CSA Z2004:24
National Standard of Canada

Mental health and well-being in long-term care (LTC) and assisted living (AL) settings

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National Standard of Canada

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Mental health and well-being in long-term care (LTC) and assisted living (AL) settings

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Preface

This is the first edition of CSA Z2004, *Mental health and well-being in long-term care (LTC) and assisted living (AL) settings*.

This Standard was prepared by the Subcommittee on Mental Health and Well-Being in Long-Term Care and Assisted Living Settings, under the jurisdiction of the Technical Committee on Home and Community Care and the Strategic Steering Committee on Health and Well-Being, and has been formally approved by the Technical Committee.

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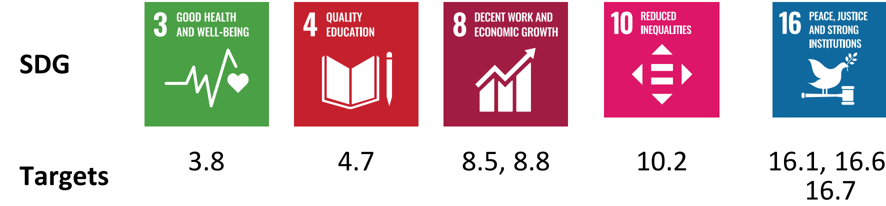

SDG	3	4	8	10	16
Targets	3.8	4.7	8.5, 8.8	10.2	16.1, 16.6, 16.7

CSA Z2004:24 has notable linkages with the following SDGs:

- SDG 3: *Good Health and Well-Being*
- SDG 4: *Quality Education*
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CSA Z2004:24
Mental health and well-being in long-term care (LTC) and assisted living (AL) settings

0 Introduction

0.1 General

The primary goal of this Standard is the promotion of mental health and well-being for residents of LTC and AL settings.

This Standard focuses specifically on care in LTC and AL that optimizes mental health and well-being. However, mental and physical health are closely related and addressing them distinctly might not accurately reflect their complex relationship. Two national Standards of Canada have been published to address the safety, needs, and quality of life of residents in LTC settings: CSA Z8004 and HSO 21001. CSA Z2004 is meant to complement the requirements and recommendations of these Standards. While these Standards outline care that indirectly supports mental health and well-being, specific Standards that are directly relevant to mental health and well-being have been cited accordingly.

0.2 Overview

In Canada, approximately 425 000 adults live in LTC or AL settings, and this population is growing rapidly (Clarke, 2021). Mental health and well-being are integral to good quality of life in these settings, both for residents with and without mental health conditions. Mental health has historically not been prioritized in LTC and AL settings, where physical health and safety have taken precedence. Creating the conditions for good mental health and for supporting mental health needs is essential to all residents living in AL and LTC.

Residents living in LTC and AL are generally older and often live with serious, chronic, or multiple health conditions, disability, and frailty. Over time, medical complexity and care needs have increased in LTC and AL. In particular, the LTC population now has higher levels of functional dependency and greater social, medical, and mental health needs compared to previous years (Zimmerman et al., 2022). Mental health problems are frequent in LTC settings where the majority (76%) of residents have a diagnosis of a mental health condition or dementia (Kehyayan et al., 2021). Among mental health conditions other than dementia, major depression is common (median prevalence, 10%) as are anxiety disorders, while milder symptoms of both depression and anxiety occur even more frequently (Seitz et al., 2010). Residents of LTC are also particularly vulnerable to delirium, which has an incidence of 40% during the course of an LTC stay (Cheung et al., 2018), and most persons with dementia in LTC (78%) have changes in mood, personality, or behaviour including aggression in 1 out of 5 residents (Seitz et al., 2010).

There are few studies focusing on mental health or cognitive impairment, including dementia, in AL settings. However, existing evidence suggests that both are common and likely to increase in AL settings alongside population aging (Hua et al., 2021; Green, 2022). Serious mental illness, including schizophrenia and bipolar disorder, is more common in both LTC and AL settings compared to other community settings and might also be increasing (Hua et al., 2021; Bucy et al., 2022).

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Furthermore, there is limited data on mental health needs in Canadian LTC and AL specifically, and generally a paucity of research in these settings (e.g., on clinical interventions for mental health conditions specific to persons living in LTC).

Although a majority of those living in AL and LTC are older, the population of younger residents, broadly defined as less than 65 years, is substantial in LTC (nearly 7%) and likely similar in AL (CIHI, 2022). More severe disability and greater care needs, higher rates of mental health conditions, and much longer lengths of stay, among other factors, contribute to distinct needs for mental health and well-being among younger compared to older residents in LTC and AL settings. Care and services in LTC and AL are typically developed for the majority (i.e., older population) and are thus often ill equipped to meet the mental health needs of younger residents.

This Standard presents an opportunity to move beyond institutional models of care to one that embraces person-centred care (PCC) to promote mental health and well-being of residents by focusing on psychosocial and emotional needs, and mental health in a compassionate way. To achieve this, direct care staff with the knowledge and skills to competently care for complex and diverse resident populations, including those with mental health conditions, is necessary (CSA Group, 2021). As the mental health and well-being of workers can directly impact that of residents, a healthy and competent workforce is equally important, so that both workers and residents can thrive.

Achieving this requires an approach based on human rights, including the right to the highest possible standard of mental, physical, and social well-being (CMHA, 2021). The intent of this Standard is to guide policy, procedure, and practice development as well as implementation to facilitate a positive care environment for residents, families, care partners, and workers. The requirements and recommendations may be implemented differently in various settings; however, the underlying principles and intent will remain similar.

Collaborative federal, provincial, and territorial government initiatives are needed to support sustainable funding models that enable the high-quality care outlined in this Standard, as well as the necessary oversights to ensure they are adopted and sustained. Although funding differs widely across provinces and territories for both LTC and AL, cost should not be a barrier to health care. There is also a shared responsibility among government and LTC and AL settings to grow and support a workforce of sufficient number and with the skill-set required to meet the complex needs of these vulnerable citizens.

The requirements and recommendations presented in this Standard are supported by principles and best practices and from evidence-based research literature. The overarching theme is framed by a health promotion lens that supports the diverse needs of all residents and aims to enhance protective factors for mental health and well-being and reduce risk factors for poor mental health (MacCourt et al., 2011).

Mental health encompasses an individual’s cognitive, psychological, and emotional health (McArthur et al., 2023). Well-being, in turn, refers to the presence of the highest quality of life in cultural, emotional, mental, physical, social, and spiritual dimensions. Mental health can be considered as existing along a continuum, ranging from optimal states of well-being to mental health symptoms and illness at each extreme; it is not a binary state defined by the presence or absence of a mental health condition (see Figure 1). Mental health for any individual is fluid over time and is influenced by a diverse set of individual, social, and structural factors. Along the continuum, the level of well-being and mental health conditions are experienced differently by each individual (MacCourt et al., 2011).

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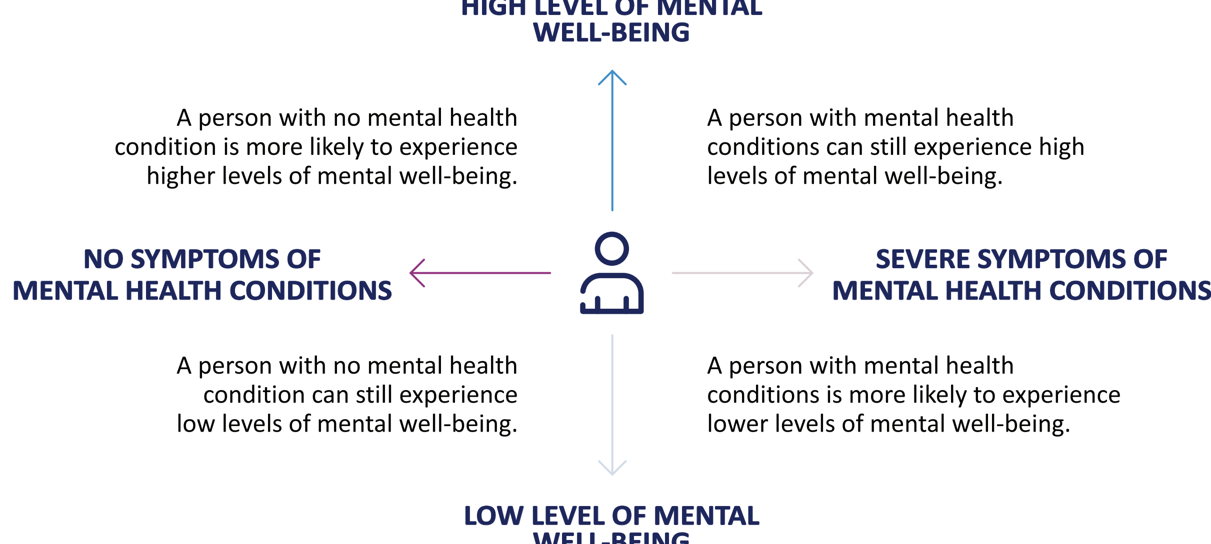
Optimal mental health and well-being in LTC and AL settings necessitates increasing the value placed on mental health in these settings, and shaping the social, physical, and care environment to support the mental health continuum. It requires mental health promotion for all residents, the prevention of illness whenever possible, and where needed, timely and equitable access to mental health treatment and support (MacCourt et al., 2011).

Figure 1
The relationship between mental well-being and symptoms of mental health conditions
(See Clause 0.2.)



Source: *Reproduced with permission from* World mental health report: Transforming mental health for all*, World Health Organization, chapter 2.1.2, Page 13, Copyright 2022.*

0.3 Background

CSA Group's research report *Supporting Mental Health and Well-Being in Community Residential Care Settings*, published in December 2021, served as a seed document for the content development of this Standard.

0.4 Users

This Standard is intended to be used primarily by administrators, workers, and broader care teams involved in LTC and AL settings, as well as by residents, families, and care partners.

1 Scope

1.1 General

The Standard provides guidance for the planning, development, and implementation of services, programs, education, training, policies, procedures, and practices to support mental health and well-

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being of residents in LTC and AL settings. This Standard also addresses physical environmental considerations that promote mental health and well-being in both new and existing builds.

This Standard is applicable to all residents who are living in LTC and AL settings, regardless of where they fall on the mental health continuum, including those without mental health symptoms or conditions, and those with or at risk of mental health conditions.

PCC, equity, diversity, and inclusion (EDI), as well as cultural safety and humility principles, are at the forefront of this Standard to ensure LTC and AL culture is positive, inclusive, and empowering.

1.2 Exclusions

This Standard does not address topics related to general operating practices in LTC and AL settings. Content related to medical practice and professional obligations is not included in the Standard. Furthermore, it does not address specific medical treatments and mental health conditions.

1.3 Terminology

In this Standard, “shall” is used to express a requirement, i.e., a provision that the user is obliged to satisfy in order to comply with the Standard; “should” is used to express a recommendation or that which is advised but not required; and “may” is used to express an option or that which is permissible within the limits of the Standard.

Notes accompanying clauses do not include requirements or alternative requirements; the purpose of a note accompanying a clause is to separate from the text explanatory or informative material.

Notes to tables and figures are considered part of the table or figure and may be written as requirements.

