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Canadian Long-Term Residential Care Staff Recommendations for Pandemic Preparedness and Workforce Mental Health

RESEARCH

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ABSTRACT

Context: The impacts of Covid-19 pandemic conditions in Canada's long-term residential care (LTRC) sector have demonstrated that future pandemic preparedness necessitates not only recovery but deeper sectoral transformation of longstanding vulnerabilities. Improving workforce mental health and resilience is central to these transformative efforts.

Objective: This study presents a content analysis of staff recommendations for pandemic preparedness and employee mental health in LTRC.

Methods: Qualitative data were gathered through semi-structured interviews conducted with 50 LTRC staff members from 12 organizations. The interviews aimed to gain insights into supporting worker mental health in the first wave of the Covid-19 pandemic. Participant responses to a question seeking recommendations for future pandemic preparedness were extracted and analyzed using qualitative content analysis.

Findings: Our findings encompass staff recommendations organized into seven categories: 1) Risk reduction and compensation, 2) Staffing reappraisal, 3) Opportunities for relief, 4) Spaces to be heard, 5) Improved communication, 6) Cultivating responsive leadership, and 7) Redefining public accountability.

Limitations: The data primarily relied on interviews with LTRC workers from western Canada.

Implications: Recommendations are situated within existing policy and research for worker mental health and staffing. We discuss how supporting and listening to LTRC workers can strengthen pandemic preparedness, workforce mental health, and delivery of quality person-centered care. We position the increased presence of worker voices in knowledge generation and policymaking as vital for realizing the sectoral transformations needed in LTRC.

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INTRODUCTION

Three days prior to the World Health Organization (WHO) declaring a pandemic on March 11, 2020, (WHO, 2020), Canada's first Covid-19 death was recorded in a Long-Term Residential Care (LTRC) facility in British Columbia, resulting from an outbreak in which a total of seven residents died, and 36 residents and 18 workers were infected (Hager & Woo, 2020). This outbreak marked the beginning of a protracted crisis with disproportionate impacts to residents and workers of Canada's LTRC homes. This crisis has many international parallels (Comas-Herrera et al., 2020) and yet the proportion of Covid-19 burden concentrated in Canadian LTRC was particularly high compared to other OCED countries (Canadian Institute for Health Information, 2021). Canada's National Institute on Ageing (2022) monitored Covid data across Canadian LTRC homes until July 2022, after which data collection was paused due to a lack of reliable provincial data. At that time, a total of 107,461 LTRC resident cases and 58,715 staff cases were reported, with the deaths of 17,177 LTRC residents and 32 staff (National Institute on Ageing, 2022). Behind these numbers are the systemic vulnerabilities of LTRC that have been newly exposed by the pandemic, and awareness is rising regarding the need for transformation. This study aims to bring residential LTRC employee perspectives to the fore of the research and policy agenda with a content analysis of worker recommendations for pandemic preparedness and employee mental health in LTRC. The remainder of the introduction backdrops our study beginning with a review of the distinct and longstanding contexts of workplace mental health in LTRC. We follow with a review of emerging evidence about how the pandemic is affecting LTRC worker mental health. The introduction closes with an overview of policymaking opportunities and challenges, and by positioning this study as contributing to LTRC sectoral reform through centering worker voices in knowledge generation.

CONTEXT OF WORKPLACE MENTAL HEALTH IN LTRC

Understandings of the Canadian LTRC workforce as a whole are limited by the lack of consistent pan-Canadian data (Canadian Institute for Health Information, 2021b), and this knowledge gap includes mental health and wellbeing. While a large cross-sectional survey found poorer mental health among LTRC staff providing direct care compared to the general Canadian population (Hoben et al., 2017), the current state of knowledge precludes broad statements about workplace mental health in Canadian LTRC. For this reason, we start with a review of pre-pandemic literature that used related concepts such as burnout and job satisfaction as a means to understand the context of workplace mental health in LTRC, including rewarding aspects of LTRC work.

Unique aspects of LTRC workplace mental health were captured in a 2015 study in which Estabrooks et al. surveyed 1381 Health Care Aides (HCAs) across 30 Western Canadian LTRC homes on various health and work measures including the Maslach Burnout Inventory (MBI). Although care aides reported moderate risk levels for emotional exhaustion and cynicism, Estabrooks et al. (2015) characterized participant scores on job efficacy, defined as meaning and purpose, as "unusually high" (p. 52). A similar profile of high job efficacy amidst moderate emotional exhaustion and cynicism was observed in a descriptive profile of 757 regulated nurses in western Canadian facilities (Squires et al., 2019). In a longitudinal study with 1899 care aide participants across a stable cohort of 18 Canadian LTRC facilities from 2010 to 2015, Chamberlain et al. (2019) found that job efficacy remained relatively stable over time and across the regions studied, while emotional exhaustion and cynicism varied regionally which Chamberlain et al. attributed to "organizational context conditions" (p. 46) produced by regional differences in LTRC delivery.

The importance of organizational context is supported by other studies which have found associations between organizational factors and job satisfaction within specific roles in LTRC. In a systematic review of 42 studies of job satisfaction among care aides in LTRC facilities, Squires et al. (2015) identified facility resources and workload allocations as predictive of care aide job satisfaction. Similarly, Chamberlain et al. (2016) reported that measures of leadership, culture, social capital, slack time, and slack space were organizational predictors of job satisfaction in a survey study of 1224 care aides from 30 western Canadian LTRC homes. In a study focused on 78 LTRC nurses, authentic leadership, resource adequacy, and participation in organizational decision-making were found to be predictive of job satisfaction (Wong et al., 2020). Aloisio et al. (2019) conducted a secondary analysis of survey data from 168 LTRC managers from 78 LTRC homes and found that social capital, adequate orientation, and leadership were associated with higher job satisfaction.

The literature thus contains glimpses into intrinsically rewarding aspects of LTRC work arising from the unique nature of the work especially in supportive organizations. Crucially, organizational conditions are modifiable and can be intervened on to improve job satisfaction and reduce burnout. Yet the capacity for organizational conditions to be altered to better support staff is challenged by longstanding sectoral characteristics that provide additional context for understanding mental health and mental health risks for LTRC workers. Low staffing, constrained funding models, job precarity, and routinization of care are examples of workplace issues that have persisted since the early 1970s (Lowndes & Struthers, 2017). Entrenchment of these sectoral problems is an expression of broader social inequities

related to gender, ethnicity, and age. Gendered norms construct care work as feminine, altruistic, and inherently meaningful while also "disappearing" it to justify its devaluation as paid work (Fletcher, 2001). A low barrier to entry makes LTRC one of the limited employment options available to migrants facing restrictive immigration policy, economic pressures, and a lack of training opportunities (Manchha et al., 2021). Regardless of immigration status, ethnic minorities and women comprise a large proportion of LTRC workers in Canada, meaning that many LTRC workers belong to a demographic that disproportionately experiences discrimination and social inequities (Chamberlain et al., 2019). Finally, stigmatization of the LTRC resident population as failing, destitute, and invisible, is paralleled with associations of LTRC work as dirty and LTRC workers as low status compared to other healthcare settings (Banks, 2018). We use these paradigmatic challenges that face the LTRC sector to inform the next section which examines impacts to Canadian LTRC worker mental health produced by pandemic conditions.

