PREVENTING PSYCHOLOGICAL HARM IN LONG-TERM CARE

Root Cause Analysis

Last Approved: May 30, 2024

Prepared by

Public Services Health and Safety Association

In collaboration with

The Ontario Centres for Learning, Research and Innovation at the Schlegel-UW Research Institute for the Aging

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ABOUT PSHSA

Public Services Health & Safety Association (PSHSA) provides occupational health and safety training and consulting services to various Ontario public sectors. These include healthcare, education, municipalities, public safety, and First Nations communities.

As a funded partner of the Ministry of Labour, Immigration, Training and Skills Development (MLITSD), we work to prevent and reduce workplace injuries and occupational diseases by helping organizations adopt best practices and meet legislative requirements. To create safer workplaces, employers and employees must work together to identify potential hazards and eliminate or control risks before injuries and illnesses occur.

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1.0 EXECUTIVE SUMMARY

In support of preventing psychological harm to workers and leaders in Ontario's long-term care sector, Public Services Health and Safety Association and the Ontario Centres for Learning, Research and Innovation at the Schlegel-UW Research Institute for the Aging jointly conducted a provincial root cause analysis workshop in November 2023. Demographic representation and participation in the workshop were sought and secured from long-term care workers, employers, and industry experts across Ontario. This work supports the Ministry of Labour, Immigration, Training and Skills Development 2021-2026 Prevention Works Strategy and aligns directly with System priorities to build capacity to conduct risk assessments and identify root causes of workplace injuries, illnesses, and fatalities.

The purpose of the workshop was to use a participatory approach to identify workplace factors leading to psychological harm in long-term care and brainstorm associated solutions to mitigate risk. The risk statement guiding the scope of the root cause analysis was: "Working in long-term care can be psychologically demanding. Leaders and worker team members experience events and situations in the workplace that may result in psychological harm".

Six workplace psychosocial factors listed below (CSA Z1003) were used as primary causal factors and informed discussions to identify the root causes (secondary and tertiary causal factors) of psychological harm in LTC. Fifty-one (51) secondary causal factors and 229 tertiary causal factors were identified. Ten of the 51 secondary causal factors – listed below - were selected for brainstorming solutions to prevent psychological harm.

PRIMARY CAUSAL FACTORS FOR PSYCHOLOGICAL HARM IN LTC

Workload management	Protection from moral distress	Organizational Culture
Psychological demands	Clear leadership and expectations	Psychological protection

SECONDARY CAUSAL FACTORS FOR PSYCHOLOGICAL HARM IN LTC

1. Staffing: short staffed	6. Resident complexity of care
2. Recruitment and retention	7. Job demands outweigh worker competencies
3. Lack of funding	8. Communication
4. Ratio of staff to residents	9. Psychological Health and Safety not integrated into work
5. Physical and cognitive abilities of staff	10. Turnover

Using secondary causal factors to guide discussions, 144 solutions - grouped by key area of focus, were identified to prevent psychological harm in long-term care.

SOLUTIONS TO PREVENT PSYCHOLOGICAL HARM BY KEY FOCUS AREA

System-level processes and/or resources: Revise provincial processes and/or resources with a focus on funding models, collaborative partnerships, assessment tools and indices.

Education and training: Standardize inclusion of situational, experience-based content in formal education programs, and formalize workplace training opportunities related to both clinical skills and mental health.

Workplace resources: Ensure that equipment, technology, and materials, are available and accessible in the LTC Home and the built environment is designed to support worker mental health.

Work arrangements and compensation: Provide flexible work hours, scheduling, and total compensation packages to meet individual and operational needs.

Staff engagement/involvement: Solicit frequent and meaningful staff input and participation.

Resident care: Identify, understand, and provide holistic resident care using a collaborative, participatory approach.

Career progression and growth: Support workers at career entry, mid-career, and late career by creating career roadmaps, position-specific development plans and mentorship programs.

Role clarity, work assignment and responsibilities: Identify, document, and communicate the unique roles and responsibilities of LTC stakeholders that lead to quality resident care and staff wellbeing.

Job demands: Use evidence-based tools to identify job demands and design work to reduce cognitive, physical, and psychological load.

Workplace policies and procedures: Develop and implement formal policies and procedures for workplace psychological health and safety.

Community interaction: Enhance public facing communication and community programs and partnerships to increase visibility and decrease stigma.

Long-term care homes and collaborators are encouraged to review the full report to best understand causal factors and work collaboratively to action solutions to prevent harm to workers in LTC Homes across Ontario.

2.0 INTRODUCTION

Workers and leaders in long-term care are frequently exposed to events and situations in the workplace that can cause psychological harm. High job demands, exposure to physical and emotional stresses, time pressures, and workplace harassment contribute to staff turnover, inability to recruit and retain staff, and the highest number of workplace injuries across Ontario's public sector Schedule 1 employers[1][2]. Staff feel burnt out, overwhelmed, and unrecognized[3].

Increased demand for complex resident care is a substantial contributor to workload and staffing issues, leading to workplace stress and the overall health and human resources crisis in the long-term care sector[4]. Ontario's long-term care staffing study reports that 'while the demand for long-term care and resident acuity have increased year over year, staffing levels and access to training have not kept a corresponding pace'. Key findings from the report suggest that while staff continue to provide excellent resident care, conditions are not consistent across the sector and 'many dedicated and skilled staff struggle with their conditions of work'. Provincial priorities for action identified in the staffing report include addressing workload and working conditions to retain staff and improve conditions of care, changing the culture at both the system and individual home level, and attracting and preparing the right people for employment in long-term care while providing continued opportunities for learning and growth.