Annexes are designated normative (mandatory) or informative (non-mandatory) to define their application.

2 Reference publications

This Standard refers to the following publications, and where such reference is made, it shall be to the edition listed below, including all amendments published thereto.

Note: *See also Annex E.*

CSA Group

CAN/CSA-Z1003-13/BNQ 9700-803/2013 (R2022)
Psychological health and safety in the workplace — Prevention, promotion, and guidance to staged implementation

Z1600-17
Emergency and continuity management program

Z2003:20
Mental health and well-being for post-secondary students

Z8004:22
Long-term care home operations and infection prevention and control

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Continuing Care Health Service Standards, January 2016, amended July 16, 2018.
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CTRA (Canadian Therapeutic Recreation Association)
Standards of Practice for Recreation Therapists and Therapeutic Recreation Assistants, 2023
https://canadian-tr.org/wp-content/uploads/2015/02/Standards_of_Practice_2006-English.pdf

Government of Canada
Accessible Canada Act (S.C. 2019, c. 10)

Canadian Human Rights Act (RSC, 1985, c. H-6)

Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada (2015, IR4-7/2015E-PDF)
https://publications.gc.ca/site/eng/9.800288/publication.html

HSO (Health Standard Organization)
21001-2023
Long-term Care Services Standard

22004-2023
Mental Health and Addictions Services standard

75000-2022
British Columbia Cultural Safety and Humility Standard

IWBI (International Well Building Institute)
WELL Building Standard™, version 2, 2020

NICE (National Institute for Health and Care Excellence)
Mental wellbeing of older people in care homes, Quality Standard (QS50), 12 December 2013
https://www.nice.org.uk/guidance/qs50/resources/mental-wellbeing-of-older-people-in-care-homes-pdf-2098720457413

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3 Definitions and abbreviations

3.1 Definitions

The following definitions shall apply in this Standard:

Assisted living setting — a place that provides housing, hospitality services, personal care services, and may include nursing care, for adults who can live independently but require a supportive environment due to physical or other health challenges.

Note: *AL settings can offer a variety of services including meals, assistance with personal care and housekeeping, support for medication administration, supervision, on-site workers (including medical), as well as social and recreation activities. Exact arrangements and services offered vary between provinces and territories. These settings are known by many names in various jurisdictions.*

Assistive technology — any item, piece of equipment, or product system that is used to increase, maintain, or improve functional abilities of individuals with disabilities, or which provides stimulation, counters isolation, promotes self-sufficiency and control over the environment, enhances mental health, or reduces workload on workers by enabling the residents to perform tasks otherwise performed by workers.

Care partner — a person or persons chosen by a resident, or if incapable, by the resident's substitute decision maker or power of attorney, to participate in the resident's ongoing care. Can be a family member, close friend, private care provider, or other paid or unpaid caregiver.

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Care plan — a written working document developed by the interprofessional care team that includes a resident's assessed healthcare needs, including mental healthcare needs, and related goals and interventions.

Source: *Adapted from Alberta Health* Continuing Care Health Service Standards*, 2018.*

Changes in mood, personality, or behaviour in dementia — a range of non-cognitive symptoms of dementia, such as agitation, aggression, depression, anxiety, sleep changes, psychotic symptoms (hallucinations and delusions), motor restlessness, disinhibition, and apathy.

Note: *Changes in mood, personality, or behaviour in dementia may also be referred to as behavioural and psychological symptoms of dementia (BPSD), neuropsychiatric symptoms (NPS), and responsive behaviours or personal expressions.*

Disability — any impairment, including a physical, mental, intellectual, cognitive, learning, communication, or sensory impairment—or a functional limitation—whether permanent, temporary, or episodic in nature, or evident or not, that, in interaction with a barrier, hinders a person's full and equal participation in society.

Source: Accessible Canada Act*.*

Equity, diversity, and inclusion (EDI) — the range of experiences of all individuals regardless of their ethnicity, race, gender, sexual orientation, sexual expression, sexual identity, ancestry, age, socio-economic status, where they live, gender identity, gender expression, abilities, health status, political beliefs, religious beliefs, or citizenship status, including those who have experienced colonization.

Source: *Adapted from CSA Z8004.*

Family — persons of various demographics chosen by residents for the purpose of meeting their individual needs. These persons can be connected by affection, biology, choice, convenience, necessity, or law.

Source: *CSA Z8004.*

Healthcare worker (HCW) — person delivering care to a resident. This includes, but is not limited to,

a) designated support persons;
b) heath care aides;
c) nurses;
d) occupational therapists;
e) paramedics;
f) personal support workers;
g) physicians;
h) recreation therapists;
i) respiratory therapists;
j) social workers; and
k) students.

Note: *In some non-acute settings, volunteers might provide care and would be included as HCWs.*

Source: *Adapted from CSA Z8004.*

Leadership — persons responsible for taking decisions that can impact the whole or part of the LTC and AL setting.

Note: *Also referred to as top or senior management.*

LTC settings — a place in which adults remain on an extended basis with varying levels of independence, receive a range of health or personal care services, and generally do not require invasive medical interventions. These settings are known by many names in various jurisdictions. A defining

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feature of such places is that they act as an ongoing home (either short-term or long-term) for the residents and as a place of work for the workers that support the residents.

Note: *These settings are sometimes referred to as "community residential care settings". As the term "residential" might be too closely associated with the term "residential schools" for Indigenous Peoples in Canada, and thus serve as an inclusivity barrier to working and fully engaging with some populations, it is not used in this Standard.*

Source: *Adapted from CSA Z8004.*

Mental health — a state of well-being in which individuals realize their own potential, can cope with the normal stresses of life, and are able to contribute to their own community.

Source: *WHO, 2022a.*

Mental health condition — characterized by alterations in thinking, mood, or behaviour associated with significant distress or that interfere with relationships and affect a person's ability to function on a day-to-day basis. These include mental health conditions such as major depression and other mood disorders, anxiety disorders, substance use disorders, dementia, delirium, and personality disorders. Individuals can have more than one mental health condition at a given time.

Source: *Adapted from CSA Z2003 and Nice, 2013.*

Person-centred care (PCC) — a focus on the resident as the centre of control that emphasizes supporting residents in making their own choices and having control over their daily lives. PCC also incorporates the healthcare system experience of residents, families, and care partners, and it is organized around the comprehensive needs of people.

Note: *This is increasingly being referred to as person- and family-centred care (PFCC).*

Source: *Adapted from CSA Z8004.*

Recreation therapy — a person-centred, strength-based, evidence-informed approach that supports people with disabilities, illness, or other limitations to engage in meaningful leisure opportunities to increase health and well-being in clinical and community-based service delivery settings.

Source: *CTRA, 2023.*

Resident — persons who reside in the LTC or AL setting, who can also be referred to as clients, tenants, neighbours, community members, or patients depending on the setting and context.

Restraint — a physical or chemical measure that controls or limits a resident's movement, behaviour, or mobility.

Note: *The use and definitions of restraints can vary by jurisdiction and population type.*

Source: *HSO 21001.*

Specialized mental health resources — services or programs provided by providers with expertise or additional training in mental health such as psychiatrists or geriatric psychiatrists, psychologists, mental health nurses, clinicians or therapists, behavioural specialists, social workers, social service workers, or other mental health professional.

Wayfinding — a spatial problem-solving process that individuals use to understand where they are in an environment or building, know where their desired location is, and know how to get to their desired destination from their present location.

Note: *See CSA Z317.14, CSA Z8004, and CSA Z8000.*

Source: *CSA Z8004.*

Well-being — the presence of the highest quality of life in its full expression of the following dimensions:

a) cultural;

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b) emotional;
c) mental;
d) physical;
e) social; and
f) spiritual.

Source: *CSA Z2003.*

Worker — a person employed by an LTC or AL setting or working in or on behalf of the setting in a term, contract, or temporary position. Can be persons who are paid or unpaid and includes clinical and non-clinical roles such as HCWs, supervisors, managers, contractors, service providers (e.g., environmental services, kitchen workers, housekeeping), volunteers, students, or other parties actively engaged in undertaking activities for benefit to the LTC or AL setting.

Source: *Adapted from CSA Z8004.*

3.2 Abbreviations

The following abbreviations shall apply in this Standard:

AL — assisted living

CAM — confusion assessment method

DOS — delirium observation screening

EDI — equity, diversity, and inclusion

HCW — healthcare workers

LTC — long-term care

PCC — person centred care

4 Guiding principles

4.1 General guiding principles

This Standard is based on general guiding principles that promote and support the mental health and well-being of residents. The LTC and AL setting shall support mental health and well-being by fully engaging in a culture of PCC, EDI, and cultural safety and humility. While each program to support mental health and well-being in LTC and AL settings is unique, based on specific needs and resources of the setting, common principles of PCC, EDI, and cultural safety and humility should guide the development and implementation of policies, procedures, and practices. Residents, families, and their care partners should have input into policies, procedures, practices, and programs.

4.2 PCC

4.2.1 General

PCC delivered by highly engaged employees who feel valued and trusted with their responsibility is foundational to creating environments of care and services where the promotion of mental health and well-being is possible. Users shall refer to CSA Z8004 and HSO 21001 for guidance and requirements for the inclusion of PCC in LTC and AL settings.

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4.2.2 PCC principles

In addition to the guidance and requirements of CSA Z8004 and HSO 21001, LTC and AL settings shall ensure the respect of the following PCC principles to promote and support the mental health and well-being of residents:

a) The physical, mental, social, and spiritual needs of residents are integrated into daily living space and care plans.
b) The lived experience of residents is recognized (including past trauma) and valued by the workers in the LTC and AL setting.
c) To the fullest extent possible, residents direct their own care. When not possible, workers use knowledge gained about the resident’s preferences either directly or through the resident’s substitute decision maker.
d) Care focuses on residents’ strengths, capabilities, preferences, and priorities and adapted to their varying cognitive abilities and communication styles.
e) Individual identity and expression (including gender, sexual, cultural, and ethnic) are respected (refer to CSA Z8004 for sexual expression).
f) Residents’ perspectives are listened to, and issues raised are resolved in a respectful and timely manner.

4.3 EDI

4.3.1 General

Principles of EDI are foundational in promoting the mental health and well-being of residents and ensuring an inclusive and non-discriminatory environment. Users shall refer to CSA Z8004 and HSO 21001 for guidance and requirements for the inclusion of EDI in LTC and AL settings.

4.3.2 EDI principles

In addition to the guidance and requirements of CSA Z8004 and HSO 21001, the LTC and AL setting shall respect the following EDI principles to further promote and support the mental health and well-being of the residents:

a) The protection, promotion, and adherence to the requirements of human rights including dignity, equity, and freedom (see Clause 4.3.3).
b) Leadership, workers, and volunteers have an individual and collective responsibility to encourage and demonstrate equitable and inclusive behaviours.
c) The LTC and AL setting strive to develop a workforce composition that is as diverse as the communities served.
d) Leadership and the workforce understand how the multiple forms of discrimination combine, overlap, or intersect and impact the mental health and well-being of residents, especially in the experience of marginalized individuals or groups.

4.3.3 Human rights

The LTC and AL setting shall ensure that the rights of residents are respected, in particular, the right to the highest attainable standard of mental and physical health (CMHA, 2021).