PANDEMIC IMPACTS ON LTRC WORKER MENTAL HEALTH

Accumulating evidence from Canada shows that the pandemic management strategies utilized in LTRC worsened pre-existing challenges in the organization and delivery of LTRC, creating work environments of severe mental health risk. A comprehensive review is beyond the scope of this study, yet the select review of recent literature provided here is sufficient to assemble the picture of workplace mental health in LTRC and position the contribution of this study toward a strengthened presence of worker voices in the LTRC policy agenda.

In a mixed-methods study of the impacts of pandemic management strategies on LTRC staff mental health in British Columbia, Havaei and colleagues identified "a vicious cycle of staffing shortages, heavy workloads, poor mental health and sub-optimal quality of care" (Havaei et al., 2022: p. 83), arising from pandemic management policies related to staffing, sick time, and visitation. A similar characterization of simultaneous and dynamic stressors was reported by Reynolds et al. (2022) in a study entailing interviews with 26 staff from a LTRC facility in British Columbia. Participants in Reynolds et al.'s study described mental health and coping as impacted by combinations of heavy workloads, fear of outbreaks and getting sick, keeping up with shifts in pandemic guidelines, and being confronted with negative public views of LTRC (Reynolds et al., 2022). Graff-McRae's (2021) report for the Parkland Institute surveyed 370 LTRC workers from Alberta to discover worker perspectives on how job characteristics and working conditions supported their ability to provide care. Congruent with above findings from British Columbia, Graff-McRae found that insufficient time to complete tasks, having to stay late or work overtime, operating in short-staffed conditions, and inadequate staff-to-resident ratios were workplace conditions that impacted the care that LTRC workers were able to provide, resulting in incidents of harm and injury to residents. Symptoms of mental distress and post-traumatic stress were reported by more than half of respondents and Graff-McRae framed these outcomes as stemming from concerns with LTRC that have been present for years and only exacerbated by the pandemic (Graff-McRae, 2021).

Ontario's Long Term Care Commission similarly reported that PPE shortages, inadequate and delayed IPAC support and action, increased staffing shortages, unmet needs for worker support, new restrictions, and inefficient or lack of screening and testing measures that influenced the spread of Covid-19 in LTRC facilities, as intensifying and adding new dimensions to issues already experienced by residents and workers long before the pandemic (Marrocco et al., 2021). These select findings show how the pandemic has shifted the backburner social crisis of LTRC into a boil, creating negative consequences including heightened mental health risks for workers. The final section of our introduction characterizes the policy and research landscape in Canada in terms of key challenges to speed and scale of transformation needed while positioning workers as drivers of the policy and research agenda.

BRINGING LTRC WORKER VOICES INTO THE FOLD OF MENTAL HEALTH POLICYMAKING AND RESEARCH

Unforeseen crises such as the Covid-19 pandemic can create critical policymaking junctures that call into question existing policies and systems. The current LTRC policy juncture is commonly being depicted through the "crisis-reform thesis," a framing of crisis in academic and popular discourse that emphasizes the need for post-crisis reformation of affected institutions and systems (Boin & 't Hart, 2022). The crisis-reform thesis framing in Canadian LTRC is succinctly illustrated in the concluding remarks of a major report by the Royal Society of Canada's Covid-19 Long-Term Care working group: "reform and redesign must tackle not just the pandemic crisis, but also long-standing systemic failures—root causes—of the pandemic crisis" (Estabrooks et al., 2020: p. 670). This framing is a powerful attribution of intolerable outcomes of crisis to pre-existing systemic deficiencies; this supplies researchers and policymakers with a clear line of reasoning for lesson-drawing and reformative policymaking. However, political science research on the historical role and impact of crises in public policymaking suggests that shifts from crisis to policy reform are not the norm (Boin & 't Hart, 2022).

The contingency of opportunities for LTRC policy reform that would create lasting improvements to supporting worker mental health is brought into focus

by three challenges. Firstly, the regulatory structure of LTRC in Canada is decentralized across federal-provincial and public-private divides, resulting in a vast and heterogenous body of policy that may be specific to LTRC or inclusive of LTRC (Beland & Marier, 2020). A second challenge is present in the overshadowing of worker experiences and wellness by a predominant emphasis on risk mitigation and strategies to limit liability. In a review of Canadian LTRC policy documents containing guidance for staff to support resident quality of life, Hande, Keefe, and Taylor (2021) found that the "safety-security-order" quality of life domain was the exclusive focus of over half of 63 included documents. Additionally, reviewers characterized the roles outlined for staff as "vague, minor, or restricted" (Hande, Keefe, & Taylor, 2021: p. 548) across the entire collection of policy documents.

The dislocation of worker mental health in Canadian LTRC policy is accentuated by a third challenge related to knowledge translation. The LTRC context, especially as compared to other healthcare settings, is resistive to knowledge which easily translates into an evidence base for standardized practice and interventions. For example, LTRC measures studied during the first year of the pandemic emphasized outbreak management and testing strategies and this focus on containment of the virus failed to yield gold standard approaches achieved in the healthcare sector while also leading to negative consequences for LTRC residents and workers (Byrd et al., 2021). Research on LTRC worker wellbeing entails similar knowledge translation challenges, as illustrated in a scoping review of practice-based approaches to supporting work-related wellbeing of frontline LTRC workers conducted by Johnston et al. (2021). Reviewing 30 studies, Johnston et al. characterized the evidence base for supporting the wellbeing of LTRC workers as a "clutter" that is inadequate for constructing services due to topical, theoretical, empirical, and practical fragmentation. Johnston et al. recommended further investigation of person-centered care and "nebulous concepts" (p. 237) of job satisfaction and support as protective mechanisms for worker resilience and retention.

The Canadian LTRC policy literature is decentralized, mostly regulation-focused, and the evidence to inform supports for worker wellbeing is thin. Yet these longstanding challenges with LTRC have not gone without efforts towards transformation. Key among these efforts is the culture change movement towards person-centered care in North America and abroad which has helped to shift the institutional, hospital-based model of LTRC into a relational-social model (McCormack et al., 2017). Further, in recent years there is growing acknowledgement of the importance of learning driven by LTRC organizations themselves (Toms et al., 2020), and the context of post-pandemic learning and preparedness appears to be serving as a catalyst for this (Law & Ashworth, 2022). Taking the view that increased presence of LTRC worker knowledge is vital to carrying these transformative efforts forwards into pandemic recovery, the purpose of this study is to present a synthesis of LTRC worker perspectives that bring together recommendations for pandemic preparedness and mental health support.