An important part of addressing the staffing crisis in long-term care is understanding the workplace factors that contribute to poor working conditions, workplace culture and ultimately lead to psychological harm. A recent evidence brief commissioned by the Schlegel-UW Research Institute for the Aging (RIA) proposes that risk factors for psychological harm to staff in long-term care exist across three tiers: (1) individual-level factors that contribute to psychological health and safety in the workplace, (2) the organization-level factors that create supportive or harmful working environments, and (3) the system-level factors that cause or contribute to workplace psychological hazards across the long-term care sector[5].

Together with the Ontario Centres for Learning, Research and Innovation in long-term care at the Schlegel-UW Research Institute for the Aging, Public Services Health and Safety Association conducted a Root Cause Analysis (RCA) workshop in November 2023 to understand causal factors and identify solutions for psychological harm to workers in long-term care in Ontario.

The scope of the RCA was defined by the following risk statement:

Working in long-term care can be psychologically demanding. Leaders and worker team members experience events and situations in the workplace that may result in psychological harm.

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[1] Workplace Mental Health in LTC Program, Ontario Centres for Learning, Research and Innovation in long-term care at the Schlegel-UW Research Institute for the Aging

[2] Workplace Safety and Insurance Board

[3] Ontario's long-term care staffing study (2020)

[4] Crisis in long-term care: Workers in need of psychological support. Mental Health Commission of Canada (2022).

[5] Workforce psychological harm in long-term care in Canada: Risk factors and promising practices. CLRI (2024)

The objectives of the RCA workshop were to:

1. Identify workplace psychosocial factors that contribute to psychological harm in long-term care.
2. Identify secondary and tertiary causal factors leading to psychological harm in long-term care.
3. Identify solutions for secondary causal factors to mitigate risk of psychological harm in long-term care workers.

This report presents an overview of the processes used to design, develop, and facilitate the root cause analysis, and an initial interpretation of findings. Long-term care collaborators are encouraged to apply findings at an organization-level (LTC Home) and at the system-level to support staff wellbeing.

3.0 METHODOLOGY

Design, development and delivery of a root cause analysis (RCA) workshop were achieved jointly by the Public Services Health and Safety Association (PSHSA) and the Ontario Centres for Learning, Research, and Innovation (CLRI) hosted at the Schlegel-UW Research Institute for the Aging (RIA).

The RCA was designed and delivered using the risk assessment/root cause analysis process principles developed by the Ministry of Labour, Immigration, Training and Skills Development in alignment with Prevention System priorities to build capacity to conduct risk assessments and identify root causes of workplace injuries, illnesses, and fatalities[6].

RISK ASSESSMENT/ROOT CAUSE ANALYSIS PROCESS PRINCIPLES

Engagement process: Involves people who may be affected by the decisions it makes or can influence the implementation of its decisions.

Empowerment process: Characterizes willingness to provide a platform for decision making with key stakeholders.

Diversity process: Encourages and welcomes diversity of thought, experiences, skills, and talents of participants of all ages, genders, races and sexual-orientations.

Inclusion process: Provides an environment in which all individuals are treated fairly and respectfully, and given equal access to opportunities, resources and accommodation where they might otherwise be excluded from participating.

WORKSHOP

The root cause analysis workshop took place in Toronto, Ontario on November 01 and 02 2023. The workshop was held in person to support a safer space for open, honest, and respectful discussions.

[6] Ministry of Labour, Training and Skills Development (2021), *Prevention Works: Ontario's Occupational Health and Safety System in Action - 5-Year Strategy*, https://www.ontario.ca/document/prevention-works/prevention-works-5-year-strategy

Stakeholder selection and participation

In line with MLITSD risk assessment/root cause analysis process principles, balanced participation in the RCA workshop from workers, supervisors and industry experts was sought and secured.

Shared experiences of workers during direct and indirect resident care, or as a member of support services directly informed identification of emotional exposures and workplace factors that contribute to psychological harm. Worker input ensured that identified solutions are relevant and applicable in large, small, urban, rural and indigenous long term care homes across Ontario.

Contribution and insight from clinical care or non-clinical leaders, directors of care, administrators or human resources leaders ensures that consideration is given to both job factors and organizational factors when identifying causes of psychological harm. Substantial knowledge of operational challenges helped inform solutions for health protection and promotion while being mindful of operational constraints such as health and human resources, funding allocation and logistical challenges.

Subject matter experts from Ontario's Prevention System, Healthcare System, Research institutes, Long Term Care Associations and National Commission brought a systems-perspective which helped participants understand constraints and enablers to prevent psychological harm in diverse long term care homes across the province.

A multi-channel call for participation using an MS Forms survey was launched widely in June 2023. The call for participation closed late July 2023 and garnered responses from seventy-one (71) interested worker and employer representatives from across Ontario. A stakeholder mapping exercise was used to ensure demographically diverse worker and employer representation in the workshop. Consideration was given to geographic location of the long-term care home being represented (rural, urban, northern), size of the home (large, medium, small), clinical care and non-clinical care/support responsibilities of the workshop participants, Indigenous communities, and public vs private homes.

An initial round of workshop invitations was sent out to worker, employer, and subject matter experts in August 2023. Not all those who had initially expressed interest in participating in the workshop were able to attend, therefore subsequent invitations were sent out by email in September and October to ensure equal worker (n = 6) and employer (n = 6) representation at the workshop.