Persons shall not be discriminated against based on the following prohibited grounds (see the *Canadian Human Rights Act*):

a) age;
b) colour;
c) disability (mental health, physical, intellectual, sensory);

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d) family status;
e) gender identity or expression;
f) genetic characteristics;
g) marital status;
h) mental health status;
i) national or ethnic origin;
j) race;
k) religion;
l) sex; or
m) sexual orientation.

Furthermore, persons shall not be discriminated against based on their socio-economic status.

4.3.4 Discrimination and stigma linked to mental health

4.3.4.1 General

Discrimination and stigma related to mental health conditions or mental health needs, including dementia, are common in LTC and AL settings, impacting access to quality care for persons living in these settings (Knaak et al., 2017). Discrimination and stigmatization in LTC and AL settings can occur on multiple interrelated levels, including intrapersonal (e.g., self-stigma), interpersonal (e.g., relationships with others), and structural (e.g., policies, organizational culture, and systems) (Henderson, 2014).

4.3.4.2 Policies

To ensure equitable services for all residents, LTC and AL settings shall develop policies that protect residents from discrimination due to mental health conditions, needs, or any of the prohibited grounds listed in Clause 4.3.3, during the delivery of services and during transitions in care (e.g., move-in, transfer, move-out). These policies should be applied according to the resident's current presentation, symptoms, and related needs with consideration of the resident's history, including past or present diagnoses, as well as the LTC and AL setting's ability to meet their care needs.

4.4 Cultural safety and humility

4.4.1 General

Cultural safety and humility are critical in promoting the mental health and well-being of residents and are a priority of the Government of Canada's *Honouring the truth, reconciling for the future* (2015). Users shall refer to HSO 21001 and HSO 75000 for guidance and requirements for the inclusion of cultural safety and humility in LTC and AL settings.

Note: *See also the Canadian Association for Long Term Care's* Position Statement on LTC Homes and Reconciliation with Indigenous People*.*

4.4.2 Addressing the call to action from *Honouring the truth, reconciling for the future*

The LTC and AL setting shall address recommendations from the Government of Canada's *Honouring the truth, reconciling for the future* (2015) call to action number 22 "to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients".

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4.4.3 Cultural safety and humility principles

In addition to the guidance and requirements of HSO 21001 and HSO 75000, the LTC and AL setting shall ensure the respect of the following cultural safety and humility principles to promote and support the mental health and well-being of residents (FNHA, 2016):

a) The recognition of Indigenous people as self-determining individuals, families, and communities.
b) The understanding of what mental health and well-being means to Indigenous people with recognition of the diversity of these understandings.
c) The recognition of the role of history, society, and current and past traumatic experiences and their impacts on mental health, well-being, and healthcare experiences.
d) Building trust by communicating respect for individual beliefs, behaviours, and values.
e) Humbly acknowledging oneself as a life-long learner when it comes to understanding another person’s experience.
f) Self-reflection on one’s own culture, beliefs, and values and on how these internal systems have the potential to transfer into one’s care practices, consciously or unconsciously.
g) Recognizing and addressing systemic barriers and biases in health care to ensure equitable and inclusive care for all residents.
h) Prioritizing and improving access to culturally appropriate and safe programs and resources that respect Indigenous residents’ knowledge systems and ways of being.

4.4.4 Cultural support

The LTC and AL setting shall create a space for spiritual and cultural support practices, including those provided by individuals from outside the LTC and AL setting.

5 Organizational commitment to mental health and well-being

Leadership responsible for the LTC and AL setting shall establish a high-level commitment to a culture that promotes mental health and well-being for all. This commitment shall be reflected in the organization’s vision, mission, and values. The funding body (whether privately or publicly funded at the municipal, regional, provincial, or territorial level) of the LTC and AL setting should be responsible to ensure that adequate and sustained resources are available. The setting shall ensure available resources are appropriately utilized for the promotion of the mental health and well-being of residents.

This shall be accomplished by ensuring the following are integrated into the policies, procedures, and practices of the LTC and AL setting to reflect a commitment that supports mental health and well-being:

a) Leadership shall advocate for keeping residents within their own community, as well as within the same setting as their partners, when possible and when such a request has been made.
b) Leadership shall commit to continuing education and be proactive regarding the mental health and well-being of residents and the psychological health and safety of workers.
c) Workers shall be supported through resources to ensure a person-centred and relationship-based culture of caring that supports mental health and well-being of residents.
d) Workforce levels and skill mix shall support mental health and well-being of residents.
e) Leadership shall proactively identify and address potential risk for the abuse and neglect of residents by developing comprehensive policies for respectful treatment of residents and consequences for abuse and neglect. This shall include education and training of workers, implementing reporting mechanisms, conducting regular audits, and responding swiftly to concerns. All workers shall follow these policies as well as identify and report any situation of abuse and neglect of residents.

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f) Violence prevention policies shall be in place. These shall include conducting regular and planned safety risk assessments to determine if additional measures are required in situations where residents, families, care partners, and workers could be exposed to a hazard.
g) Residents, families, care partners, and workers shall contribute, be involved in, and be engaged in decision making, and advocate for change within the LTC and AL setting.
h) Residents, families, care partners, and workers shall practice civility and respect in the LTC and AL setting.
i) Residents, families, and care partners shall be made aware of activities, resources, or programs supporting mental health and well-being of residents.
j) A policy and procedures on using the least amount of restraint shall be in place and communicated to workers, residents, families, and care partners.
k) An evaluation process shall be in place where residents, families, care partners, and workers can safely provide feedback about how programs and services support the mental health and well-being of residents. This process shall be inclusive of the diverse capabilities of those providing feedback.

6 Quality improvement

6.1 Quality improvement process

The LTC and AL setting shall establish and implement a process for continuously monitoring and improving quality of care for mental health and well-being. Within the quality improvement process, leadership shall demonstrate support and commitment to organizational level activities.

6.2 Alignment

The quality improvement process shall align with the mission, vision, and values of the LTC and AL setting and be integrated into or compatible with governance practices and other systems in the LTC and AL setting. The quality improvement process shall also guide local research, program planning, and operational practices.

6.3 Quality improvement process elements

The quality improvement process shall include the following foundational elements:
a) evidence of governing body and leadership commitment and support;
b) resident, family, care partner, and worker participation and engagement; and
c) procedures for measuring and monitoring quality of care, addressing identified gaps in care, and monitoring the impact of changes to improve quality of care.

6.4 Applying the quality improvement process

6.4.1 General

The quality improvement process includes gathering information on quality of care and using this information to identify opportunities for improvement. The quality improvement process also involves selecting appropriate strategies for change and for evaluating the effects of any changes implemented. The quality improvement process should consider using quality improvement models [e.g., Plan-Do-Study-Act (PDSA), Six Sigma] and change management models. The quality improvement process shall include a commitment to continuous improvement. Workers involved in quality improvement processes should have the requisite knowledge and skills or receive the required training for these activities.

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6.4.2 Steps

The key steps in the quality improvement process should include
a) gathering data to establish an organizational baseline or current state with an emphasis on quality of care for mental health and well-being of residents;
b) performing a gap analysis between its current and desired state;
c) identifying areas for improvement and strengths within its policies, practices, and programs that have a direct or indirect impact on mental health and well-being;
d) setting of priorities, goals, and targets to address identified gaps between current and desired state and areas of poor quality of care. Goals should be specific, measurable, achievable, relevant, and time-bound (SMART);
e) determining change strategies and interventions to achieve priorities, goals, and targets with input from residents, families, care partners, and workers;
f) implementing these strategies and interventions;
g) evaluating the impact of implemented strategies and interventions using data collection;
h) reporting on the outcomes of implemented strategies and interventions using the data collected;
i) obtaining feedback on the outcomes of these strategies and interventions, including from residents, families, care partners, and workers;
j) sustaining successful strategies and interventions that improve quality of care; and
k) continuously seeking to identify opportunities for improvement using the quality improvement process.

6.4.3 Quality indicators

The LTC and AL setting shall monitor quality of care related to mental health and well-being by selecting relevant quality indicators, when available, or by establishing ways to measure this care by determining
a) what needs to be routinely monitored via quality indicator or other methods for measurement;
b) the methods for measuring and analysis;
c) how frequently the monitoring should be performed;
d) the targets for quality indicators or other methods for measurement;
e) the actions to be taken when quality indicators or other methods for measurement fall short of targets; and
f) when and how the results will be reported and disseminated to relevant parties.

6.4.4 Evaluations

The LTC and AL setting shall perform regular and planned self-evaluations of its policies, practices, and programs to ensure they continue to promote the mental health and well-being of the residents. The LTC and AL setting should consider the use of evidence-based tools to inform these evaluations (e.g., Seniors Mental Health Policy Lens Toolkit) and incorporate existing reporting tools where possible.

The LTC and AL setting shall evaluate the following elements:
a) the effectiveness of any implemented change strategies and interventions;
b) the results of routine monitoring of quality of care via quality indicators or other methods for measurement;
c) reported safety incidents; and
d) feedback from residents, families, care partners, and workers.

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7 Workforce

7.1 General

The knowledge, skills, and abilities of all workers are critical to supporting and maintaining a healthy resident population. This Standard identifies the requirements to support and enable all workers to promote and support the mental health and well-being of residents.

7.2 Mental health and well-being of workers

The mental health and well-being of workers are essential to enable the workers to deliver high-quality care that supports the mental health and well-being of residents. The requirements and guidance in HSO 21001 shall apply for enabling a healthy and competent workforce.

7.3 Workforce practices

7.3.1 General

The LTC and AL setting shall ensure they have optimal ratios, skills, and occupational mix of workers grounded in evidence-based practices and according to residents' mental health and well-being needs. In addition to the workforce requirements and guidelines in HSO 21001, Clause 7.3 of this Standard shall apply for promoting the mental health and well-being of residents.

7.3.2 Recruitment

The LTC and AL setting shall ensure the recruitment process identifies and allows for the selection of workers who demonstrate emotional intelligence, compassion, and capacity to form relationships with diverse resident populations.

7.3.3 Continuity of care

The LTC and AL setting shall ensure continuity of care to promote understanding of individual residents and relationships between residents and workers. This should be achieved by applying a team-based approach through consistent worker assignments, when possible, and taking into consideration operational needs. The LTC and AL setting shall also facilitate continuity of care by developing an interprofessional or team-based approach to care to minimize the use of temporary work assignments from external employment services who might be less familiar with the residents and the setting.

7.3.4 Workforce ratios

The LTC and AL setting shall have workforce ratios that allow workers the required time for compassionate interactions with residents, especially those who might have varying cognitive capabilities. The LTC and AL setting shall have plans and mitigation strategies in place for residents whose needs might temporarily surpass usual operational workforce ratios (e.g., implementing a temporary 1:1 worker resident ratio).

7.3.5 Skills and occupational mix

The LTC and AL setting shall have a mix of skills and occupations within its workforce that supports the mental health and well-being of the residents. Where these workers are not available within the setting itself, the LTC and AL setting should ensure access to these professionals on a regular basis.