METHODS

RESEARCH DESIGN

The analysis presented in this article is part of a broader study on supporting mental health and preventing moral injury among LTRC workers during the Covid-19 pandemic. Ethics approval for this study was granted by the University of Calgary Conjoint Health Research Ethics Board. Calls for participants were distributed through contacts at LTRC partner organizations. Overall, a sample of 50 workers was recruited from a total of 12 LTRC organizations. Our participants are 30 workers from Alberta, 19 from BC, and 1 from Ontario. Participants encompass a variety of LTRC roles. Interviews were conducted remotely using Zoom at times selected by participants, on dates ranging from March 8th to July 2nd, 2021. Audio recordings were transcribed using Rev.com.

Following a semi-structured interview guide, socio-demographic information was first collected from participants to understand their role and role changes during the pandemic. Participants were then asked a series of open-ended questions under broad topics of personal impacts and managing stress. The final question in the interview guide was "Can you provide us with recommendations for how to be better prepared for another global pandemic?" Answers to this "big question," a paraphrase offered by several participants and eventually adopted among our interview team, were the subject of the analysis presented here. We selected qualitative content analysis because this methodology suited the close and concrete interpretation of participant responses which we formulated into categorical recommendations for improving worker mental health outcomes.

PROCEDURE

Data analysis was guided by influential qualitative content analysis sources, namely Lindgren, Lundman, and Granheim (2020), Hsieh and Shannon (2005), and Bengtsson (2016). We began with extracting participant responses to the recommendation question from transcripts and arranging them in a Microsoft Excel workbook. Coding entailed a close reading of each response and creating inductive codes labelled with exact phrasing or concise paraphrasing of the words of participants. The first and second authors independently

coded the first 10% of responses and then met to review initial results. A main topic of discussion at this meeting was a difference reflected in the data between 1) explicit recommendations and 2) participant experiences which only sometimes served as a preamble to an explicit recommendation. A decision was made to preserve this naturalistic distinction by coding the two types of data in separate columns while treating both as relevant for synthesizing overall recommendations. First and second authors each completed the remainder of initial coding independently with meetings at regular intervals and after this initial coding was completed, they consolidated individual codes into a single Excel workbook during collaborative sessions.

Subcategories were first created by sorting and organizing codes into descriptive, mutually exclusive groupings according to what aspects of LTRC participant responses referred to. Examples of subcategory labels include infection prevention and control, staffing, and mental health resources. Then, categories were created to synthesize subcategories into recommendations. Subcategory creation was informed by the recurrence of codes, while category creation involved a degree of abstraction as the analytic focus shifted to importance, defined as tailoring categories to be meaningful recommendations (Buetow, 2010). These analytic steps resulted in seven categories taking the form of the recommendations presented below.

FINDINGS

The seven recommendations for pandemic preparedness and worker mental health yielded through our analysis are organized into categories of 1) Risk, 2) Staffing, 3) Relief, 4) Talk-based support, 5) Communication, 6) Leadership, and 7) Public Accountability. Each recommendation is presented separately following Table 1, which displays demographic characteristics of our 50 participants including sex, age, job category, length of employment, and job status, and Table 2, which summarizes each recommendation along with relevant worker experiences. All participant names that appear in the findings are pseudonyms.

SEX	NUMBER OF PARTICIPANTS (N = 50)
Female	42
Male	8
Age group	
18–26	11
26–35	14
36–45	6
46–55	14
Over 55	4
Not reported	1
Job category	
Care Aide/Assistant	18 (3 with additional roles)
Nurse (incl 2 Clinical Nurse Leaders)	9
Supervisor/Manager/Director	5
Social Worker	5
Spiritual Health Practitioner	3
Receptionist	2 (1 with additional role)
Music Therapist	2
Dietician	1
Physical Therapist	1
Human Resources Specialist	1
Length of employment	
Less than 1 year	8
1–5 years	20
6–10 years	9
11–15 years	6
More than 16 years	7
Not reported	
Job status	
Full-time	35
Part-time	7
Casual	3
Pandemic hire	5

Table 1 Participant demographics.

RECOMMENDATION 1. LOOK OUT FOR STAFF THROUGH RISK REDUCTION AND COMPENSATION

Our first recommendation synthesizes 23 participants' answers linking workplace mental health to equitable accounting for and mitigating of the risks that pandemic conditions introduce to LTRC workers. This recommendation is further organized into subcategories of 1a) Risk reduction and 1b) Hazard pay.

1a) Risk reduction: Participants referenced workplace processes for preventing and controlling the spread of Covid 19 infections, such as Personal Protective Equipment (PPE), sanitation, screening, vaccination, and testing. Participants were united in recommending greater PPE supplies and many recalled acute memories of limited PPE at the beginning of the pandemic. Some elaborated by suggesting greater stockpiles of PPE would be best achieved through government intervention and cultivation of business relationships with PPE vendors. Participant experiences added nuance to the shared

CATEGORY NAME	# OF CODED RESPONSES (N = 50)	RECOMMENDATION SUMMARY
Look out for staff	**N = 23**	Experiences: Workplace responses to pandemic risks through reduction (PPE) and pay increases were helpful and brought reassurance. Some staff felt their roles were underprioritized in disbursement of PPE within the organization. Recommendations: Conduct worker-driven appraisals of equity in plans to reduce and compensate for risk.
More hands	**N = 22**	Experiences: Inadequate staffing, key people down at the same time. Recommendations: Ensure adequate baseline staffing held to a publicly accountable benchmark. Develop robust backup plans for staffing. Incorporate greater flexibility in role descriptions during outbreaks. Introduce new roles into staffing mix such as staff support, resident companions, more designated infection prevention and control (IPAC) staff.
Opportunities for relief	**N = 13**	Experiences: Mistakes and suboptimal care occurred due to the stress of assigned workloads, taking on too much, and overlooking necessity of breaks. Recommendations: Provide more time off for mental health. Support staff in recognizing overwork and give reminders to take breaks throughout day.
Spaces to be heard	**N = 19**	Experiences: Lack of workplace mental health resources and divergent individual preferences for types of mental health support. Recommendations: Offer a variety of accessible and free talk-based options (individual counseling, peer debriefs) for different needs and preferences. Provide additional individual resources for staff well-being, including support for mindfulness, self-awareness, and mood. Staff must have enough time to access resources.
Refine Communications	**N = 13**	Experiences: Deluges of information created feelings of overwhelm and confusion about who to trust and follow. Misinformation created mistrust among workers. Recommendations: Implement clear, consolidated, and documented organizational communication. Improve information sharing with other healthcare settings where staff work to assist with contact tracing and adapting to single-site orders. Proactively anticipate and address media-driven information.
Cultivate responsive leadership	**N = 18**	Experiences: Some workers criticized lack of presence and responsiveness of managers in pandemic conditions. Recommendations: Cultivate authentic connection with, and lasting appreciation for, staff. Learn and adapt from the initial stages of the pandemic. Create a "playbook" for preserving institutional memory of what worked and what didn't work during the pandemic.
Redefine public accountability	**N = 13**	Experiences: Exposure to the public and alienation from the public. Worsening of systemic issues preceding pandemic. Recommendations: Promote more widespread recognition and higher valuation of LTRC in society. Foster greater harmonization of pandemic response from governments, health authorities, and LTRC facilities.