In addition to worker and employer representation, participation was sought and secured from subject matter and industry experts from the Ministry of Labour, Immigration, Training and Skills Development (MLITSD), Ministry of Long-Term Care (MLTC), Mental Health Commission of Canada (MHCC) AdvantAge Ontario, the Ontario Long Term Care Association, Ontario Tech University, CLRI and PSHSA.

Twenty-four (24) participants, four (4) facilitators, and six (6) administrative support individuals participated in the workshop. Participant roles and responsibilities were clearly communicated during workshop orientation and at the outset of the workshop.

Orientation

A one-hour virtual workshop orientation session was held three weeks prior to the workshop date. The orientation session introduced participants to the workshop objectives, key materials required for review before the workshop, and requested completion of a pre-workshop survey. The pre-workshop survey sought information from participants on their existing level of knowledge and understanding of psychological health and safety in long-term care, and their expectations of the workshop. The orientation session was recorded and shared with all participants.

Workshop Materials

Many materials were developed to support an engaging and participatory experience during the root cause analysis workshop.

Participant Materials

Workshop orientation materials were developed and shared with workshop participants by email. Orientation materials were housed and available for reference electronically. Materials required for review by participants prior to the workshop included the workshop agenda, definitions of workplace psychosocial factors, information on root cause analyses, participant roles and responsibilities and the workshop orientation session deck. Optional review materials were provided to enhance knowledge of psychological health and safety and enable meaningful, participatory discussions during the workshop.

A workshop package was created, and hard copies were printed and provided to participants at the outset of the workshop for reference throughout.

Workshop Participant Package

- Name tag
- Workshop agenda
- Psychological harm – definition
- Psychosocial factors definitions
- Workshop guiding principles & roles
- Breakout groups
- RCA process document
- Workshop team contacts
- Community supports available

Facilitator Materials

A series of electronic materials were created to assist the facilitators prepare for and lead meaningful and effective discussions during the workshop. A pre-workshop survey sought information from participants on their existing level of knowledge and understanding of psychological health and safety in long-term care, and their expectations of the workshop. The survey also requested that participants identify six workplace psychosocial factors most likely to cause psychological harm to LTC workers including three specific examples that are likely to negatively impact worker mental health.

To record/document root causes, electronic cause-and-effect diagrams were used to document identified secondary and tertiary factors in real-time during both large-group and breakout-group discussions. Visio sheets with cause-and-effect diagrams for each primary causal factor were created before the workshop.

An electronic survey was used to prioritize the top ten causal factors to bring forward for solution brainstorming.

An electronic survey was used to evaluate the effectiveness of the workshop at the end of day two. The MS Form was created in advance of the workshop. Participants accessed the form via their mobile device at the end of day two.

Facilitator guidance notes were created and provided to facilitators knowledgeable in workplace psychosocial factors and the RCA process to help guide discussions during causal factor identification and solutions brainstorming on days one and two of the workshop respectively.

Workshop Activities

Workshop activities were scheduled over two days. Due to the sensitive nature of discussions, participants were provided a quiet space to take a break, a workshop facilitator to connect with and access to community resources should they be required.

Objectives of workshop activities were to:

- Identify workplace psychosocial factors that contribute to psychological harm in long-term care
- Identify secondary and tertiary causal factors leading to psychological harm in long-term care
- Identify solutions for secondary causal factors to mitigate risk of psychological harm in long-term care workers

Please refer to Appendix A for the detailed agenda.

Identifying Primary Causal Factors for Psychological Harm

At the start of the workshop, participants were presented with a definition of psychological harm and led through a review of the root cause analysis process using a cause-and-effect fishbone diagram. The fishbone diagram is considered one of the seven basic tools for quality control and improvement and the most robust method for conducting a root cause analysis[7]. It helps users identify the various causes leading to an effect, usually depicted as a problem to be solved. Causes and sub-causes are usually grouped into six main categories - people, equipment, material, environment, process and culture. Here, workplace psychosocial factors[8] were used as causal factor groupings in lieu of the six traditional categories.

Workplace psychosocial factors (primary causal factors) are defined as follows:

Balance: A work environment where employees are supported to manage the demands of work, family, and personal life.

Civility and Respect: A work environment where all stakeholders are considerate and fair in their interactions with each other.

Clear Leadership and Expectations: A work environment where employees know what they need to do, have confidence in their leaders, and understand impending changes.

Engagement: A work environment where employees are motivated to do their job well and feel connected to their work, co-workers, and organization.

Growth and Development: A work environment where employees receive ongoing encouragement and support in the enhance their interpersonal, emotional, and job-related skills.

Involvement and Influence: A work environment where employees are included in discussions and have input into decisions that impact their respective jobs.

[7] Canadian Society of Safety Engineers, Essentials of Risk Management for OHSE Practitioners, CHSC Certification Course, 2022.

[8] CSAZ1003 Standard for Psychological Health and Safety in the Workplace

Organizational Culture: A work environment with shared values of trust, honesty, fairness and accountability.

Protection of Physical Safety: A work environment where management takes appropriate action to protect all employees against injury and illness and ensures they have what they need to do their jobs safely.

Psychological Competencies and Demands: A work environment where employees are continually supported to meet the psychological demands of their position.

Psychological Protection: A work environment where employees are free from bullying, harassment, stigma and discrimination.