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7.3.6 Models

LTC and AL settings should develop models for specialized mental health workers and resources internal to the setting to support behavioural care plans and real-time mentoring or coaching workers. This might require funding positions or innovative care models (see Clause 11.1.6 for examples of models for providing specialized mental health care).

7.4 Work environment

7.4.1 Psychological health and safety in the workplace

The LTC and AL setting shall develop, implement, and maintain policies, procedures, and practices to promote and support a psychologically healthy and safe work environment, including those addressing violence, harassment, and bullying.

Note: *Refer to CSA Z1003 for more information.*

7.4.2 Accessible mental health support

The LTC and AL setting should ensure worker access to internal and external mental health supports as well as supporting access to peer support networks, when available.

7.5 Worker training

7.5.1 General

In addition to the standard worker training requirements and guidelines in HSO 21001, Clause 7.5 of this Standard shall apply to further promote the mental health and well-being of residents.

7.5.2 Content of training

The LTC and AL setting shall ensure the content of the training promotes the mental health and well-being of residents. All workers shall be trained according to their expected level of interaction and occupational function on the following topics, including, but not limited to,

a) PCC, which shall include
   i) developing an understanding of the care partner-resident relationship as crucial to the resident's well-being and promoting partnership in care;
   ii) recognizing signs and symptoms that could be related to a mental health condition and identifying when to implement interventions;
   iii) recognizing changes in mental health or behaviour of residents that could escalate towards a critical incident, preventative strategies, and when necessary, intervention techniques to mitigate the risk of harm; and
   iv) promoting physical, social, environmental, or situational factors for positive interactions;
b) EDI, including mental health-related bias and stigmatization and how to respond appropriately when witnessing such biases and stigmatizations;
c) cultural safety and humility;
d) trauma-informed approach, including knowledge to recognize and navigate trauma or other factors in an individual's past that could affect their response to care (i.e., trauma-sensitive care);
e) respectful workplace practices, such as civility and respect;
f) effective communication skills;
g) conflict resolution;
h) de-escalation skills;
i) non-pharmacological interventions for mental health conditions, including for mood, personality, or behaviour changes in dementia;

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j) appropriate use of restraints (i.e., applying the least restraint policy), including anti-psychotic medications; and
k) suicide risk assessment and intervention.

8 Design of the LTC and AL setting

8.1 General

The physical environment of the LTC and AL setting is a determining factor for the mental health and well-being of residents. CSA Z8004 provides guidance on safe operating practices, design, and infection prevention and control in LTC homes. Much of the guidance on the design of the physical environment of LTC homes presented in CSA Z8004 also promotes the mental health and well-being of the residents of LTC and AL settings alike. In addition to CSA Z8004, Clause 8 of this Standard shall apply to further optimize mental health and well-being of residents in these settings.

8.2 Building design elements

8.2.1 General

The LTC and AL setting shall ensure its building design elements, such as basic design attributes, ambiance, and environmental attributes, promote the mental health and well-being of residents (Wrublowsky, 2018). Residents, families, care partners, and workers shall be consulted, when possible, in the planning and design process for planned renovations of existing buildings and for new builds, to ensure the building design elements accommodates the needs of the residents, addressing the physical, environmental, and social aspects of their quality of life.

8.2.2 Basic design attributes

8.2.2.1 General

The design and wayfinding elements in CSA Z8004 shall be incorporated into planned and renovated settings, as applicable. In addition to CSA Z8004, the design attributes in Clause 8.2.2 of this Standard shall apply to further optimize mental health and well-being of residents in these settings.

8.2.2.2 Religious and cultural practice accommodations

The LTC and AL setting shall perform an assessment of the religious and cultural practice needs of the residents as a community. For existing builds, LTC and AL should provide spaces to accommodate the assessed needs while balancing health, safety, and practical considerations. For new builds, LTC and AL should incorporate spaces to accommodate religious and cultural practices based on the assessment of the community the LTC and AL settings will serve.

8.2.2.3 Spatial layout

The LTC and AL setting shall favour open concepts when renovating or designing new builds. Connecting spaces such as hallways should be designed or adapted, where they already exist, to encourage more homelike settings. Quiet zones or designated common rooms should be available to meet the needs of residents who require low stimulation time.

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8.2.2.4 Neighbourhood

Neighbourhood sizes have an important impact on the mental health and well-being of residents. The LTC setting should strive to create units or spaces where small groups of compatible residents can co-reside to promote social engagement, a more homelike environment, and better quality of life, all of which can support mental health and well-being.

8.2.2.5 Kitchens

8.2.2.5.1 General

The LTC and AL setting should make kitchens available and accessible that provide therapeutic benefits for the residents (Wrublowsky, 2018). Their function and equipment may vary according to the type of setting and level of independence of the residents (as assessed by the LTC and AL settings). The kitchen environment shall incorporate safety measures and technologies that may be utilized as needed according to the capabilities of the residents, families, and care partners to ensure their safety.

8.2.2.5.2 Therapeutic kitchens in LTC settings

Cooking can stimulate a familiar sensorial response through colour, aroma, and touch, which can promote a calming environment, improve appetite, and enhance the residents' dining experience. In LTC settings, a kitchen should be made available for families, care partners, and visitors who wish to occasionally cook for or with the resident, with supervision if required. This type of kitchen may also serve as a type of recreation activity space that allows for socializing in a familiar place.

8.2.2.5.3 Kitchens in AL settings

In AL settings, for residents who are more independent and able, a kitchen should be equipped to allow these residents to perform familiar household tasks, such as baking, setting the table, and washing dishes.

Note: *The benefits of access to kitchens, in addition of those presented in Clause 8.2.2.5.2, include the reinforcement of previous roles, the encouragement of feelings of pride and accomplishment by supporting choice, and meaning in the resident's day-to-day activities.*

8.2.2.6 Resident's room

8.2.2.6.1 Privacy

LTC and AL designs shall incorporate strategies that promote privacy for residents, provide autonomy over personal space and belongings, and limit intrusion by other residents and workers, so that residents have a sense of ownership and security in their rooms.

8.2.2.6.2 Single-occupancy rooms with private bathrooms

Single-occupancy rooms with private bathrooms are especially important for residents' privacy, which can help support their mental health and well-being. The LTC and AL setting shall plan for these rooms in new constructions, additions, and renovations. Prioritization shall be given, when feasible, to eliminating rooms with more than two residents (e.g., quad rooms).

8.2.2.6.3 Double-occupancy rooms

Double-occupancy rooms might be appropriate for residents wishing to live with another resident of their choice (e.g., spouse, sibling, long-time friend). The LTC and AL setting shall assess the suitability of this option, both from an infection prevention and control standpoint, as well as according to the level

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of care required by the residents. The LTC and AL setting should plan for these rooms in new constructions, additions, and renovations.

8.2.2.6.4 Temperature and lighting

Each room shall, when feasible, be equipped with individual control of temperature and lighting. The LTC and AL setting shall plan for these controls in new constructions, additions, and renovations.

8.2.2.6.5 Family areas

For younger residents parenting minor children, the LTC and AL setting should offer child-friendly areas and lounges and private rooms where families can visit for longer periods, including staying overnight.

8.2.2.7 Outdoor natural spaces

8.2.2.7.1 General

The LTC and AL setting shall provide year-round access to outdoor natural spaces that allow residents to sit and circulate in areas that provide both sunlight and shade. Special consideration should be placed on the stimulation of the senses, such as sound, smell, vision, and touch.

Note: *Refer to CSA Z8004 for information relating to gardens.*

8.2.2.7.2 Safety measures

Outdoor natural spaces may have additional safety measures in some settings (e.g., where there can be a risk of problems with wayfinding or residents leaving the area). The outdoor natural space shall have safe wheelchair and walker access. Wayfinding elements and lighting for both daytime and evening use shall be included.

8.2.2.7.3 Horticulture

To encourage and facilitate horticulture, raised flower beds and harvesting tables should be made available with accessibility in mind.

8.2.3 Ambiance

8.2.3.1 General

The LTC and AL setting shall strive to create a homelike ambiance with the use of familiar design elements (e.g., picture frames, plants) in shared spaces and avoid a clinical atmosphere (e.g., with signage associated with clinical settings such as posters for biohazardous waste).

Note: *Refer to CSA Z8004 for information relating to wayfinding and other strategies to promote the mental health and well-being of residents.*

8.2.3.2 Residents, families, care partners, and workers involvement

The LTC and AL setting shall involve residents, families, care partners, and workers in the setting design and decor decisions, as well as support decorating the resident’s space to promote individuality. This may involve the use of recognizable items, personal belongings, and cultural items.

8.2.3.3 Artwork

Artwork displayed within the LTC and AL setting can enhance residents’ mental health and well-being.

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Artwork should be carefully chosen, in consultation with art therapists, residents, families, and care partners, when possible, and placed in locations that support a homelike setting.

Note: *Refer to Wrublowsky (2018) for descriptions of the types of preferred artwork (e.g., non-abstract, tactile).*

8.2.4 Environmental attributes

8.2.4.1 Stimulation

Some residents can become more confused, anxious, and restless when overstimulated by light, noise, and activity. The LTC and AL setting shall ensure that the background stimuli of the settings are mitigated and reduced as much as possible.

8.2.4.2 Lighting

The LTC and AL setting shall provide residents with illumination which simulates the natural and diurnal variation of light exposure to have a positive effect on mood and sleep. Lighting to promote circadian rhythm shall be of a higher intensity white upon wakening and throughout the day. Three hours prior to bedtime, the lighting should transition to warmer, lower intensity lighting.

Note: *Refer to Annex A for additional information on lighting levels to promote mental health and well-being.*

8.2.4.3 Noise

The LTC and AL setting shall attempt to reduce noise and other environmental stimuli from outside and between rooms through acoustic dampening or eliminating strategies (e.g., silent call bells), as higher noise levels could be a barrier to social interactions or cause distress for some residents.

8.2.4.4 Assistive technologies

The LTC and AL setting shall incorporate current and emerging technologies, such as high-speed internet capabilities, unobtrusive technology that ensures the safety and localization of residents (e.g., coded entries, location bracelets, motion sensors), and technologies that assist with safe exploring for residents and allow monitoring if exploring in unsafe areas (e.g., hook-and-loop fasteners on doors). These technologies shall be used in a way to support a balance between the residents' need for privacy and quality of life with their safety and security, and to promote their mental health and well-being.

8.2.4.5 Use of technology

Residents shall be assisted in the use of technology to enable them to participate in the recreation therapy program and facilitate social activities. Residents shall have access to internet connectivity permitting them to stream live content (e.g., videos, movies, social media) and to enable video-conferencing activities.

The LTC and AL setting shall

a) provide the necessary infrastructure to support resident participation in the recreation therapy program and enable connectivity with family, care partners, and friends (this may include providing the necessary equipment including access to phones, translation applications, and other electronic devices);

b) ensure residents can easily access the required technologies;

c) ensure time and technological support is available to aid workers in using these technologies; and

d) ensure workers have the time to help residents in learning and using the technology.

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

9.1 Offering recreation therapy programs and activities

9.1.1 General

The LTC and AL setting shall take an evidence-informed, holistic person-centred and strengths-based approach in offering recreation therapy programs and activities that embrace and meet the diverse individual and collective needs of all the residents, in all stages of their lives. The implementation of recreation therapy programs and individualized interventions will enable residents to maintain physical, cognitive, emotional, and social skills to maximize their mental health, well-being, and sense of belonging, and reduce social isolation and loneliness.