Table 2 Summarized Recommendations.

desire for more PPE by highlighting the need for equity in risk assessment within different roles in LTRC facilities. Kathleen, a dietary aide hired during a Covid outbreak, was critical of how PPE was distributed among staff at her facility. Kathleen recalled working in the kitchen and seeing housekeeping staff wearing PPE to clean the dining area even as this area remained unused during outbreak, leading Kathleen to question: "So why do they (RNs and Housekeeping) have to wear PPE, and we in the kitchen, that handle everything coming back from the Resident's room, do not have to wear PPE?" Kathleen's experience reinforces the credibility of workers as evaluators of pandemic risk reduction efforts. Soliciting evaluations of best practices during times of outbreak from all LTRC employee roles can expose contradictions or inequities behind risk reduction through bringing workers' shared personal investment in feeling protected into tension with workers' divergent roles and perspectives within LTRC facilities.

Other participants spoke of using worker experiences and lessons with risk reduction for future pandemic preparedness. Brayden, 57, a music therapist, presented a scenario of LTRC being affected by another pandemic far enough in the future such that "everybody that was there the first time, is gone." Brayden subsequently recommended that the "institutional knowledge" of the Covid-19 pandemic be used for "coming up with some really good steps that would happen right away… so that people aren't confused." Kristen, 28, a day program manager and pandemic site support lead, spoke in similar terms about reducing future risk at her facility as she described efforts to "make sure we do a really good job of documenting what's worked and what's not… almost like a playbook, in terms of it were to happen again." Workers navigated a high degree of risk during the Covid-19 pandemic and one way that LTRC organizations can demonstrate that these worker experiences matter is by using worker experiences as an input for risk reduction.

1b) Hazard pay: Participants recommended LTRC organizations provide workers with financial benefits and pay increases as means of recognizing the inevitable risks pandemic conditions impose on LTRC workers. Cynthia, 42, a rehab manager and occupational therapist, suggested that financial compensation may be more beneficial for mental health than other supports such as counseling:

> During the pandemic, I think the financial aspect is the best way to compensate people, because they can do whatever they want with the money to compensate their stress. So it's giving them more options and control because during the pandemic, it feels like things are not in our control... so by giving them control, that will help them to reduce stress. Support by talking with counseling, all these kind of things, is not practical to me in a way during the pandemic.

Cynthia's answer highlighted the ways in which the pandemic constrains worker control and discretion and how increasing financial power may be the most direct way to support wellbeing. Beyond instrumental benefits, hazard pay can also be experienced as a token of recognition as conveyed by Tyler (47, director of care), who followed his recommendation for "more compensation for the effort and time put in" during outbreaks with saying "I know it's about money. But it's not entirely about that." Also in support of financial compensation for employees facing risk, Emilia, 33, a social worker, supported pay increases given to compensate risk but critiqued the rationale by which dietary staff and housekeeping staff did not receive pay increases:

> I know the HCAs [Healthcare Aides] were given a $2 increase, but that didn't include our housekeeping staff or our dietary staff who are also putting themselves in harm's way to be here. If we didn't have housekeeping, this thing would have gone everywhere. If we didn't have dietary [aides] here to cook food for people that would have been a huge issue. So I really do think that an increase in pay is the least that could have been done for these people coming in day in, day out, putting themselves and their families at risk. It would have been really appreciated.

In order for workers to sustain their capacities for giving care in adverse conditions, LTRC organizations need to do everything possible to preserve safety and provide compensation that is commensurate with risk. Participants pointed to greater parity in disbursement of PPE and hazard pay as ways for organizations to recognize contributions of entire teams working in LTRC.

RECOMMENDATION 2. "MORE HANDS": REAPPRAISE STAFFING MODELS

Participants spoke of weathering impacts to LTRC staffing brought on by single site orders, leaves of absence, and turnover, and our second recommendation synthesizes 22 responses pertaining to the urgent need to reappraise how staffing is organized in LTRC in order to better uphold standards of care and working conditions. Reappraising staffing models also includes participant views about how the pandemic revealed the need for new roles in LTRC.

"One of the biggest things that weighed on everyone's mental health was not knowing whether or not we'd have enough staff." These are the words of Lily, 38, a recreation therapy aide. Lily reflected on the introduction of single site orders in 2020 as a main driver of staff shortages, and Lily suggested having "big companies, or company, already set up with employees that are ready to go... in case people were restricted in where they were allowed to work." Sarah, 31, a recreation therapist, also referenced staffing in terms of the support among the team working at the facility:

> We could be better prepared to not only support the people that we're caring for with additional staff, but better support each other. It might still be a stressful environment, but then I can do 100% of my work, not working at 130% and only being able to do 70%. It really comes down to having more hands.

Edgar, 45, director of nursing, framed the staffing systems of LTRC being "caught off guard" by the pandemic and Edgar envisioned a staffing plan at the level of government or healthcare provider while emphasizing the importance of staffing for worker well being:

> The biggest recommendation I would have is just to be flexible with staffing. Having the government have a staffing plan, or Alberta Health Services, or the health service provider. Whatever. Have a plan for staffing... it doesn't only affect the residents. It affects the staff too.

Increasing the supply of readily available LTRC staff is a larger sectoral project, yet opportunities remain for individual LTRC facilities to optimize existing staffing systems for pandemic preparedness. A managerial perspective on the challenges of responding to single site orders was shared by Minsheng, P17, 50, a clinical operations supervisor. While Minsheng endorsed the merits of single site orders, he provided insight into feeling unprepared for the human resources challenge of managing information to meet single site orders:

> There are a lot of staff members who work across the health care field. For example, acute care, to

> long-term care, group homes in community and assisted living, and independent living. But we do not capture where the staff have been working in the past, until this pandemic. It took a lot of resources to find out any information. I think to prepare for the future…we need to have more of a regional approach in terms of human resources.

Participants also pointed to new roles in LTRC, and their ideas about new roles reflected favorable experiences with the introduction of pandemic-specific roles like screeners and extra cleaning staff. Participants also imagined new roles centered on the need for more support for residents and staff. Amy, 18, a comfort care aide, recommended "hiring more people… but hiring more people that can just visit and talk to the residents. Because they've definitely gotten depressed." Meanwhile, Emilia, 33, social worker, imagined a position dedicated to reviewing and allocating workloads and defining roles in more detail: "someone who is designated as support to staff…if someone in that role could say 'we've given enough to Emilia right now and I think we need to maybe try and spread this out a little bit,' or, 'let's define these roles a little bit more closely.' Something like that." Sophie, 35, an occupational therapist, built on the idea of having staff available to respond to needs of the day. Sophie explained that the increase in responsibilities and workloads created by the pandemic was not evenly distributed across LTRC departments and Sophie recommended a resource for instructing workers on "ways to support each other" in various pandemic scenarios. In all, the recommendation to reappraise staffing models encompasses the pervasive view of a need for a greater supply of staff but also includes ideas for broadening contact tracing, adding new roles, and enhancing the flexibility of existing roles in times of need.

