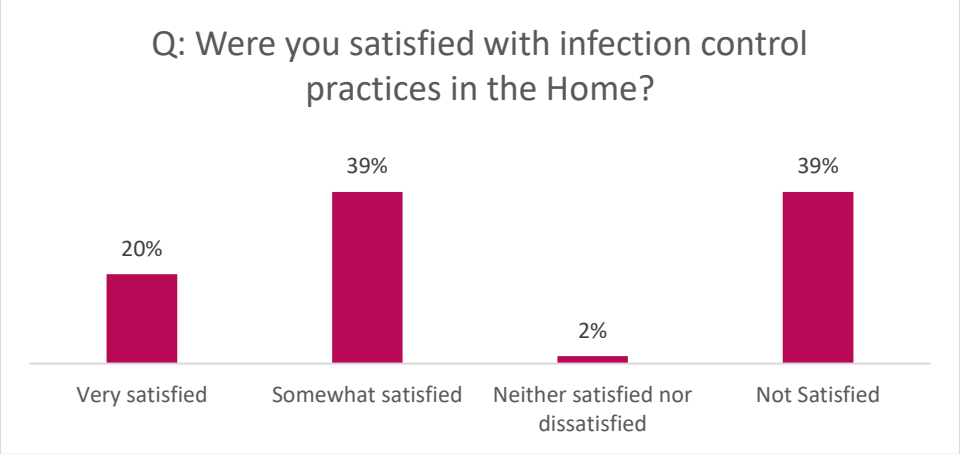
Of the 61 respondents who were redeployed to LTC, 36% indicated they were not provided with information and training in advance, and 47% said the information and training they received did not sufficiently prepare them to work in LTC.

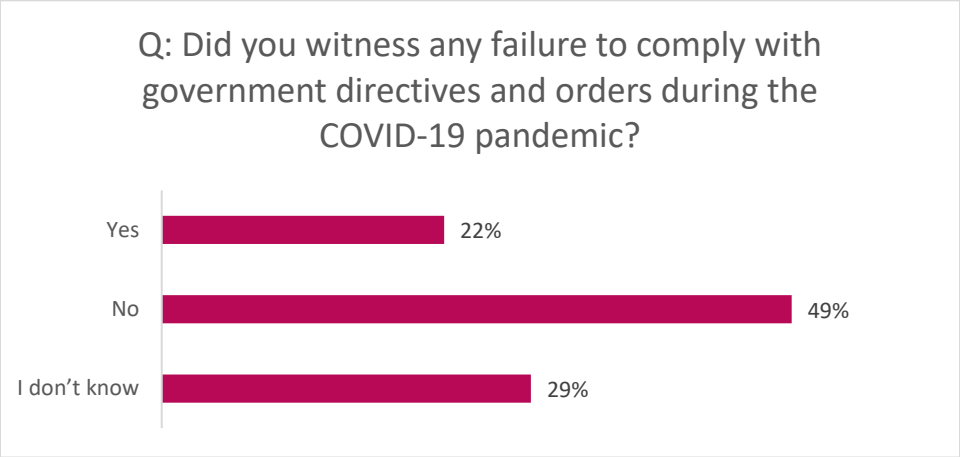
A significant percentage (43%) of the redeployed respondents had issues with the PPE they were provided; they were either lacking certain PPE or provided an insufficient quantity.



2. Experiences in LTC homes

The redeployed respondents were asked a series of questions regarding IPAC in the homes to which they were deployed. Their responses indicate concern about what they found: 39% said they were not satisfied with the IPAC practices in the home, and 51% said they witnessed failure to comply with IPAC best practices. 22% said they witnessed failure to comply with government Directives and Orders.





A significant proportion of redeployed workers were not given the proper information and equipment before entering LTC homes. This is concerning given that a large percentage of this workforce report seeing non-compliance with government Directives or did not have the necessary information to determine compliance. More efforts need to be directed to ensuring those being redeployed are given the proper resources to support the needs of the LTC home safely and effectively.

Significant numbers of the respondents who were redeployed to LTC found themselves working in conditions where they lacked adequate PPE and where IPAC procedures were not optimal.