9.1.2 Content of the recreation therapy program

Residents shall have access to recreation therapy interventions and programming that allow them to enjoy leisure activities, develop new skills, and function independently. There shall be a mix of therapeutic and leisure focused, facilitated and non-facilitated activities options available for residents to choose from.

The LTC and AL setting shall connect residents with others that share similar interests to engage with them in these activities.

9.1.3 Development of the recreation therapy program

Residents should be assessed by a qualified recreation therapist or other trained health professional and engaged to determine and co-develop a program and interventions using recreation, leisure, and play to address their physical, emotional, cognitive, social, and spiritual needs. The recreation therapy interventions and programming should ideally be developed, delivered, and evaluated by a qualified recreation therapist. The recreation therapist or other trained health professional should assess, plan, implement, evaluate, and document interventions to ensure quality service delivery are designed to meet the interests, choices, needs, previous lifestyles, and daily schedules of the residents. Workers, volunteers, and residents may lead, support, and deliver leisure activities, where appropriate.

9.2 Resident input into the recreation therapy program and activities

The recreation therapy program and activities shall be established according to the diverse needs of the residents. Every resident, family member, care partner, and worker shall be included in identifying activities that promote optimal mental health and well-being of residents. The assessed interests, strengths, abilities, preferences, needs, and goals of the residents shall be monitored and evaluated to determine if and when adjustments are needed. Residents shall be provided with an opportunity to express and share ideas for programming in their setting.

9.3 Types of therapy interventions and activities offered

9.3.1 Range of activities

The LTC and AL setting shall provide a diverse range of therapy interventions and activities to support residents to engage in meaningful experiences and interactions.

Note: *Refer to Annex B for a list of activities that may be offered within a recreation therapy program.*

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The LTC and AL setting shall include activities that operate at different times of the day (including ideally in mornings, afternoons, and evenings) to accommodate the schedules and routines of residents to optimize inclusion and participation.

Many of these therapy interventions and activities may be offered one-on-one, available for individuals to participate in on their own, or in a group setting. The types of therapy interventions and activities offered shall reflect the needs, abilities, and preferences of the resident population, to support their engagement and maximize their independence.

9.3.2 Culturally appropriate therapy interventions and activities

All residents have the right to request and engage in culturally appropriate therapy interventions and activities. The recreation therapy program shall include culturally appropriate therapy interventions and activities that support and affirm the individual resident's culture. The appropriateness should be determined by the resident in partnership with the care provider and through a lens of cultural safety and humility. The LTC and AL setting shall engage residents, families, care partners, and communities to ensure the recreation therapy program represents the diverse culture mix of residents in the setting. As diversity in the resident population changes, programming shall be adapted to reflect these changes.

9.3.3 Internal and external activities

The recreation therapy program shall include activities that operate inside and outside of the LTC and AL setting, including opportunities for residents to go outdoors and connect to natural environments.

Residents who express interest in visiting external settings, and are able to, should be supported and encouraged to do so when appropriate (e.g., shopping, café, theatre, botanical gardens, nature, library). Residents who wish to volunteer outside the setting, and are able to, should also be supported to do so.

The LTC and AL setting should facilitate access to appropriate transportation services that meet residents' needs, abilities, and preferences.

Note: *Refer to HSO 21001 for more details on transportation services.*

Efforts should be made to engage persons from the community and invite them to the LTC and AL settings to provide in-house access to meaningful activities, connection, and engagement opportunities for residents (e.g., local choir, magician, community service organizations).

9.4 Accessibility

9.4.1 General

The LTC and AL setting shall ensure that all residents have access to and have necessary accommodations to participate in the recreation therapy program and activities, according to their abilities.

This includes residents in secure areas as well as residents that are isolated from other residents, whether by choice, by language, by abilities, or due to public safety measures (e.g., outbreak protocols, infection prevention and control measures), etc. These residents should have access to the same level of engagement in the recreation therapy program and activities as other residents.

9.4.2 Adaptability to individual strengths and abilities

The activities and interventions selected within the recreation therapy program should enhance residents' autonomy and provide positive stimuli, varying levels of difficulty, and meet the resident's

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individual goal and desired level of interaction. The LTC and AL setting shall identify barriers and put mitigation measures and resources in place, when possible, to support inclusion of all residents with diverse physical, emotional, cognitive, mental, and psychosocial abilities in the recreation therapy activities.

Key barriers to be addressed to enhance inclusion and participation often include
a) pain management;
b) sensory impairment (e.g., hearing and vision loss);
c) mobility to participate in activities (e.g., obesity, functional or movement disorders, or residents at risk of falls);
d) sleep disturbances (e.g., daytime sleeping, insomnia);
e) cognitive and mental health conditions (e.g., dementia, anxiety, depression, apathy, and delirium);
f) linguistic abilities; and
g) social withdrawal, sense of belonging, isolation, and loneliness.

The LTC and AL setting shall support requests from residents when appropriate for assistance with accessing tools or resources needed to initiate activities independently or with minimal assistance (e.g., being handed a writing tool or turning on a radio).

As individual experiences intrinsically differ, the LTC and AL setting shall provide accommodations and support to ensure resident’s safety, security, and emotional support to enable them to participate in activities and programs.

9.5 Resources

9.5.1 General

The LTC and AL setting shall review and conduct a comprehensive evaluation of the recreation therapy program and activities involving formal and informal ways to capture feedback from residents and families at least once a year. This may also include analyzing program and resident outcomes, policies, and procedures, as well as human resources, program materials, and budget allocation.

9.5.2 Coordination of outside resources

The LTC and AL setting should have a process and policy in place to support access to outside resources that provide services within the setting and a contact person to coordinate this access.

9.6 Implementation and communication

The LTC and AL setting shall implement its recreation therapy program and activities, and communicate its availability to residents, families, care partners, and workers in a format that considers accessibility requirements, the language spoken, culture, literacy, writing, and oral comprehension of the residents. The LTC and AL setting shall enable and support its workers in the delivery of the recreation therapy program and activities. For non-facilitated activities, the LTC and AL setting shall ensure the required infrastructure (e.g., mobility devices, technology, Wi-Fi) and human resources are easily accessible to residents.

9.7 Evaluation

The LTC and AL setting shall regularly evaluate the effectiveness of its recreation therapy program and activities based on resident, worker, volunteer, family, and care partner feedback, attendance, participation, and assessed improvements in residents’ mental health and well-being.

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

10.1 General

The LTC and AL setting shall optimize mental health and well-being of residents by building, supporting, strengthening, and maintaining relationships with residents and their families and care partners. Users shall refer to HSO 21001, which covers topics relating to building caring relationships with residents and promoting the role and presence of their families and care partners. In addition to HSO 21001, Clause 10 of this Standard shall apply to further optimize mental health and well-being of residents.

10.2 Optimizing mental health and well-being of residents by building relationships with workers and volunteers

10.2.1 Promotion strategies and planning to support the mental health and well-being of residents

The LTC and AL setting shall develop strategies and plans with measurable outcomes intended to support the mental health and well-being of residents that include

a) providing orientation to the LTC and AL setting prior to move-in or immediately after move-in that includes information about care practices, routines, relevant policies, who to contact to raise questions, concerns, and suggestions, and how to raise concerns and suggestions;

b) ensuring that workers and volunteers introduce themselves and state their role to the resident when approaching them (unless they are already known by the resident);

c) encouraging and supporting the creation of a resident council (where not already provincially or territorially mandated);

Note: *This can be known as the tenant council in AL settings.*

d) supporting the participation of residents, family, and care partners in the resident council through appropriate technology, when necessary;

e) informing residents, families, and care partners of the resident council, associated activities, and initiatives, when in place;

f) implementing a process where concerns and suggestions identified by the resident council are addressed in a timely manner;

g) recognizing that mealtimes, food choices, and preferences are important from a mental health and well-being perspective. CSA Z8004 shall apply for guidance and requirements for nutrition and food management;

h) facilitating access to the services of spiritual care practitioners;

i) ensuring high-quality care at end of life (for guidance and requirements for end of life and palliative care approaches, refer to HSO 21001); and

j) providing training for workers and volunteers to support the development of positive relationships with residents (see Clause 7.5 for worker training requirements).

10.2.2 Supporting mental health and well-being of residents through shared knowledge and understanding

The LTC and AL setting shall implement practices to gain and share knowledge and understanding of residents as individuals that include

a) gathering information that includes the resident’s preferred name, what is meaningful to them, their goals, preferences, interests, strengths, limitations, capabilities, and social connections (recognizing that all of these can change over time);

b) honouring preferences and lifelong habits of the residents;

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c) designing the move-in process to get to know the resident and their family and care partner as quickly, thoroughly, and holistically as possible;
d) engaging families and care partners to share their knowledge about residents' life history, care needs, and effective care practices;
e) identifying, when possible, family members, care partners, or other individuals that will be involved in their care and their level of involvement. This may also include identifying the worker or volunteer that will provide care, when possible;
f) engaging families, care partners, and cultural organizations as appropriate to gain knowledge, promote cultural competency, and deepen the understanding of the residents' culture, language, belief systems, and traditions; and
g) ensuring the information collected above is recorded in the resident's care plan and used to support PCC planning.

10.3 Optimizing mental health and well-being of residents by building relationships with families and care partners

10.3.1 Implementing practices to engage and involve families and care partners

The LTC and AL setting shall develop a welcoming environment for families and care partners to actively participate in the promotion of mental health and well-being of residents by implementing the following practices:

a) promoting understanding of the setting by sharing the vision, mission, values, strategy, and PCC philosophy of the LTC and AL setting with families and care partners;
b) providing orientation to the LTC and AL setting prior to move-in or immediately after move-in that includes information about care practices, routines, and relevant policies, who to contact to raise questions, concerns, and suggestions, and how to raise concerns and suggestions;
c) for LTC settings, and as appropriate for AL settings, inviting families and care partners to participate in regularly scheduled resident care conferences;
d) engaging families and care partners in social connection time and providing care (e.g., family style dining, group activities, personal care, and meals where training has been provided and safety is not an issue);
e) reflecting on the importance of the presence of families and care partners as a vital source of emotional and psychological well-being for residents in visitation policies, balancing the well-being of residents with that of the risk outside visitors can introduce in some circumstances (e.g., during infectious outbreaks);
f) ensuring families and care partners are supported and informed in times of crisis and emergencies;
g) providing regular updates on resident care and health status to families and care partners; and
h) designating or providing dedicated space for families and care partners to visit or support residents.