Psychological and Social Support: A work environment where all employees feel a sense of belonging and contribution.

Recognition and Reward: A work environment where there is appropriate acknowledgement and appreciation of employees' efforts in a fair and timely manner.

Workload Management: A work environment where employees feel supported to complete their assigned tasks and responsibilities successfully.[9]

Support for Psychological Self-Care (Healthcare): A healthcare workplace where staff are encouraged to care for their own psychological health and safety.

Protection from Moral Distress (Healthcare): A healthcare work environment where staff are able to do their work with a sense of integrity that is supported by their profession, their employer and peers.[10]

An electronic cause-and-effect diagram - pre-populated with primary causal factors (psychosocial factors) - was displayed on a large screen visible to participants. Select secondary causal factors were pre-populated on the diagram based on participant responses to a pre-workshop survey. Additional secondary and tertiary causal factors were identified and documented on the cause-and-effect diagram during a large-group discussion. Following the large group discussion, six psychosocial factors were selected for further exploration of secondary and tertiary causes of psychological harm. Selection was informed by results of the group discussion, a high-level jurisdictional scan of psychological harm in LTC, and findings of the Guarding Minds @ Work survey administered provincially to LTC homes participating in the MH in LTC initiative led by CLRI at the RIA.

Identifying Secondary Causal Factors for Psychological Harm

Secondary causal factors for psychological harm were identified during small group discussions. Three groups, each comprising two workers, two employers, subject matter experts, ministry and LTC association representatives identified secondary and tertiary causal factors related to two workplace psychosocial factors (Appendix B). Facilitators prompted discussion by encouraging participants to think critically about:

- How psychosocial factor constructs used in the Guarding Minds at Work survey apply in Long Term Care, and

[9] Guarding Minds at Work

[10] Mental Health Commission of Canada

- How people, equipment, materials, environment and processes contribute to the respective psychosocial factor.

Where relevant, facilitators used the '5 why's' approach, and asked participants to 'tell me more' to gain a deeper understanding of causal factors.

A summary of secondary causal factors identified during small group discussion was shared with the large group and opportunities were presented for further discussion and clarification. Cause-and-effect diagrams for the six primary causal factors and their respective secondary and tertiary causal factors are found in Appendix C.

Causal factor prioritization

At the end of day one of the workshop, participants used a survey to rank the relative importance of each secondary causal factor on the following seven-point scale.

1. Not Important
2. Low Importance
3. Slightly Important
4. Neutral
5. Moderately Important
6. Very Important
7. Extremely Important

Scores for each causal factor were added across respondents and ranked in order of highest score to lowest score across the following respondent groups: All respondents, Worker respondents, Employer respondents and Subject matter expert respondents. Causal factor rankings were compared across groups. The top ten causal factors identified by *both* the worker and employer respondent groups were prioritized to bring forward to brainstorm solutions to prevent psychological harm. Secondary consideration was given to the subject matter expert respondent group rankings.

Brainstorming Solutions to Prevent Psychological Harm

On the second day of the workshop, using a 'blue-sky' mindset, participants brainstormed solutions to prevent psychological harm to workers in long-term care. The top ten secondary causal factors for psychological harm identified during day one were used to inform discussions.

The large group collectively identified solutions for one causal factor before moving back into the small groups from day one. Each small group brainstormed solutions for three secondary causal factors. Participants were instructed to consider solutions at the system, workplace, and individual levels and to identify potential collaborators for each solution. Facilitators guided discussion with reference to the broader categories of people, equipment, materials, environment and process and the hierarchy of controls where applicable.

At the end of the workshop, participants completed a survey to evaluate the effectiveness of the workshop. Evaluation criteria included the quality of preparation materials, connection opportunities, successful identification of root causes and solutions for preventing psychological harm in LTC, quality of facilitation and overall value of the workshop (refer to section 6.0).

4.0 FINDINGS

A summary of findings and a high-level interpretation of data from the root cause analysis workshop are presented in this report. Readers are encouraged to access a more fulsome data set through the Public Services Health and Safety Association website.

CAUSAL FACTORS FOR PSYCHOLOGICAL HARM

Primary Causal Factors for Psychological Harm in LTC

Fifty-one (51) secondary causal factors and 229 tertiary causal factors for psychological harm were identified across six workplace psychosocial factors. Primary and secondary causal factors for psychological harm are summarized below. Brackets ( ) indicate number of associated tertiary causal factors i.e. Workload Management (81) indicates that there are 81 tertiary causal factors related to workload management.

Detailed cause-and-effect diagrams for each of the six primary causal factors are found in Appendix C.

Workload management (81)	Psychological demands (28)
• Consistently short staffed (3) • Ratio of staff to residents (5) • Physical environment (6) • Lack of preventative maintenance of equipment (4) • Staff skill levels (6) • Human resources (5) • Resident health status/care levels (8) • Physical and cognitive abilities of staff (5) • Funding (7) • Team (12) • Continuous requests for additional required tasks (9) • Recruitment/retention (11)	• Resident complexity of care (0) • Job demands outweigh worker competencies (5) • Communication (6) • Lack of support & communication on resident death (3) • Psychological health and safety not integrated into work (3) • Not recognizing emotional bonds with residents (3) • Professional practice vs policies and procedures (2) • Reactive system or organizational response to needs (0) • Care not in line with beliefs/values (2) • Invisible work (4)
Organizational Culture (21)	**Clear leadership and expectations (31)**