RECOMMENDATION 3. CREATE OPPORTUNITIES FOR RELIEF FROM WORK

This recommendation synthesized thirteen responses connecting heavy workloads to negative repercussions for mental health and quality of care. Together, these workers pointed to the need for adequate breaks and time away from work during times of increased demand such as in pandemic conditions. Elizabeth, 22, an activity aide, depicted how day-to-day worker burnout forms problems in the LTRC sector that eventually become visible to the public:

> You just look into long-term care, there's a lot of problems and you'll be able to find them super fast. But a lot of it is due to that burnout. These people aren't bad people, they're just tired and overworked. And no one else is stepping into that position.

The experience of workplace pressures was illustrated by Hannah, 22, a comfort care aide and recreation assistant, as Hannah described rigidly unadjusted work expectations during an outbreak: "They [managers] were still going after us for not doing enough recreation-wise, or doing enough activities with the residents. We're struggling to keep them alive right now." Emilia, 33, a social worker, similarly described the need to navigate unrelenting organizational pressure to do extra work during the pandemic: "I had to really set some clear boundaries because I felt I was at a point being taken advantage of, in terms of I was just always willing to help out." Experiences shared by Hannah and Emilia show how additional responsibilities and resource constraint created by the pandemic led to workloads not being realistically evaluated and the need for relief going unrecognized. In the absence of organizational definitions and assessments of reasonable workloads, external accountability for the pressures that workers face is weakened, and the boundaries of overwork are left to the judgement of individual workers. Tyler, 47, a Director of Care, connected the pernicious quality of stress associated with workloads to the nature of helping professions:

> In this industry especially, we're yes people. We're helpers, and we don't put ourselves first until sometimes it's too late. I've actually watched my boss burnout doing it, and I've done it myself. So, sometimes just having your leadership say, "Hey, how are things going? You've worked 90 hours [per week] for three weeks, you're not coming in next week." Having somebody take care of you without you having to ask is a remarkable feeling… I think that's what's lacking this time here. It should almost be a process, policy, procedure, put in.

Tyler's recommendation suggests the need for more organizational embedding of opportunities and support for staff to be relieved of work. Sam, 49, a social worker, made a similar recommendation while emphasizing that opportunities need to be clearly communicated to break through the default tendencies to continue working:

> You almost have to be commanded to stop because you're running on automatic. And you almost feel like there's a pressure to keep going… whereas if you're given permission to just stop for five minutes. Put your back against the wall and just breathe for five minutes. I think that would have helped a little bit. Just to stop.

Incorporating more time off into the structure and rhythms of work can occur at different levels ranging from Tyler's suggestion of taking a week off, to the level of mental health days, to reminders to take five-

minute breaks throughout work shifts. It is critical that opportunities for relief are presented such that staff feel covered in terms of pay and time away from work, as Elizabeth (22, activity aide) described:

> A lot of these people that I was working with have really severe back pain and just headaches or migraines, or that kind of thing, and are just working anyway and just pushing through. And their body was obviously telling them this is too much, slow down, take a break kind of thing. But they either couldn't financially or just weren't listening to the signals of their body. So either kind of having what does burnout look like and what are signs that your body is telling you to slow down... I think it's really important to check in with yourself.

Financial necessity and limited self-awareness about needed breaks can thus intertwine in how workers relate to needs and opportunities for relief. In summary there are three aspects of the recommendation for more relief. First, participants spoke to a need for detailed workload expectations along with clearer communications of workloads from workers to management. Second, greater opportunities for time away from work—minutes as well as weeks—should be built into workplace policies for sick time, vacation, time off, and breaks. Finally, workers can be helped in becoming stronger advocates for their own relief through opportunities for cultivating awareness about falling into patterns of busyness and overwork.

RECOMMENDATION 4. SPACES FOR WORKERS TO BE HEARD

This fourth recommendation builds on the overall need for time away from work duties with a focus on the importance of spaces for workers to talk and be heard to support mental health. Nineteen participant answers reflected divergent preferences for, and pros and cons of, individual types of talk-based workplace mental health support. The responses categorized in this recommendation reflect the need for a spectrum of resources for workers to be heard, or in the words of Ella, 46, a clinical nurse leader: "a variety of different ways that people can have a place to share what's going on for them." Offering diverse opportunities for workers to connect and feel heard can support everyone in the team-based setting of LTRC where moods and stress can spread amongst colleagues. Ava, 19, a healthcare support worker, noted that when colleagues access suitable resources they generate indirect mental health benefits for others because "vibes are a huge thing" in LTRC and Ava elaborated: "Everybody will deal with things differently... like if somebody is panicking and rushing, while you're in a peaceful zone, I'll tell you right now, you're not going to be in a peaceful zone." Our synthesis of participants' perspectives on talk-based resources is delineated below into the subcategories of 4a) Peer settings and 4b) individual counseling settings.

4a) Peer settings: Several participants endorsed the idea of scheduled time for talking about mental health with colleagues. Alexa, 29, a recreation therapy assistant, described the benefits of spending a half hour of the workday with colleagues that she felt safe to "confide in and talk to and be open with."

Similarly, Braydon, 57, rehab music therapist, described colleagues availing themselves of "group debriefs" held at his facility as a safe place to discuss experiences shared as a community of workers. While the structured nature of opportunities for conversations with peers is key to this recommendation, the idea that these sessions should be voluntary was emphasized by several participants including Tyler, 47, a director of care, who recommended "not mandatory, but really strongly encouraged weekly sessions or biweekly sessions." The importance of peer sessions being voluntary was also supported by Driya, 18, a healthcare aide who was concerned about practicality of attending peer sessions in a time constrained work environment: "I know if you had a support group nobody is going to come because people like HCAs, they're just all very busy, they're all worn out sometimes." Busyness was not the only barrier to participating in peer support sessions. Indeed, a counterpoint to the assumption that discussions with colleagues would be beneficial to mental health was presented by Elizabeth (22, activity aide), who pointed to how workers can be desensitized to the struggles inherent in LTRC work and correspondingly impatient with colleagues:

> This is not an easy job. Someone from outside the home would be able to see that automatically. But when you're in it, and you've been in it for so long, you're kind of like, oh, this is what it is, this is how it is, so kind of toughen up. So I don't think that is really good for anybody.

Further countering the value of peer debriefing, Raina, 45, a social worker, pointed to risk of feeling exposed to colleagues as she noted that "some of the staff may not be comfortable... they do not want to share information with a person they know" and anonymity "will be appreciated" by staff. Raina's endorsement of anonymity alludes to benefits of individual counseling on which we now provide further worker perspectives.

4b) Individual counseling: Workers recommended talk-based resources originating outside of the organization, such as licenced therapy and Employee Family Assistance Program (EFAP) counseling. The importance of extra counseling capacity during crises

was highlighted by Ava (19, healthcare support worker) who suggested that an enhanced "supply chain" of counseling "should be ready to go" for a pandemic. The benefits of EFAP, such as 24/7 access and anonymity, were endorsed by some while others described limits to these services. Ella, 46, a clinical nurse leader with 18 years of experience, noted that "A lot of the staff that we work with are English as a second language. Having a counselor over the phone, not great. You really need that in-person interaction." Capped sessions are another limitation of EFAP as told by Tyler, 47, director of care: "Last time I did my EAP, I got to my fourth session, and they were just like, oh, our next session will be 250 bucks. I'm like, Well, sorry."