10.3.2 Building relationships between workers, and residents, families, care partners, and communities that promote mental health and well-being of residents

The LTC and AL setting shall put the following elements into place to promote and support positive relationships and interactions between workers, residents, families, care partners, and communities:

a) allowing time for workers to develop professional relationships with family members and care partners;
b) communicating and sharing defined roles of workers and the role of families and care partners as partners in PCC and EDI;
c) when applicable, implementing a regular communication process in multiple ways to provide clear and timely information to the care partner(s) designated by the resident about changes in the

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health, capabilities, and behaviour of the resident and provide access to their care plan. The LTC and AL setting shall ensure they have the resident's or substitute decision maker's consent before sharing this information. Families and care partners shall also be kept informed of any significant changes to activities, resources, or programs that impact the mental health and well-being of the resident;

d) encouraging and supporting the creation of a family council (where not already provincially or territorially mandated);
e) informing residents, families, and care partners of the family council, associated activities, and initiatives, when in place;
f) implementing a process where concerns and suggestions identified by the family council are addressed in a timely manner;
g) building relationships that will support resident engagement and involvement with the community outside of the setting;
h) providing ongoing education to workers and volunteers on understanding families and care partners' experiences in care, recognizing emotional responses and reactions such as stress and grief, and interacting with families and care partners effectively and as essential partners in care;
i) considering the creation of care navigator roles to facilitate effective communication and advocacy, particularly for residents without family or care partners; and
j) providing access to education to families, care partners, and volunteers about dementia and mental health, as well as how to support persons living with dementia who are experiencing changes in their mood, personality, or behaviour.

10.3.3 Resources to support the mental health and well-being of families and care partners

The LTC and AL setting shall facilitate support for families and care partners through times of transitions and emotional distress related to the resident. This may include ensuring contact with family and care partners shortly after move-in and encouraging families and care partners to seek available emotional and mental health support if required.

10.4 Building relationships among residents to support their mental health and well-being

The LTC and AL setting shall foster spaces that encourage relationships, communication, and positive interactions between residents.

Note: *Examples include*

a) *social gatherings within the setting;*
b) *group activities (see Clause 9.3);*
c) *meet and greets;*
d) *pairing residents with similar backgrounds and interests; and*
e) *offering education to residents about EDI, mental health, and dementia (including how to support residents experiencing changes in their mood, personality, or behaviour).*

11 Support for residents with mental health conditions

11.1 Addressing mental health needs

11.1.1 General

Mental health conditions including dementia, depression, anxiety, and serious mental illness, such as schizophrenia and bipolar disorder, are more common in LTC and AL residents than among similarly

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aged individuals in other community settings (Seitz et al., 2010; Bucy et al., 2022). The transition to AL or LTC is a major life event for many, and relocation to these settings represents a period of increased stress and vulnerability to depression, anxiety, or worsening of underlying mental health conditions (Polacsek and Woolford, 2022). Despite the need, owing to many barriers to mental healthcare in these settings, mental healthcare has historically been inadequate in LTC and AL. Amid a growing population of residents with mental health conditions or symptoms in LTC and AL, access to high-quality and person-centred mental healthcare should be prioritized.

Mental health support in LTC and AL settings shall address needs across the continuum of mental health and well-being as applicable to each individual, including the promotion of mental well-being for all. For residents with complex needs, such as those with mental health conditions, mental health support shall additionally include accurate recognition and diagnosis, as well as comprehensive treatment.

Note: *Refer to HSO 22004 for more details on mental health and addictions services.*

11.1.2 Specialized mental health resources

The majority of residents in LTC, and many in AL settings, have a mental health condition, including dementia, often in addition to other medical problems (MacCourt et al., 2011). Approximately 40% of LTC residents have clinically significant, active mental health needs (Perlman et al., 2019; Kehyayan et al., 2021). This creates the need for access to specialized mental health resources.

For workers to be able to address the care needs of residents requiring mental health support, the LTC and AL settings shall have sufficient staffing levels and appropriate workforce skill mix and training. Where residents have additional or complex mental health needs, LTC and AL settings shall ensure residents have access to specialized mental health resources needed to support their overall well-being and healthcare needs.

11.1.3 Planning

While availability of specialized mental health resources can vary within a geographic area, LTC and AL settings shall have a plan in place to access specialized mental health resources when required.

The LTC and AL setting should ensure that dedicated mental health workers (such as social workers, mental health clinicians, therapists, or other mental health workers), based on needs, are available to support the mental health of the residents on an on-going basis.

11.1.4 Continuation of services

The LTC and AL setting should attempt to ensure continuity of specialized mental health services and supports that the resident received prior to admission into the setting, whenever possible. This includes ensuring that information pertaining to current and past treatment or other history that is relevant to ongoing mental health care is obtained.

To support continuity of care with pre-existing mental health services and supports, the LTC and AL setting should facilitate transportation, appointment scheduling and communication with services and supports, and other related needs (e.g., technology and staffing for remotely delivered care).

11.1.5 Workforce training

The LTC and AL setting shall ensure that all workers involved in care have received the training outlined in Clause 7.5 such that they have basic knowledge and skills in the support of common mental health conditions. Furthermore, specialized mental health workers should provide proof to the LTC and AL

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setting of the maintenance of their required competencies and skills to support mental health conditions.

11.1.6 Models for providing specialized mental health care

In the absence of direct consultation support, models of care that leverage available specialized mental health resources among the LTC and AL workers should be explored.

Note: *Examples of models of care include*

a) *Behavioural Supports Ontario (BSO) that utilizes a stepped care approach consisting of embedded or mobile specialized teams (e.g., registered nurses, registered practical nurses, personal support workers) in the LTC and AL setting (https://hnhb.behaviouralsupportsontario.ca/);*

b) *mobile teams supported by a psychiatrist or geriatric psychiatrist providing case conferencing opportunities that support both patient care and worker development;*

c) *psychogeriatric consultation teams or consultation liaison services that provide both direct and indirect consultations;*

d) *virtual healthcare delivery such as videoconferencing, e-consult, and other emerging technologies; and*

e) *dedicated behavioural support or dual diagnosis units for complex cognitive or mental health needs.*

11.1.7 Specialized mental health resources as essential workers

Specialized mental health resources, such as mental health workers, shall be considered essential workers in the event of situations necessitating visitor restrictions such as infection control restrictions. Access to mental healthcare shall be maintained by continuing to allow mental health workers to enter the LTC and AL setting according to the setting's policies.

11.2 Mental health assessments

The LTC and AL setting shall put into place the following:

a) assessments for residents displaying mental health symptoms (e.g., anxiety, depression, suicidal ideation), cognitive impairment, and/or changes in behaviour (e.g., aggression). The resident's circumstances (e.g., personal history, recent major life or health changes, losses, or other stressors), shall be considered in the interpretation of assessments and in related care planning;

b) reassessment with frequency determined based on the resident's needs, observed or documented changes, circumstances, and the setting;

c) validated, standardized assessment instruments appropriate to the individual (e.g., instruments validated for specific age groups or in persons with dementia) and culturally and language-appropriate assessment tools where available;

d) routinely used assessment tools in LTC settings [e.g., interRAI Long-Term Care Facilities (LTCF) assessment] and AL settings [e.g., interRAI Community Health (CHA-AL) assessments] incorporated in resident assessment processes. For example, results of these routine assessments can serve as a tool for care coordinators to identify residents requiring further assessment;

e) clear protocols for acting on assessment results; and

f) the incorporation of the results of assessments into care plans to address identified needs.

The LTC and AL setting shall ensure that workers conducting assessments are trained in the administration and interpretation of the assessment tools administered.

11.3 Care plans

11.3.1 General

The LTC and AL setting shall develop care plans for each resident that address mental health promotion and treatment of mental health conditions, where necessary. This shall be developed by an

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interprofessional team, which may be composed of physicians, pharmacists, social workers, nurses, or leadership, depending on the setting. Users shall refer to HSO 21001 for requirements and guidelines to develop individualized care plans. In addition to HSO 21001, Clause 11.3 of this Standard shall apply to further promote and support the mental health and well-being of residents.

11.3.2 Care plan development

The LTC and AL setting shall include input and preferences from the resident, family, and care partner where possible in the care plan development. This input shall be integral to the care plan. The care plan shall be regularly updated and promote the principles of PCC and be based on the resident's history, diagnoses, needs, preferences, and capabilities.

The LTC and AL setting shall also recognize and emphasize the significance of cultural competence and gender sensitivity in all aspects of mental health support, spanning from assessment to the development of care plans.

11.3.3 Care plan content

Care plans shall include

a) goals of care that are specific, measurable, attainable, realistic, and time-bound (SMART), whenever possible;
b) strategies for promoting mental health and well-being;
c) documentation of signs and symptoms or changes in symptoms for new and existing mental health conditions;
d) interventions for identified mental health conditions or symptoms, including non-pharmacological approaches and, where indicated and if appropriate, pharmacological treatment; and
e) provisions for monitoring and evaluating the outcome of interventions, to be shared with the resident or their substitute decision maker.

11.3.4 Treatment approaches

11.3.4.1 General

Interprofessional interventions in treatment approaches shall be employed. Interventions shall routinely include non-pharmacological approaches, either alone or in combination with pharmacological treatments, when indicated. See Annex C for non-pharmacological treatment options for dementia, delirium, and depression.

Physical health problems (e.g., pain, infection) and/or medications that can contribute to or exacerbate mental health conditions shall be recognized and appropriately addressed.

Pharmacological treatment approaches should be prescribed where indicated (e.g., based on severity of symptoms and/ or response to non-pharmacological approaches) and described in the care plan with monitoring of effectiveness.

Treatment approaches shall be guided by the LTC or AL setting's policy and procedures on the use of least restraint.

The LTC or AL setting should strive to address changes in mental health status of residents, either due to pre-existing mental health conditions or due to new symptoms, using resources available or possible to access within the setting when possible, and in collaboration with families and care partners.

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11.3.4.2 Intervention outcomes in care plans

An assessment of the outcome of interventions shall be documented in the care plan and shall include
a) evaluation of the effect of any newly implemented treatment approaches at regular intervals;
b) identification of the individual(s) responsible for assessment and reassessment;
c) determination of the frequency of monitoring and follow-up; and
d) documentation of the response to interventions.

For residents who have been or who are newly prescribed antipsychotic or other hypnotic/sedative medications, there shall be a process for regular review of appropriateness, ongoing need, and for medication discontinuation when deemed no longer necessary. Where antipsychotic or other hypnotic/sedative medication are appropriate and there is ongoing need, the indication for treatment shall be clearly documented in the care plan.

12 Critical incident management

12.1 General

LTC and AL settings are at heightened risk of critical incidents and crises occurring, which can be particularly distressing to the mental health of residents as well as to their families and care partners. Such events can include natural disasters, public health (e.g., pandemics), or human-caused events (e.g., physical aggression, self-harm) that threaten the health and safety of workers or residents.

Note: *Refer to CSA Z1600 and to CSA Z8004 for more information.*

12.2 Management by the workforce

The LTC and AL setting shall ensure that critical incidents are managed by the workforce working as a team. The LTC and AL setting shall ensure workers are appropriately trained in recognizing and responding to these events. They shall be made aware of emergency resources available both in their setting and through community and health system partners.

12.3 Support

The LTC and AL setting shall be aware of the potential impacts of critical incidents on the mental health and well-being of the residents and workers.

LTC and AL settings shall make resources available to support workers, residents, families, and care partners during and following critical incidents. After a critical incident, the LTC and AL setting should encourage workers, residents, families, and care partners to seek mental health support or other assistance as needed through available resources such as their own healthcare provider, support groups, or employee assistance programs. A post-critical incident stress debrief shall be made available.