- Staff response to difficult situations (3)
- Sociopolitical climate (2)
- Turnover (6)
- Inherent bias, prejudice, privilege (3)
- Demographics and home location (1)
- Task-oriented (4)
- Fairness and accountability (2)

- Challenges not addressed (4)
- Leaders unclear of their role and expectations (3)
- Constant change (6)
- Training (1)
- Lack of accessible people resources for problem solving (4)
- Lack of understanding of employee needs and journey (5)
- Leadership skills (2)
- Communication (6)

Protection from moral distress (36)	Psychological protection (32)
• Lack of understanding from HC systems of LTC services and public image (10) • Scheduling (4) • No operational pause (8) • Prioritization of resident care over self-care (2) • Competing and contrasting priorities (12)	• Presence of leaders (2) • Equity, Diversity and Inclusivity (5) • Conflict of workers rights vs resident rights (4) • Fear/blame culture (12) • Compliance focus (4) • Workplace provision of emotional supports (5)

Secondary Causal Factors for Psychological Harm in LTC

Of the 51 secondary causal factors for psychological harm identified on day one, ten were prioritized to guide discussions for solutions to prevent harm on day two. When selecting the top ten, worker and employer group rankings were prioritized, with secondary consideration given to the subject matter expert group. (See Appendix D for rankings by group). Worker and employer groups reached agreement on 8 of the top 10 secondary causal factors and the top three causal factors (short staffed, resident complexity of care and lack of funding) were mutually agreed upon by all participant groups.

1. **Staffing: short staffed**
2. **Recruitment and retention**
3. **Lack of funding**
4. **Ratio of staff to residents**
5. **Physical and cognitive abilities of staff**
6. **Resident complexity of care**
7. **Job demands outweigh worker competencies**
8. **Communication**
9. **Psychological Health and Safety not integrated into work**
10. **Turnover**

Fifty percent of secondary causal factors for psychological harm relate to workload management, 33% relate to psychological demands and the remainder relate to organizational culture and leadership & expectations. Causal factors are largely interconnected.

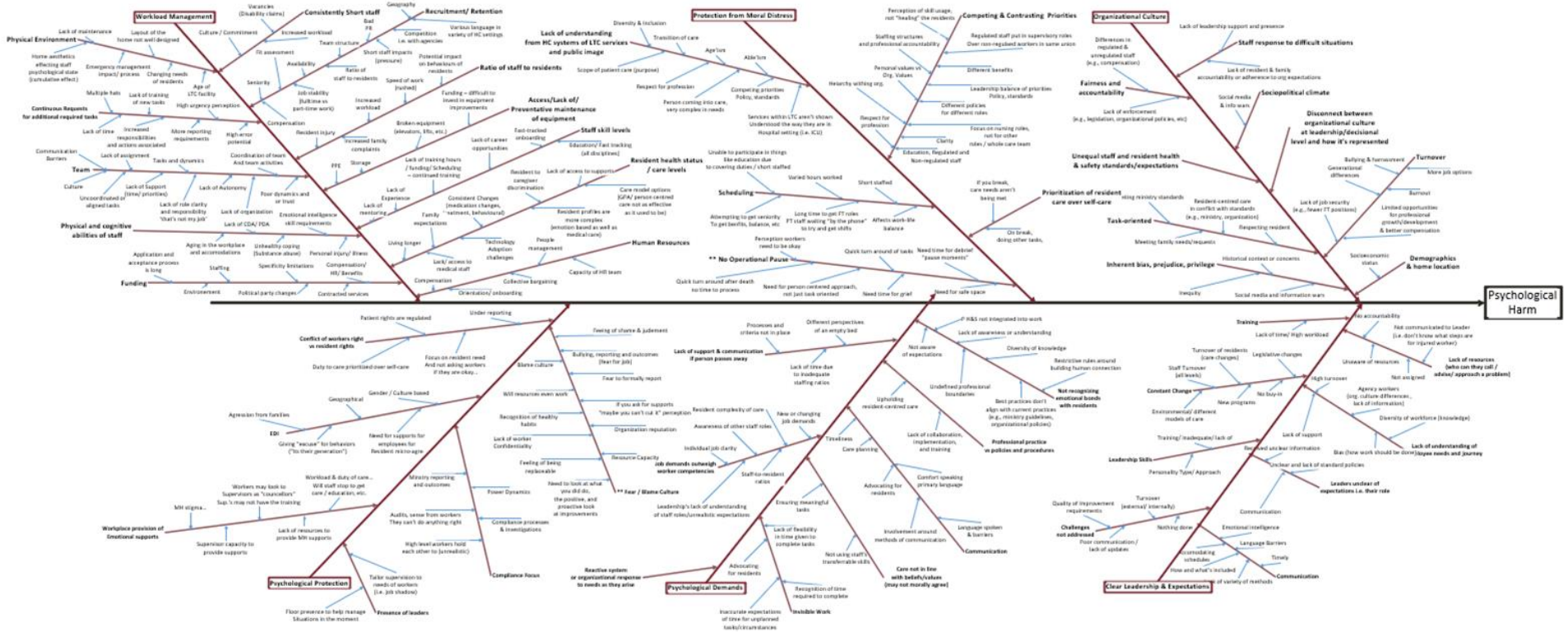


Figure 2. Cause and effect diagram illustrating the six selected primary causal factors and associated secondary and tertiary causal factors for psychological harm for workers in long-term care.