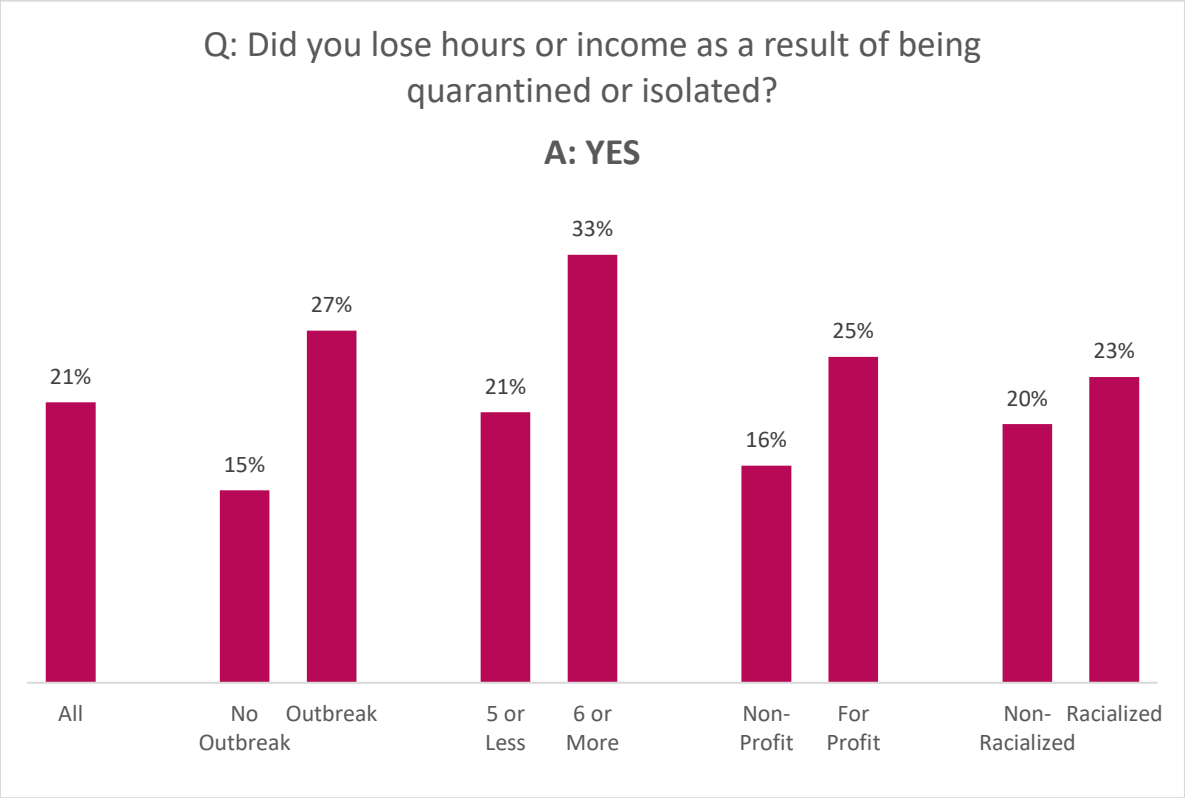
Section 9: Personal Impact

In this section, respondents were asked a series of questions about the impact of working during the first wave of the pandemic. They were asked questions about the personal, emotional, professional and financial consequences they may have experienced working in LTC during the pandemic.

All respondents were able to complete this section.

21.3% of all respondents reported losing income or hours as a result of quarantine and isolation. When segmenting the data, we can see that those working in for-profit homes and in large outbreaks are disproportionally impacted.