12.4 Processes and protocols

The LTC and AL setting shall develop, document, and sustain processes and protocols for critical incident management, which shall be reviewed regularly, at minimum on an annual basis.

These processes and protocols shall include the following strategies for incident preparedness, prevention, mitigation, and response:
a) Ensure workers are trained to recognize and respond to critical incidents or crises including recognizing and responding to the adverse effects of critical incidents on the mental health of residents, families, and care partners.

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b) Perform a risk assessment and put in place a management process that includes identifying possible early warning signs of a crisis or critical incident and strategies, plans, and procedures that aim to prevent an incident, where possible.
c) Establish a response plan describing the actions to be taken during or immediately after an incident to manage its consequences, including
   i) responding during a crisis or critical incident, which may include intervention techniques such as
      1) appropriate and timely involvement of other healthcare professionals or community partners (e.g., primary care physicians, police, fire, and rescue services);
      2) appropriate use of mechanical and chemical restraints (e.g., emergency PRN medication); and
      3) appropriate indications and procedures for transfer for treatment (e.g., to emergency department) and if appropriate, use of relevant mental health act legislation (e.g., certification);
   ii) evacuation protocols for natural disasters;
   iii) infection prevention and control protocols that consider the mental health of residents (refer to CSA Z8004); and
   iv) identifying residents who require additional mental health support and provide appropriate support.
d) Document and report critical incidents and crises as per policy and per jurisdictional requirements, which should include
   i) a description of the event with suspected precipitating or causative factors;
   ii) which worker, resident, family member, or care partner was affected by the incident;
   iii) what actions were taken; and
   iv) the outcome of the event and who was informed (e.g., police, physicians, family members, care partners).
e) Provide support to affected residents and their families and care partners during and after a crisis (including grief counselling).
f) Provide a supportive environment for families and care partners to communicate concerns regarding the potential or actual impact of a critical event or crisis on the mental health of a resident.
g) Establish a process for communicating timely information regarding a critical incident or crisis event to those impacted.

13 LTC and AL considerations for younger residents

13.1 General

Younger residents (defined as 18 to 64 years) are a minority in LTC and AL settings, where the average age is 83 years old (CIHI, 2022). However, younger residents differ from older residents by more than age. Compared to older residents, younger residents are more likely to have developmental or severe physical disability, chronic disease, and mental health conditions, particularly depression (Barber et al., 2021). Generational differences, earlier life stage, and longer lengths of stay in LTC and AL settings coupled with complex health challenges create distinct needs for their mental health and well-being. These age- and illness-related differences also influence the perspectives, values, and preferences that can impact transitions, programming, activities, and relationships in LTC and AL settings. See Annex D for additional context on younger residents.

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13.2 PCC principles for younger residents

Note: *Many of the needs and challenges relevant to mental health and well-being in LTC and AL settings are common among all residents. However, owing to the variety of factors described in Clause 13.1 that are more common among younger residents, these settings are experienced differently by younger compared to older residents.*

While the LTC and AL setting shall embrace and enable all PCC principles (see Clause 4.2), the following additional PCC considerations shall inform care to support mental health and well-being of younger residents. The LTC and AL setting shall

a) address medical needs arising due to earlier stage of life (e.g., personal hygiene, reproductive health);

b) consider unique preferences (e.g., activities, socializing) due to differences in perspectives, priorities, and preferences based on age and abilities;

c) facilitate maximum independence for those with physical disabilities (e.g., accomplishing some tasks alone, emphasizing choice, and autonomy);

d) promote self-expression and identity (e.g., via choice of grooming and clothing); and

e) consider potential losses particular to the younger resident (e.g., over physical abilities at an early life stage, employment, school, and early separation from family and community) and include practices to mitigate the effect of these losses.

Note: *These principles might not be unique to younger residents but are known to be of particular importance for supporting their mental health and well-being while residing in LTC and AL settings.*

13.3 Transitions

Note: *The transition to living in LTC and AL requires adaptations for all ages. However, the adjustment process for younger residents can be atypical. Adjustment to the LTC and AL setting for younger residents can be complicated by the grieving process over many losses more common in earlier life, as well as challenges unique to earlier life stages, such as parenting minor children, careers cut short, and limited income due to interrupted employment, lack of pension, or retirement savings.*

The LTC and AL setting shall develop a specific transition approach for younger residents, taking into consideration the unique psychosocial needs of this population. The LTC and AL setting should promote access to psychological counselling to support coping, adjustment, and grieving processes linked to the transitions and losses for younger residents.

Assessment tools specific for younger residents may be used to help LTC and AL settings develop specific transition approaches for this population (Hazelton-Provo and Weeks, 2021).

13.4 Rehabilitation program

Note: *Younger residents in LTC and AL have greater physical care requirements on average compared to older residents. Required equipment (e.g., motorized wheelchairs, splinting devices) and rehabilitation needs might be unfamiliar to workers in these settings. Enhanced rehabilitation programming helps younger residents be as independent as possible in everyday activities and enables participation in school, work, leisure, and meaningful life roles that are essential to their mental health and well-being.*

The LTC and AL setting shall implement a rehabilitation program focused on younger residents with access to rehabilitation professionals who can assess and prescribe equipment (including assistive technology) and therapeutic activities that address mobility needs (including management of spasticity, positioning, sensory dysfunction, tremors, ataxia, and positioning needs), eating, communication, swallowing, and limitations in performing age-appropriate activities of daily living.

This program shall ensure access to occupational therapists, physical therapists, speech therapists, as well as restorative aides, with expertise in the conditions of younger residents to help maximize independence, mobility, and quality of life through rehabilitation.

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13.5 Workforce and care relationships

The LTC and AL setting shall ensure

a) workers have knowledge and specific training for the complex care support of younger residents and the unique mental health and well-being issues they face;
b) consultations with healthcare providers or specialists with expertise of younger residents with complex conditions are accessible;
c) workforce levels and mix are sufficient to take into consideration younger residents whose interests and activities are aligned with the broader community working age population, whose majority of activities might occur evenings, nights, and weekends;
d) younger residents are involved in the development, design, and implementation of worker training; and
e) training regarding appropriate boundaries in relationships with younger residents is provided.

13.6 Activities and community participation

Note: *Younger residents in LTC and AL settings value connection with the community and with peers that are similar in age and life stage. Age and life stage also influence interests and preferences for recreation activities.*

The LTC and AL setting shall provide younger residents opportunities to continue to participate actively in community life, in their pursuits of work, school, or leisure, if desired, both within the LTC and AL setting and in the broader community by

a) providing access to places that facilitate the instrumental aspects of daily living (e.g., grocery shopping, personal care services, banking) that will enhance autonomy and independence;
b) facilitating access to assistive technology and other technology necessary (e.g., high-speed Wi-Fi) to facilitate work, school, and leisure activities;
c) working with the younger residents to identify their leisure and recreation interests inside and outside the care setting that can be adapted to meet their needs;
d) seeking opportunities to work with external organizations (e.g., community service organizations, libraries, post-secondary schools) to support younger residents to enrich their work, school, and leisure activities;
e) providing access to opportunities that foster social engagement (e.g., accessible restaurants, parks, coffee shops) with those of similar age, ability, or interests;
f) support flexible scheduling of activities of daily living and outside activities including those that occur on evenings and weekends; and
g) working with community agencies, families, care partners, friends, and municipal governments to arrange accessible transportation.

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Annex A (informative)
Lighting levels to promote mental health and well-being

Note: *This Annex is not a mandatory part of this Standard.*

A.1 General

Residents will benefit from lighting levels synchronized to promote their natural circadian rhythms, improve their sleep hygiene, their daytime wakefulness, facilitate appropriate melatonin production, and prevent night-time falls, as well as help to support their emotional and behavioural health (Brown et al., 2022).

A.2 Daytime lighting

To promote mental health and well-being, it is best to be exposed to 10 to 30 minutes of natural light each day. If this is not possible, daytime lighting should mimic bright daylight levels, achieving at least 1000 lux, though increased benefit is realized at levels above 2000 lux, with lighting rich in blue spectral wavelengths (460 to 520 nm) or full spectrum white light, to help cue wakefulness. This should be maintained for at least 1 to 2 h starting upon wakening but can also be maintained throughout the day (Bailes and Lucas, 2013; Brown et al., 2022).

A.3 Evening lighting

At least 3 h prior to bedtime, the lighting should shift to yellow-amber spectral wavelengths (>580 nm) with intensity at 50 lux (Munch et al., 2006; Brown et al., 2022).

Light switches capable of producing an arc of dimming light towards evening are preferrable (IWBI, 2020; Brown et al., 2022).

A.4 Nighttime lighting

Resident rooms should be fitted with effective window coverings capable of reducing light to below 5 lux during sleep hours. Floor-level, down-facing lighting illuminating a path to the bathroom should also be installed (IWBI, 2020; Brown et al., 2022).

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Annex B (informative) ***Examples of activities offered within a recreation therapy program***

Note: *This Annex is not a mandatory part of this Standard.*

Activities offered within a recreation therapy program are typically those that meet a variety of cognitive, physical, emotional, psychosocial, or social needs. These activities may also be offered outside of a therapeutic program to support well-being and engagement. The following is a non-inclusive list of activities that may be offered by LTC and AL settings within their recreation therapy programs:

a) animal support interventions;
b) arts and crafts;
c) board games, puzzles, cards, chess, bingo, trivia, etc.;
d) bocce ball, bowling, mini golf, etc.;
e) book clubs or other topic-based clubs;
f) choir singing;
g) comfort therapy (e.g., plush toys, lifelike dolls; therapeutic robots);
h) cooking (including table setting and food conservation);
i) drama and musical theatre;
j) education or learning programs;
k) exercise (e.g., stretching, walking, rolling, tai chi, yoga, dancing);
l) family-style dining;
m) horticulture;
n) intergenerational activities;
o) journaling;
p) laughter sessions;
q) music (listening to radio and personal electronic devices or playing instruments, individually or as a band, as well as drumming);
r) problem solving;
s) reading;
t) religious or spiritual activity;
u) mindfulness activities (meditation, relaxation);
v) reminiscence sessions;
w) sensory stimulation such as acupressure, aromatherapy, massage or touch therapy, and light therapy;
x) special entertainment (e.g., dancers, singers, musicians);
y) storytelling;
z) quilting, embroidery, and sewing;
aa) watching television programs, internet and video streaming, and movies;
ab) woodworking or carving, mechanics, handyperson activities; and
ac) virtual reality, video games, and internet or computer use.

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Annex C (informative) ***Non-pharmacological treatment options for dementia, delirium, and depression***

Notes:
1) *This Annex is not a mandatory part of this Standard.*
2) *This Annex is not meant to present exhaustive information on non-pharmacological treatment options for dementia, delirium, and depression, nor serve as an implementation guide. The treatments, therapies, interventions, or approaches listed are provided as examples only to support the care outlined in this Standard.*

C.1 Non-pharmacological treatment options for changes in mood, personality, or behaviour in dementia

C.1.1 General

The benefits of non-pharmacologic approaches in the treatment of dementia, as well as changes in mood, personality, or behaviour due to dementia, are influenced significantly by the setting in which they are administered. This includes the design and implementation of interventions that consider both the physical and the social environment, and both initial and ongoing training in dementia and mood, personality, or behaviour changes supported by enabling organizational factors (Caspar et al., 2018).