Variety and consistent accessibility are key to the recommendation for spaces for workers to be heard. Options within the general categories of peer support and individual counseling should be visible and equally accessible in workplace communications, with messaging centered on worker choice.

RECOMMENDATION 5: REFINE COMMUNICATIONS

High volumes of urgent workplace communications strained the communicative climate in LTRC and our fifth recommendation is for workplaces to refine processes of communication. Covid-19 related information flow at work was referenced by 13 participants. The feeling of being overwhelmed by multiple information channels was captured by Anna, 28, a music therapist: "one thing that definitely I experienced is communication coming from so many different kinds of people. It was unclear whose communication was what we should do and what we should follow."

The importance of coordinating points of contact and number of media was also described by Ella, 49, a clinical nurse leader, who emphasized that "it can't just be emails. It can't just be verbal communication." Ella suggested "very clear documentation around what stays, what changes… in black and white." Emilia, 33, a social worker, spoke in similar terms about the need for clear communication and Emilia recommended clarity be improved through better harmonization of communications within and beyond LTRC:

> Very clear communication, both from the government down to the healthcare system down to the frontline workers is key. And I don't know what that might look like, but having one source of contact and having that communication be looked at by a number of people to ensure that it is clear and concise, and that there is a minimal interpretation allowance so that families can see it and understand why we're making these decisions.

The need for harnessing the flow of pandemic related information including information coming from outside of LTRC organizations was further illustrated by Clara, 20, a receptionist and screener: "we were hearing all kinds of stuff… You hear everything from the news. You hear so many different opinions and people panicking and things like that." Stressful impacts of misinformation from TV and media were also noted by Edgar, 45, a director of nursing, who described the tension of information being delivered by media versus the work organization as "very difficult." Edgar recommended:

> An information package, being able to be ahead of the news media and social media. I know that that is difficult, but proper information to people who work in long-term care, in continuing care, who put themselves in the line of danger, is very important… because the I don't knows don't help our staff.

Yet the realities of emerging scientific evidence complicated the goal of workplaces quickly acting on correct information. Danika, 28, an occupational therapist, depicted a struggle in which workplace leaders were forced to make decisions in accordance with limited scientific evidence while striving to retain the trust of employees. Danika reflected on "the number of mistakes that were made. And the number of times things went back and forth… sparked a lot of doubt and mistrust for authority figures." Edgar shared similar struggles within his organization and Edgar recommended transparency as a guiding principle in circumstances of contingent information:

> Even for (LTRC) companies to say, "Listen, we are going to deal with this as well as we can with the information we have, bear with us. Give us your suggestions, but be aware things are going to change." Having that upfront openness. I find anybody in the world, whether it's an organization or a person or whatever has a problem saying, "I don't know." And I think just having that where maybe at the beginning say, "This is an ongoing situation. It is developing, we are going to do the best we can with anything we have."

To summarize, participants expressed a desire for clear channels of pandemic-related communication, which workplaces can act on by consolidating the delivery of pandemic updates into fewer, or even a single, information source. Workplace leaders also desired a means to be forearmed in order to manage misinformation about Covid-19 from external media sources. Attaining this goal is challenging given the inherent tension for workplace leaders who are expected to be clear and unambiguous

in their communication while also authentic in disclosing the evolving basis of new workplace measures.

RECOMMENDATION 6: CULTIVATE RESPONSIVE LEADERSHIP

Our sixth recommendation is a synthesis of 18 responses expressing a heightened need for responsive leadership during pandemic conditions. Responsive leadership referred both to leadership presence to support individual workers and leadership capacity to act decisively in response to pandemic conditions such as outbreaks. Although increased administrative and managerial workloads during the pandemic was acknowledged in several responses, some non-managerial workers were critical of their leaders. Brayden, 57, a music therapist, endorsed workers being perceptive to leadership authenticity as he expressed how "staff have a really credible bullshit radar" and Brayden described the importance of LTRC managers cultivating an authentically supportive presence: "My experience was they [managers] were very much in the office and in the control room, like the war room." Brayden went on to recommend:

> Leadership that's not about running from one thing to another, but actually is just being available, seeing what each other are doing, making positive comments, correcting something, answering questions, that kind of thing. It would be a huge morale booster, if it was authentic and genuine.

The absence of responsive leadership can leave workers feeling alienated from workplace leaders. Kathleen (33, dietary aide) shared an experience of frustration related to PPE provision for kitchen staff and she connected her frustration to having impersonal and distant relationships with supervisors. Upon beginning training during an outbreak, Kathleen was not given an N-95 mask despite having asked for a mask. Days later, two co-workers who trained with Kathleen tested positive for Covid-19. After Kathleen shared this, the interviewer asked if Kathleen felt secluded or if she does not often interact with supervisors. Kathleen responded: "We see them. Because they still get food from us [laughs]. But it's not like we interact with them." The importance of individual relationships with leaders was also shared by Lily, 38, a therapy aide, who praised the "open-door" policy of her administrator yet also expressed a desire for more personal contact:

> It would have been nice to have a sit down with the administrator either by department or one or two people at a time, just to do a little bit of a check-in. Our administrator is really good and when she has a Covid meeting, she'll send us the minutes. So, I've learned a lot of things from just being able to read that. But to actually sit down and have somebody be like, "How are you doing?"

Feeling supported by workplace leaders can take different forms yet responses in this category reflect a core need for leaders who are dependably present in day-to-day work life and who take initiative to cultivate relationships with individual staff. Given worker need for responsive leadership amidst pandemic conditions of increases in both administrative and direct care workloads, leaders may require more resources in order to respond to workers' needs.

RECOMMENDATION 7: REDEFINE RELATIONS OF ACCOUNTABILITY TO AND FROM THE PUBLIC

Our final recommendation is for redefining relations of accountability between LTRC and the public. Taken together, the thirteen responses categorized in this recommendation draw attention to systems upstream to LTRC as the driver of constrained pandemic response in LTRC and the necessary targets for positive transformations.

Danika, 28, an occupational therapist, first responded with laughter at the understated introduction of our "big question" and, following a pause, Danika began her answer by saying "this was a lot bigger than just 'workplace'. This was very much at levels that were beyond us." Connections between systemic and workplace-level pandemic challenges were similarly drawn by Catherine, 25, a dietician, who expressed that "a lot of the stress has come from, I guess, the structural part of our society" and Catherine elaborated: "you see the weaknesses of the system once a pandemic hits. We definitely bear the brunt… of big structural issues that no one really anticipated." Catherine described how factors such as the age and layout of facility buildings, shortages of healthcare aides, and shortfalls in overall funding of the LTRC sector limited the possibilities for pandemic response. Participants focused on government as the driver of transformation in the LTRC sector. Lucy, 51, a spiritual care practitioner, recommended that "to be better prepared in long-term care specifically, we need to look at our systems and our funding and our layouts of sites." Stemming from her observations of multiple residents living in one room, Lucy said: "just learn that having four residents to a room does not keep people safe… it wasn't dignified and fair and respectful to begin with, but now it harms people. Because they're breathing the same air."