SOLUTIONS TO PREVENT PSYCHOLOGICAL HARM

Using secondary causal factors to guide discussions, 144 solutions were identified to prevent psychological harm in long-term care. Solutions were reviewed and collated into eleven key areas of focus to support knowledge mobilization and action planning. Readers are encouraged to review the solutions presented by key areas of focus within this report and explore the full list of solutions identified in the workshop, available in a sortable Microsoft Excel table.

Key areas of focus to prevent psychological harm to workers in long term care

System-level processes and/or resources: Revise provincial processes and/or resources with a focus on funding models, collaborative partnerships, assessment tools and indices.

Education and training: Standardize inclusion of situational, experience-based content in formal education programs, and formalize workplace training opportunities related to both clinical skills and mental health.

Workplace resources: Ensure that equipment, technology, and materials, are available and accessible in the LTC Home and the built environment is designed to support worker mental health.

Work arrangements and compensation: Provide flexible work hours, scheduling, and total compensation packages to meet individual and operational need.

Staff engagement/involvement: Solicit frequent and meaningful staff input and participation.

Resident care: Identify, understand, and provide holistic resident care using a collaborative, participatory approach.

Career progression and growth: Support workers at career entry, mid-career, and late career by creating career roadmaps, position-specific development plans and mentorship programs.

Role clarity, work assignment and responsibilities: Identify, document, and communicate the unique roles and responsibilities of LTC stakeholders that lead to quality resident care and staff wellbeing.

Job demands: Use evidence-based tools to identify job demands and design work to reduce cognitive, physical, and psychological load.

Workplace policies and procedures: Develop and implement formal policies and procedures for workplace psychological health and safety.

Community interaction: Enhance public facing communication and community programs and partnerships to increase visibility and decrease stigma.

Key areas of focus and associated solutions to prevent psychological harm in LTC are expanded below.

SYSTEM-LEVEL PROCESSES AND/OR RESOURCES

Opportunities exist to create or enhance collaborative partnerships between LTC homes, research institutes and post-secondary institutions related to exploration of evidence-based measurement and assessment tools applicable within the home. New or enhanced funding models and funding autonomy may be explored based on the use of predictive resident status and level of resident care. These solutions have the potential to positively impact both staff wellbeing and quality resident care.

Partnerships and collaboration

- Explore collaborative partnerships between LTC homes and research institutes to develop systems and processes for ongoing evidenced based measurement of resident-acuity.
- Enhance collaboration and partnership between LTC homes and post-secondary institutions to recruit and provide LTC position opportunities.
- Expand access to organizational psychology services at the System level.
- Include psychological health and safety in Ontario's Occupational Health and Safety Act and Regulations

Funding

- Review funding models used in Acute Care and consider using similar models when allocating resources and support to LTC homes.
- Explore benefits to changing the funding model based on:
    - predictive and current resident status vs delayed resident assessments.
    - number of staff hours required for highest resident care category.
    - quality outcomes vs care criteria.
- Develop and institute system-level funding for residents on the Crisis List.
- Enhance streams for funding infrastructure updates.
- Enhance visibility/access to available funding and funding forums.
- Allow flexibility and spend autonomy related to available and provided funds.
- Extend timeframes for funding applications and spending.

Assessment tools and indices

- Standardize measurement tools in LTC homes to better allocate resources based on available funding.
- Revisit the Case Mix Index and hours of care to ensure accurate reflection of current state of residents in LTC.
- Review and update Resident Assessment Instrument-Minimum Data Set (RAI-MDS) system to accurately reflect "date in time" resident changes and care needs, contributing to funding needs.
- Develop and/or enhance systems to audit LTC homes on clinical and non-clinical practice variances (what homes practice versus professional standards and scopes of practice).

Pay equity

- Create legislation to support equitable pay for workers working in LTC homes versus staffing agencies.
- Standardize and align role-based pay across the industry/homes.

Other

- Create standard reporting guidelines or criteria to allow homes to indicate shifting priorities (during crisis) without penalty.
- Integrate mental health care into OHIP.

EDUCATION AND TRAINING

Providing financial assistance for students entering careers in LTC through scholarships and paid internships can lead to better recruitment and retention. Creating and offering standardized post-education, pre-placement, experience-based programs for new workers entering LTC enhances knowledge-to-practice and supports worker-retention post-hire. Post-hire, LTC homes can create robust workplace-training programs where workers and leaders are given the opportunity and time to attend both clinical/practical skills-based sessions, and mental-health related training to support a psychologically safe workplace.

Formal education

- Offer provincial scholarships or bursaries for LTC-related education.
- Offer/standardize pay for clinical hours for nursing students. Share costs provincially, municipally and in-home.
- Sponsor secondary/post-secondary co-op programs in-home to promote opportunities and careers in LTC.
- Review education requirements for non-clinical roles. Identify which roles require secondary vs post-secondary education to widen candidate pools during recruitment.
- Develop international education standards for clinical roles to support efficient transfer between countries.
- Work with formal education institutions to ensure that educational programs include content/situational training relative to LTC role activities, environment, and demands.

Practical education and experience

- Restructure interdisciplinary clinical bridging programs (PSW, RPN, RN) to upskill and retain staff.
- Create and require participation in a standardized post-education, pre-placement program prior to starting work in LTC. This program should be an experience-based, practical program to support knowledge-to practice competencies and ensure 'real-world' experience prior to onboarding in the home for clinical and non-clinical roles.