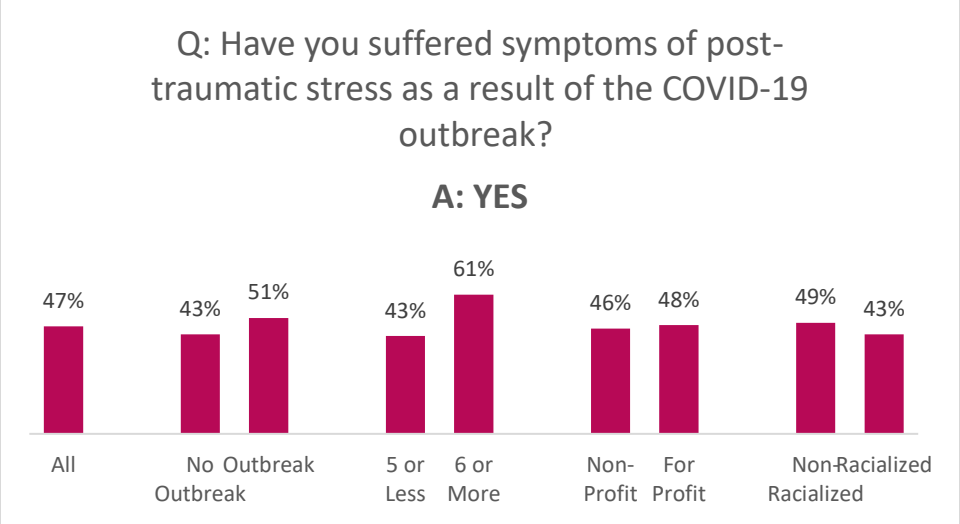
1. Economic impact

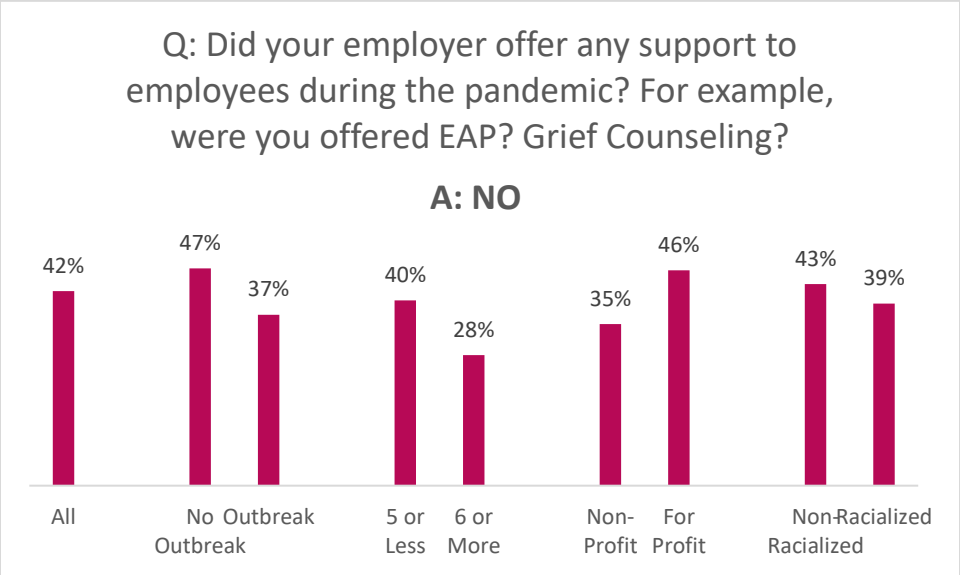


2. Emotional and psychological impact

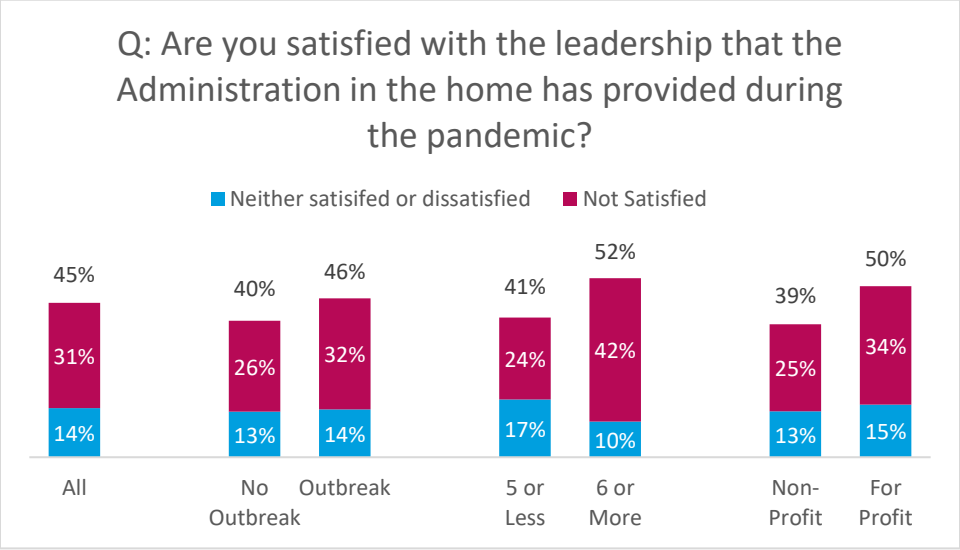
The emotional and psychological impact of working during the first wave cannot be overstated. Over half (50.7%) of respondents who worked in a home with an outbreak report symptoms of post-traumatic stress disorder. The percentage increases to 60.8% in homes with a large outbreak.