Actions that should have been taken by government and health authorities were also the focus of a response from Cynthia, 42, a rehabilitation manager, who expressed that the provincial health authority abandoned LTRC facilities. She believed that the health authority

should take more charge in enforcing public Covid-19 restrictions. Cynthia described LTRC facilities as powerless to enforce rules, whereas she saw the health authority as having more power in influencing the public to stop the spread of the virus. Valentina, 32, a licenced practical nurse, expressed the difficulty of witnessing people who were unaware of the gravity of the pandemic in LTRC as "they continued on living their life." Valentina described having expected a spike in the virus as a result of people continuing to gather during the pandemic. Participants believed that their facilities' success in handling a pandemic hinged on the public's efforts to understand and adhere to public health protocols.

Mingshen, 50, a clinical operation supervisor, shared that problems driven by underfunding in LTRC might be improved if LTRC were more highly valued and prioritized. A lack of public support for LTRC may stem from many people having little knowledge about what LTRC entails and Mingshen described how the pandemic has exposed the "inside stories" of LTRC:

> We have one care aide for almost like 25 residents during the night. Can you imagine. And when something went wrong and the residents are confused, and the hours on the per capita basis (allocations of staff time per resident) are far, far below the general public expectations. Most of them they don't know the inside stories, but through the pandemic, we're being exposed to the level that we never imagined to the public.

Responses included in this recommendation were in support of public accountability for systemic issues such as funding, improvements of LTRC facility buildings, and overall care and attention allocated to the LTRC sector. Participants spoke of challenges as reflecting longstanding issues spanning the entire LTRC system, albeit subject to new dimensions of strain introduced by the pandemic. Participants gave evidence of LTRC as thrust into heightened public accountability given how pandemic realities were displayed to the public. This leaves a need for increased public understanding and recognition that has yet to be fulfilled. The pandemic has made the interface between LTRC and the public more porous, and participants emphasized the need to redefine relations of accountability in order to repair the sector and strengthen its resilience for future pandemic preparedness.

DISCUSSION

Our findings synthesized 50 worker responses to a question eliciting recommendations for future pandemic preparedness. The seven recommendations contribute to efforts to supporting the LTRC workforce during and beyond the pandemic. The discussion is organized in two sections which 1) elaborate findings through connections to other staff-focused policy recommendations from Canada, and 2) show that our findings support sustained engagement with LTRC workers in research and policymaking as necessary to cultivate a resilient and supported workforce and broader transformations in LTRC.

CONNECTIONS TO OTHER STAFF-FOCUSED POLICY RECOMMENDATIONS FOR MENTAL HEALTH SUPPORT AND STAFFING

Our analysis was sensitized to worker mental health as a context for understanding pandemic preparedness and this gives our findings a unique point of convergence with existing LTRC policy recommendations and research already undertaken in response to the pandemic. In this section we connect our findings to recommendations for improved mental health support, staffing, and workforce improvement found in Canadian policy and research literature reporting on surveys and interviews with LTRC staff.

Mental health support

The overall need for more mental health support for LTRC workers that we identified aligns with recommendations in a report by The Royal Society of Canada Task Force on COVID-19 (Estabrooks et al., 2020) and provincial reports undertaken in Alberta (Graff-Mcrae, 2021; MNP LLP, 2021), British Columbia (Ernst & Young LLP, 2020; Howegroup, 2020) and Ontario (Marrocco, Coke, & Kitts, 2021). Our participant-identified need for a mix of options to meet LTRC workers' diverse preferences for mental health supports also accords with findings from a study by Reynolds et al. (2022), whose 70 staff and management survey participants from central Canadian LTRC facilities reported similarly varied preferences for mental health supports ranging from counseling, online therapy, online discussion groups, peer support discussion groups, additional staff support, and additional work-related debriefings (Reynolds et al., 2022). An important component of enhancing the capacity, accessibility, and variety of workplace supports to meet pandemic-era mental health needs of LTRC workers is evaluating existing mental health supports. The Ernst and Young (2020) report from BC recommended assessment of existing psychological health, wellness, and safety supports available to LTRC staff to ensure supports are sufficient and that there are no unnecessary barriers to access. The abundant ideas for new supports combined with ambivalence about existing supports in our findings endorses the value of collective deliberation that includes workers in the processes of assessment. Alberta's MNP report (2021) recommended forming a "workforce improvement task force" to assess ways of improving workforce design, workforce culture and working

conditions for LTRC staff (p. 148). If such a task force were created, one way to harness its efforts towards assessment of workplace mental health supports is through facilitated reflection meetings which Banerjee et al. (2021) found to be effective means of structuring opportunities for staff deliberation on workplace issues in LTRC. However, involving workers in participatory deliberative processes requires additional relational labour and rests on the premise of adequate staffing. In striving to improve mental health and wellness supports for LTRC, the ways in which understaffing contributed to adverse mental health experiences during the pandemic must be considered.

Need for staffing and workforce improvements

Our findings showed that revitalization of mental health supports for the LTRC workforce must occur alongside interventions to enhance supply, role flexibility, and skill development within LTRC staffing models. Similar staffing recommendations were made in Alberta's MNP report (MNP LLC, 2021) which suggested a "forecasting methodology" (p. 145) for the supply and demand of staff to meet the needs of the continuing care system. Needs, as defined by MNP, encompass pandemic surge capacity alongside overall growth, and include an increase in direct care per day from 3.4 to 4.5 hours by 2025, more consistent staffing assignments, and a full-time employment benchmark (MNP LLC, 2021). A higher proportion of full-time positions was also recommended in the Ontario commission report (2021) which articulated a benchmark of 70% full-time direct care positions in LTRC homes. Further, the Ontario Commission report recommended publicly available reporting on staffing plan progress (2021: p. 302), in alignment with our recommendation for enhanced relations of accountability between LTRC and the public.

Sector-level interventions to increase supply and skills of workers will be necessary to meet increasing demand while achieving higher benchmarks in LTRC staffing plans described above. Correspondingly, the Ernst and Young (2020) report recommended redesigning employment pathways to incorporate more specialized expertise and skills in order to strengthen perceptions of LTRC work as a career role rather than a stepping stone (Ernst & Young LLP, 2020: p. 28). Estabrooks et al. (2020) similarly proposed professional growth opportunities as part of needed efforts to attract, train, and retain LTRC staff. Estabrooks et al. further specified that additional training should be paid during regular work hours and should prioritize geriatric care, dementia care, end of life care, and IPAC training (Estabrooks et al., 2020: p. 306). Beyond training in specific care skills, our findings build on existing recommendations calling for greater flexibility in staffing patterns (Howegroup, 2020; MNP LLC, 2021). As part of our recommendation to reappraise staffing, participants identified the need for new roles and ways for staff to support each other in pandemic conditions to enhance workplace adaptability and alleviate the burden of direct care tasks completed by aides and nurses.