Education and upskilling in the workplace

- Upskill staff and enable them to work within their full scope of practice.
- Train staff to support multiple functions across roles in the home.
- Ensure that LTC leaders have the knowledge, skills and abilities to recognize, address and validate worker physical and psychological needs.
- Provide access to and ensure compliance with mental health awareness training for LTC workers and leaders.
- Use small huddles to transfer information and education more efficiently to team members.
- Ensure systems are in place to support knowledge transfer from leaders to workers.
- Train workers and leaders on effective communication and collaboration practices. Provide appropriate tools and resources to ensure effective team communication.
- Engage external providers and subject matter experts to upskill staff where internal expertise and/or capacity are not available.
- Educate staff on psychological health and safety during safety huddles, job shadowing, job coaching or other means. Ensure equitable access to training and information.
- Provide leaders with education and tools for psychologically safe conflict resolution to support inter team dynamics, conflicts, and toxicity.

WORKPLACE RESOURCES

Workplace resources include equipment, materials (including reference materials) and technology available in the LTC home, and the built environment/physical space. Employers must provide adequate and appropriate job resources to enable workers to perform job tasks safely and effectively. Chronic under-resourcing and exposure to high physical job demands contributes to job-stress and may lead to both physical and psychological harm. Access to available workplace resources can be enhanced by allowing LTC homes to have flexibility and spend autonomy related to provincially provided funds.

Technology and Equipment

- Explore use of assistive devices (exoskeletons, client mechanical lifts and devices) to reduce strain during manual patient handling tasks.
- Identify and provide resources that enable staff to meet the cognitive demands of their job (training, technology, equipment, leadership and co-worker support etc).
- Explore use of automation and machines for repetitive/manual tasks to reduce physical and administrative burden on staff.
- Optimize staffing models.
    - Use machine learning to predict required staffing levels by resident, time of day/shift and unit location.
    - Use automated applications (ie Staff Scheduled Care) to fulfill staffing needs.
- Provide means and mediums for digital communications for staff to communicate with each-other from separate floors/rooms within the LTC home.
- Use technology (software equipment, apps) to create efficiency during administrative tasks and resident interaction (google translate).
- Provide a centralized and consistent means for housing and communicating information and resources for staff wellbeing.
- Improve charting, documentation and medical records systems across all LTC homes and community providers to improve sharing of information.

Built Environment

- Enhance staff break areas in the built environment to encourage healthy practices (healthy food preparation and storage, comfortable chairs, etc.).
- Change the built environment (LTC Home) to foster inter-generational connections and partnerships.
- Provide quiet spaces free from distractions for cognitively demanding tasks such as charting and resident care plan development.

WORK ARRANGEMENTS AND COMPENSATION

Exploring increased flexibility related to work hours and work schedules in LTC Homes were identified as a possible means to better retain staff and decrease turnover. Competitive and flexible compensation and benefits packages that move beyond traditional extended benefits by offering unique incentives in-line with operational need may also support retention and help mitigate staffing shortages by enhancing worker satisfaction. Many solutions identified may be implemented by collaborative partnerships between LTC Homes, benefits providers and the Ministry of Long-Term Care.

Flexible work arrangements

- Explore job-sharing with creative and standardized approaches, such as a passport program idea, to assist with an easier and consistent transition between roles and homes/organizations.
- Where feasible, plan for and offer flexible work schedules to staff (e.g. compressed work weeks).
- Offer flexible working hours with consideration for shift start times to accommodate part-time workers and/or students. (e.g. 4:00pm start time for high school students working in dietary services).
- Offer virtual or hybrid flexible work arrangements to allow worker flexibility and control.

Flexible compensation and benefits

- Improve employee total compensation packages by allowing flexible use of extended benefits.

- Explore options for providing flexible benefits and incentives to staff in line with operational and organizational need. For example, reward good attendance or additional shifts (within reason) with a flexible points system awarded to the individual worker or offer a paid day off for becoming a preceptor.
- Align and maximize total compensation packages including financial and non-financial incentives for staff.

STAFF ENGAGEMENT/ INVOLVEMENT

Opportunities to seek input and feedback from workers in more frequent, engaging ways related to evolving need, risk identification and mitigation, means of communication, and leadership presence were identified as possible solutions to increase staff wellbeing and reduce risk of psychological harm.

- Solicit input directly from workers on an ongoing basis to identify their own unique needs. Continue to seek ongoing input to support staff as needs evolve.
- Solicit and encourage worker participation when developing communication strategies and knowledge translation strategies.
- Demonstrate leadership presence by engaging in walk-throughs to talk to staff and residents.
- Clarify and communicate how workers can best approach leaders with health, safety, and wellbeing concerns.
- Identify LTC worker values. Link worker values to LTC home culture activities. Explore opportunities for team agreements.
- Conduct a home-specific Root Cause Analysis exercise related to turnover. Ensure that key stakeholders are engaged.

RESIDENT CARE

Identifying, understanding, and communicating the full scope of resident physical, cognitive and psychological care needs was identified as an area of opportunity across and within LTC Homes. Solutions related to collaborative resident care include ensuring that residents are provided access to enhanced medical care for complex needs and community-based resources and programs. Residents can be provided with a sense of purpose and community by being assigned small and meaningful tasks in the LTC home that support organizational/operational need.