In each approach, it is important that the resident’s autonomy and self-determination be facilitated and promoted as a key outcome. Similarly, best outcomes are achieved when applied on an individualized, resident-specific basis.

C.1.2 Indirect and direct interventions

Two broad categories of non-pharmacological strategies have been identified in the literature: indirect interventions, including working with care partners or adapting the environment, and direct interventions, including those that focus directly on individuals with dementia (e.g., individualized recreation therapy, sensory-based therapy, exercise, music therapy, massage) (Grand et al., 2011).

C.1.3 Essential mechanisms

Along with these approaches, the following mechanisms are considered essential for the effective implementation of interventions to reduce mood, personality, or behaviour changes (Caspar et al., 2018):

a) the caring environment;
b) care skill development and maintenance; and
c) individualized care.

C.1.4 Behavioural and environmental modification strategies

Many behavioural and environmental modification strategies can be helpful for mood, personality, or behaviour changes in dementia. The following strategies have been proposed (Kales et al., 2014):

a) activity and routine:
   i) providing activities that optimize a resident’s strengths, capabilities, and interests;
   ii) creating or providing structured, consistent daily routines;
   iii) providing activities involving repetitive motion (e.g., folding towels, sorting buttons); and
   iv) setting up activities and helping the resident initiate participation;

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b) care partner education and support:
   i) conveying that changes in behaviour can be an indication of an unmet need of the resident or caused by changes in the brain (e.g., progression of dementia);
   ii) relaxing the rules (e.g., baths do not have to occur every day);
   iii) explaining that with dementia progression, the resident might require more guidance and cueing for initiating or completing tasks;
   iv) avoiding confrontation and avoiding trying to reason and convince;
   v) self-care and finding and taking opportunities for respite; and
   vi) identifying and utilizing a support network;
c) communication and person-centred care approaches:
   i) interacting in a non-confrontational way, appropriate to the resident's cognitive capabilities, and allowing adequate time for the resident to respond;
   ii) providing one- to two-step simple verbal commands;
   iii) using a calm, reassuring voice;
   iv) offering simple choices (e.g., no more than two at a time);
   v) avoiding a harsh tone and negative words;
   vi) approaching the resident in the resident's direct line of sight;
   vii) requesting permission to provide care (especially when it requires physical touch);
   viii) letting the resident know beforehand what care will be provided (e.g., step-by-step);
   ix) reassuring, validating concerns, and redirecting;
   x) identifying self or other residents for those with difficulty recalling names; and
   xi) helping the resident find words for self-expression through verbal or non-verbal methods (e.g., art, music, dance, visual materials, communication tools);
d) environment:
   i) removing clutter;
   ii) ensuring the temperature is ideal for the resident's comfort (e.g., temperature control, providing a warm blanket);
   iii) encouraging proper sleep hygiene, by controlling sounds, temperature, and light, as well as attempting to limit daytime napping and night-time wakefulness;
   iv) using labelling and visual cues (e.g., arrows pointing to bathroom);
   v) eliminating noise and distractions whenever possible;
   vi) ambient music; and
   vii) enhancing and making the environment more interesting; and
e) simplifying tasks:
   i) breaking tasks into simple steps; and
   ii) using verbal, tactile, visual, or other prompts at each step.

C.1.5 Other therapies

Alternative non-pharmacologic treatments and approaches that may be considered and tried on an individual or incident-specific basis include, but are not limited to,
a) cognitive behavioural therapy;
b) cognitive rehabilitation programs;
c) problem adaptation therapy;
d) validation therapy;
e) art therapy;
f) music therapy;
g) light therapy;
h) aroma therapy; and
i) reminiscence therapy.

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For more severe symptoms, a comprehensive, integrated interprofessional team-based approach combining medical, psychiatric, and nursing interventions may be utilized.

C.2 Non-pharmacological treatment options for delirium

C.2.1 General

Non-pharmacological treatment approaches for delirium include

a) direct care strategies;
b) organizational support strategies built on the education of workers on delirium;
c) the development of policies and guidelines for a proactive approach over the use of physical restraints;
d) polypharmacy; and
e) use of indwelling catheters.

Communication, education, information, and resident support (reassurance and support when not lucid and education when they are) are vital in these approaches as delirium can be quite distressing for all involved.

C.2.2 Prevention and observation

The management of delirium using non-pharmacological approaches starts with active prevention and observation. The Registered Nurses' Association of Ontario recommends in their clinical best practice guidelines that healthcare providers working in a hospital or long-term care setting observe residents at least daily for recent (e.g., within hours or days) changes or fluctuations in behaviour (RNAO, 2016). Early screening and diagnostic tools (such as the DOS and CAM) can improve diagnosis. There is also a need for training of workers in the proper administration of these tools.

C.2.3 Direct care strategies

Direct care strategies for delirium may include, but are not limited to (Boland et al., 2019),

a) correcting predisposing conditions (e.g., hearing or vision);
b) encouraging mobilization;
c) improving sleep-wake patterns (e.g., day exposure to daylight, discouraging naps, evening non-caffeinated drinks, relaxing music, minimizing light and noise disruptions);
d) providing orientation activities (e.g., explaining where the resident is, who they are, who you are, and your role, as well as using an orientation board, a visible clock, and cognition stimulation activities such as reminiscence); and
e) minimizing room changes.

C.2.4 Organizational support strategies

Organizational support strategies for delirium may include, but are not limited to,

a) providing workers with education on delirium;
b) allocating adequate workforce; and
c) developing policies and guidelines for harmful procedures (e.g., physical restraints, polypharmacy, unnecessary indwelling catheters).

C.2.5 Process of care strategies

Process of care strategies for delirium may include, but are not limited to,

a) routinely screening for delirium and changes in cognitive function;

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b) encouraging or aiding with eating and drinking to ensure adequate intake, including use of dentures, proper positioning, and nutrition supplements as needed;
c) providing regular bowel routines to avoid constipation;
d) minimizing the use of indwelling catheters; and
e) avoiding the use of physical restraints.

C.2.6 Physical environment strategies

Physical environment strategies for delirium may include, but are not limited to,
a) providing lighting to match time of day windows for outdoor exposure, curtains or blinds open during the day, and minimal lighting at night;
b) avoiding room changes; and
c) providing a single room for the resident.

C.3 Non-pharmacological treatment options for depression

C.3.1 General

Availability of non-pharmacological treatments for depression varies widely by location and setting, and some treatments might not be appropriate for all individuals. Most non-pharmacological treatments for late-life depression have been studied in persons without cognitive impairment or frailty, with mild depressive symptoms, and “younger” older adults (i.e., less than 80 years old). Choice of non-pharmacological treatments should thus be guided by accessibility and individual factors (e.g., treatment preferences, ability to participate, depression severity). The following non-pharmacological options for the treatment of depression may be considered:
a) psychotherapy cognitive behaviour therapy, problem solving therapy, life review or reminiscence therapy;
b) physical exercise;
c) interventions that reduce social isolation; and
d) mind-body interventions (e.g., tai chi, yoga, and mindfulness-based stress reduction).

Grief or bereavement counselling may be considered to support residents who are experiencing grief or mourning the loss of a loved one.

C.3.2 Additional treatment options for LTC

In LTC settings specifically, the following non-pharmacological treatments for depression may be considered:
a) horticulture and gardening therapy;
b) pet therapy;
c) music therapy;
d) physical exercise programs;
e) psychoeducation;
f) CBT and life review or reminiscence therapy; and
g) other interventions that reduce social isolation (e.g., intergenerational activity programs).

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Annex D (informative)
Additional context on younger residents

Note: *This Annex is not a mandatory part of this Standard.*

D.1 Background

In this Standard, younger residents are defined as those aged 18 to 64 years old, which includes middle aged adults (50 to 64 years old). Residents younger than 65 made up 6.8% of all residents in 2021 and 2022 (CIHI, 2022) and the percentage of younger residents in LTC might be increasing (Shieu et al., 2021). Barber et al. (2021) noted that "Adults with disabilities younger than 65 years are the fastest growing population within public long-term care (LTC) health systems". This subset of the population comprises approximately 15% of the total LTC population across the United States (Harris-Kojetin et al., 2019), 6% in England (NHS, 2018), and 7% in Canada (CIHI, 2022).

D.2 Length of stay

The average length of stay for older residents in LTC is approximately 1 to 2.5 years (Hoben, 2019), which differs from younger residents whose length of stay might be several decades long.

D.3 Characteristics of younger residents

Younger residents in LTC can be characterized based on the etiology of common illnesses and/or disabilities among younger residents (Barber et al., 2021; The Society for Post-Acute and Long-Term Care Medicine, 2023) which includes

a) chronic and progressive neurologic disease [multiple sclerosis (MS)];
b) Huntington's disease (HD);
c) amyotrophic lateral sclerosis (ALS);
d) serious mental illness (e.g., schizophrenia);
e) catastrophic or traumatic injury; and
f) developmental disability.

Compared to older residents in LTC and AL settings, younger residents are more likely to have had long-term or severe disability, sometimes from birth or childhood, abrupt onset of disability due to trauma (e.g., traumatic brain injury, spinal cord injury), or mental health conditions.

Additionally, as a minority in the LTC and AL setting and because they might have less extensive family support, the issues of loneliness and social isolation from their peers are considerable. All the above have implications for younger residents' mental health and well-being.

D.4 Needs of younger residents

The different clinical syndromes affecting younger adults as well as psychosocial factors combine to influence the needs and goals of care for younger residents. Specifically, younger residents have distinct needs from older residents in several areas including, but not limited to, physical health including sexual and reproductive health, social, psychological, and emotional needs (Oliver et al., 2020). This is not to say that these areas are not as important for the mental health and well-being of all residents, including older residents. In fact, what both younger and older residents consider as important to quality of life in LTC and AL is similar (Shieu et al., 2021).

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D.5 Additional articles related to younger residents in LTC and AL settings

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D.6 Innovative practices

The following is a list of innovative practices:

a) *Inclusio* by Accessible Housing (Calgary, Alberta) is a fully accessible, supportive living home for adults with limited mobility who require some assistance with activities of daily living but also value autonomy and independence (https://accessiblehousing.ca/inclusio/).

b) *The Boston Home* is a national model for the care of adults with advanced progressive neurological disorders, primarily multiple sclerosis. They provide the highest level of care in a specialized residential facility. The Boston Home's mission is to help the residents live as independently as possible. Residents have full access to the building and campus grounds. They use motorized wheelchairs equipped with wireless door and elevator sensors. iPads and computers with voice recognition software enable residents to connect to others beyond the campus (https://www.thebostonhome.org/).

c) *Leonard Florence Center for Living* offers revolutionary ALS (amyotrophic lateral sclerosis) and MS (multiple sclerosis) houses. The advanced technology used enables the residents to independently navigate the spaces. Some highlights include first urban Green House® model of care in the country, ventilator homes, traditional long-term care, short term rehab, 10 households comprised of 10 rooms each, all private rooms and baths, and meals prepared in each household (https://chelseajewish.org/communities/leonard-florence-center-for-living/).

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Annex E (informative)
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