Our findings converge with policy recommendations in support of the idea that the mental health of the LTRC workforce can be positively attenuated through improved staffing models which entails increasing the supply of staff, revising staffing models, and cultivating the skilled work requirements inherent in LTRC. We now build on connections made between our findings and existing policy and research with a final discussion section that draws on the concept of person-centeredness to show the need to center workers in the research and policymaking activity gathering around deeper transformation in LTRC.

CENTERING WORKERS IN LTRC REFORM

Shifting focus from recommendations to what is needed to carry recommendations forward into meaningful change in LTRC, our findings support thinking of future pandemic preparedness, resident quality of life, and workforce mental health as connected concepts that can be supported through greater emphasis on relational and social dimensions of care in LTRC (Lowndes & Struthers, 2017; Power & Carson, 2022). This emphasis aligns with the person-centered approach in LTRC, which is defined as a standard of care that upholds the person at the center of care by integrating values of relationship, individualism, holism, respect, and empowerment (McCormack et al., 2017). The person-centered approach was developed as a response to concerns that the delivery of LTRC was overly routinized and medicalized (Banerjee, 2018) and its goals are best facilitated when people behind professional caregiving roles are allowed to emerge and make use of both professional and personal experience, skills, and stories (Cruise & Lashewicz, 2022; Lood, Kirkevold, & Edvardsson, 2022). Yet LTRC facilities remain highly structured work environments where the relational aspects of work that are key to person-centeredness can be perceived as not meeting the standard of "real work," which is bound up with instrumental values of linearity, abstraction, and rationality (Banerjee et al., 2021). The historically low station of LTRC in society has depended on the moral complexities and relational skills found beneath the surface and on the margins of "real work" failing to be accounted for (Garratt et al., 2021). Dissonance between tenets of person-centered philosophy and delivery of LTRC is reflected in the policy landscape which does not emphasize social care guidelines for building relationships (Hande, Keefe, & Taylor, 2021; Lowndes & Struthers, 2017). If the recommendations in our findings are to be realized, we must acknowledge the inertia of the Canadian LTRC policymaking process itself which until now has displaced workers as full partners in the person-centered philosophy of LTRC. In this section we show that bringing a worker focus to person-centeredness in

LTRC can guide the process of reform in LTRC through 1) *sustaining opportunities for engagement* by responding to workers' most pressing recommendations for improvement in working conditions so that workers can contribute to organizational learning and innovation, and 2) *partnering with workers in reform* to enact change towards developing LTRC policies that better support worker wellbeing by more authentically recognizing workers as partners in the philosophy of person-centered care.

Sustaining opportunities for engagement

As shown in our recommendation for relief at all scales, precarity and resource constraint in LTRC is experienced as exploiting the caring capacity of those in the helping profession. The broader expression of this process pushes workers to the epistemic periphery of the knowledge generation processes that inform policy and research. This idea of workers being pushed to the periphery was supported in a study on barriers to research participation in LTRC by Law and Ashworth (2022), which characterized structural limitations of time and space as a key barrier alongside needs for relationship building and knowledge about research. Banarjee (2018) has similarly argued that without a robust foundation of working conditions to ensure conditions of care, new initiatives simply take time from another area of care. In addition to constraints of time and competing priorities, the precarity of staffing combined with workplace hierarchies may create cultures where workers prefer to withhold creative or critical ideas for fear of repercussions. Opportunities for LTRC staff engagement in organizational learning and change initiatives therefore must build out from a foundation of working conditions that can sustain cultures where workers trust their capacity to innovate and contribute to shaping LTRC. One of the most instructive lessons from the onset of the Covid-19 pandemic was that person-centered engagement initiatives disappeared as organizations reverted to top-down, paternalistic patterns of decision-making to weather the crisis (Healthcare Excellence Canada, 2022). Preventing this reversion in the future is crucial because, as our recommendations demonstrate, organizational learning is especially needed during crises. An unsparing evaluation of the resources that the workforce needs to sustain LTRC as a learning health system is therefore a key consideration for future pandemic preparedness.

Workers as partners in reform

Our findings support the idea that if given conditions of sustained opportunity, workers are capable of, and willing to, take on a partnership role in orienting policy priorities and research agendas for deeper sectoral transformation towards a more co-creative and person-centered vision of LTRC. In particular, our recommendation for redefining relations of accountability beyond LTRC facilities showed many participants to be keenly aware of systemic constraints and political and funding contexts that serve as barriers to the deeper transformations needed in LTRC. This finding is supported by work from Lightman (2021), who reported on interviews with immigrant women HCAs from Alberta and found that participants wished for their voices to be better understood and taken as integral to public conversations about reform and improvement of the LTRC sector. Similarly, Garratt et al.'s (2021) meta-synthesis of LTRC staff perspectives on quality care found that staff positioned broader institutional and political contexts, government funding, regulation, and minimum staffing/training levels as occupying the space between "what is and what ought to be" in quality care (Garratt et al., 2021). Ideals of what workers know to be possible supply a promising source of engagement towards greater congruence between care realities, organizational cultures, and policy.

Workers can guide further understandings of how existing policy is expressed and embodied in organizational contexts through identifying beneficial local practices which are "disappeared" from the medium of policy and also identifying how existing policy contradicts tenets of the person-centered approach in ways that create harms to worker wellbeing and mental health. Some promising groundwork has been laid for this by Taylor and Keefe's (2021) delineation of an asset-based, interpretive foundation for policy analysis which can be used to re-assess Canada's unwieldy collection of LTRC policies and determine whether these policies reflect the values of residents, workers, and society (p. 382). Engaging with workers to reassess and reimagine policy in this way entails a shift into a more co-creative vision of LTRC by expanding what counts as policymaking and evidence, and who are considered policy actors and decision makers.

In summary, an overarching finding from our recommendations is that workers can contribute to reforming LTRC policy, and the Covid-19 crisis has created an imperative that appears to support transformation along these lines. Yet shifting complex policy systems such as LTRC also requires reform-minded leaders, an abundance of resources, the support of powerful external actors, and the favor of public opinion (Boin & 't Hart, 2022). Harmonizing these conditions requires steering public discourse through meaning-making and we argue this is only possible if LTRC worker voices are further centered in knowledge generation and policymaking.

CONCLUSION

This study synthesized seven recommendations from 50 LTRC workers who drew on experiences during the

first wave of the Covid-19 pandemic as they made recommendations for future pandemic preparedness in LTRC. Recommendations were presented corresponding to categories of risk, staffing, relief, talk-based support, communication, leadership, and broader perspectival shifts around the role of LTRC in society. Our findings contribute to policy and research aiming to create LTRC work environments that better support worker mental health, while also strengthening the linkages between pandemic preparedness, employee mental health, and quality person-centered care. The tension between current realities of care and the ideals of what workers know to be possible supplies a promising source of engagement for change initiatives in LTRC, thus positioning workers as key partners in guiding LTRC sectoral transformation in response to the Covid-19 pandemic.

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The authors have no competing interests to declare.

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