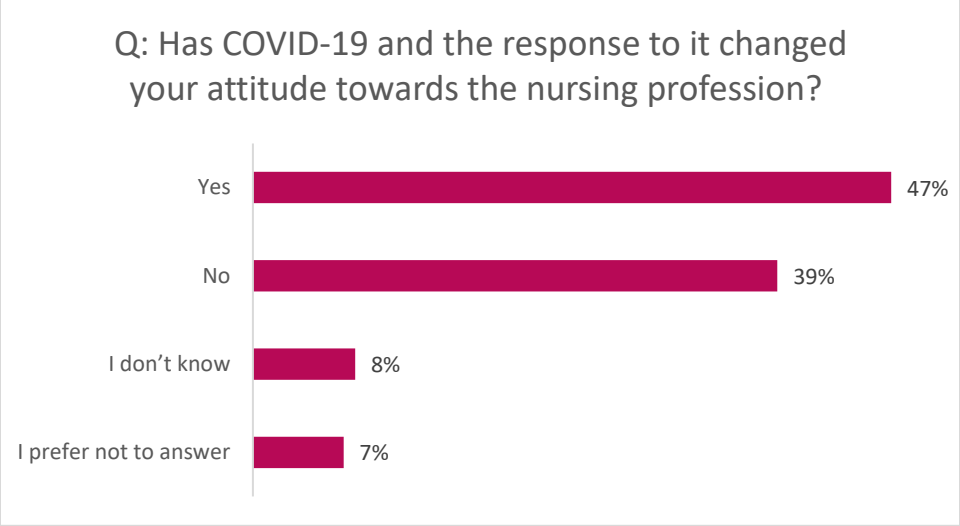
Respondents from not-for-profit homes were more likely to report that they had been offered assistance through an Employee Assistance Plan (EAP) or grief counselling. Homes with outbreaks were more likely to offer this than homes with no outbreak.

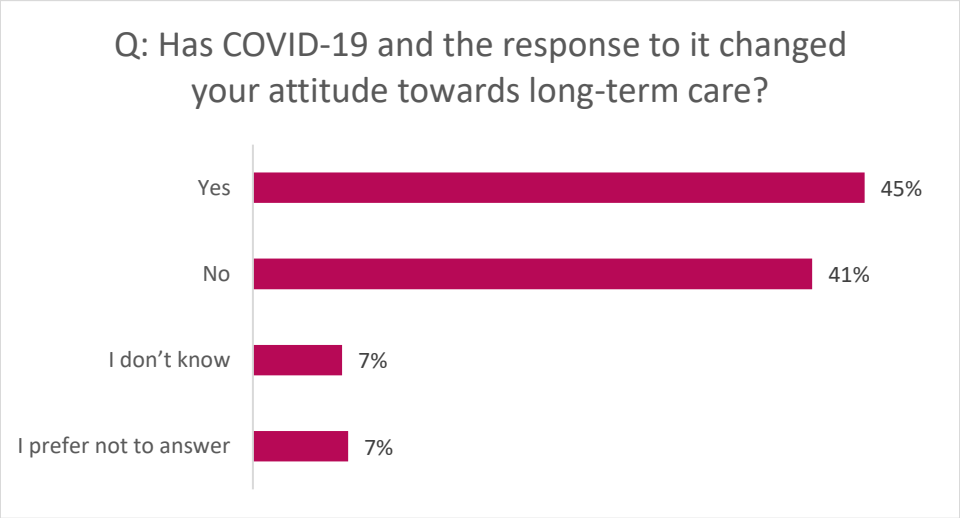




3. Views about nursing and LTC







In the first wave alone, over one-fifth of respondents indicate having lost hours or income as a result of being quarantined or isolated during the pandemic. These statistics would have substantially increased during the second wave. These statistics give support to the creation of paid sick days for isolating or quarantining.

Although the survey results show respondents working in the for-profit sector were more likely to experience an outbreak, and more likely to have experienced a large outbreak, they are less likely to have access to counselling and EAP programs.

Extremely high proportions of nurses report having their perspectives change about the nursing profession and long-term care. This is deeply concerning, especially given that those who experience large outbreaks or work in for-profit homes have expressed higher levels of dissatisfaction with management. A sector like LTC, with well-documented issues in staffing levels, recruitment and retention, cannot afford to lose nurses through disillusionment and burnout. Sadly, the myriad failures in the sector's response to COVID-19 may lead to exactly that result.