Resident Assessment

- Identify and meet the holistic needs of residents (physical, cognitive, sexual, relational, etc.). Ensure that a comprehensive resident needs assessment is completed on admission and as needed, with consideration for physical and psychological need.
- Recalibrate measurement tools such as RAI (Resident assessment instrument) LTC version 2.0 with residents life factors, and care giver factors. Can also include clinical assessment protocols (CAPs).
- Revisit resident ratios with consideration for resident complexities and social needs (not just physical clinical needs), to develop plans and allocate staff appropriately.

Collaborative care

- Need to ensure considerations for worker rights, emerging technology, codes of conduct, health and safety legislation, and professional scope of work as well as Resident Rights.
- Demonstrate leadership presence by engaging in walk-throughs to talk to staff and residents.
- Develop standardized processes/approaches to seek input from residents and families on information gathering, decision making and communication.
- Shift the focus of care from illness to wellness to help residents thrive. Provide the necessary people and equipment resources.

- Provide access to enhanced medical/professional support for complex resident cases. E.g., medical/language communication.
- Ensure that the appropriate people resources are in place to support the psychological needs of residents.
- Give residents a sense of purpose and community by assigning them meaningful tasks (little jobs).
- Provide residents and staff with access to community-based supports such as recreational programs and facilities, occupational therapy, chaplains, and therapy dogs.

CAREER PROGRESSION AND GROWTH

Implementing solutions to better support workers at career entry, during mid-career years and approaching end-of-career were identified as opportunities to positively impact recruitment and retention, staffing levels and turnover, while also mitigating risk of psychological harm to workers. LTC Homes can work collaboratively with LTC associations and the Ministry of Long-Term Care to create career roadmaps, position-specific development plans, and mentorship programs and practices that prioritize succession planning and the aging workforce.

Career Entry

- Create big picture roadmaps for career entry and visible paths for career growth and development in LTC. Include entrance-to-practice education requirements, skill progression, growth and development opportunities, and insight into the day-to-day experiences.
- Consider job skills, experience, and education at recruitment.
- Develop and institute formal processes for knowledge transfer between generational (and experienced/new) workers in long term care homes.

Career Progression

- Develop position-based professional development plans. Monitor and support implementation of the plans.
- Strengthen mentorship programs and practices by adopting coaching models to support worker success. Assign LTC success coaches to workers.
- Conduct regular “stay at work” interviews with LTC staff. Questions may include what is working well, what you enjoy about your job, challenges, and safe environments.
- Prioritize succession planning in support of recruitment and retention by regularly reviewing staff demographics and career progression.

Career End

- Explore solutions to support the aging workforce in LTC such as modifying retirement ages and job roles/tasks within the home.
- Explore feasibility of supporting/retaining workers who wish to work past normal or traditional retirement age.
- Conduct employment exit interviews to identify and understand staff concerns and apply prevention and improvement measures to support future retention

ROLE CLARITY, WORK ASSIGNMENT, AND RESPONSIBILITIES

Every LTC Home stakeholder has a unique and important set of responsibilities that, when executed properly, ensures that residents receive quality care, staff work in a healthy and safe environment and organizational/operational needs are satisfied. Role clarity, work assignment and job responsibilities were

identified as having substantial opportunities for improvement in LTC leading to subsequent reduction of worker psychological harm.

Human Resources

- Clarify the scope of support of human resources professionals in LTC homes related to worker recruitment and retention.
- Review organization position structure to support alignment of role activities, expectations, responsibilities, and support.
- Communicate, confirm, and ensure LTC home leaders and senior leaders are aware of their supervisory responsibilities under the Occupational Health and Safety Act. Put resources in place to support supervisor competency.
- Involve staff (as appropriate) in development/updating of job descriptions, and clearly communicate responsibilities and expectations.
- Integrate community relations-related work as part of standard job tasks for staff to establish the LTC home as a part of the surrounding community.
- Build HR time and space into workflow for workers during regular working hours.
- Explore creative and standard approaches to job-sharing (e.g. passport program), to facilitate simple and consistent transition between roles and homes/organizations.
- Hold supervisors accountable for addressing workplace discrimination, stigma, bullying, and harassment.

Leaders

- Assign work according to evidence-based assessment of resident acuity.
- Capture the value potential of workers by documenting staff knowledge, skills, abilities, and competencies. Assign work appropriately/equitably.
- Consider autonomy when assigning work. Job match according to worker strengths, education, job skills, experience, interests, etc.
- Ensure that leaders communicate both by words and through actions that time for staff self-care and/or emotional support is organizationally supported.
- Document and communicate expectations related to changes in scope of practice (i.e. RN prescribing medications) as they relate to increased job demands.
- Focus on cross-functional teams and roles to decrease silos and create more autonomy. Upskill staff and enable work within the full scope of practice.

Joint Health and Safety Committee/Health and Safety Representative

- Build organizational capacity for psychological health and safety by empowering and educating the joint health and safety committee/health and safety representatives.
- Provide psychological health and safety training, role clarity and relative procedural/template updates for joint, health and safety committees and health and safety representatives.

Volunteers

- Recruit, retain and utilize volunteers and students to support LTC Home tasks.
- Enable volunteers and students to provide basic support for residents (get water, etc.) to increase capacity for clinical and non-clinical staff to meet complex resident needs.

Residents and Family Members

- Define (expand) and communicate the role and expectations of resident family members such as giving staff access to information on resident medical/personal/language needs.

JOB DEMANDS

Job demands are the physical, cognitive, psychological, and environmental demands of the job. LTC Homes can work with their Health and Safety Association or industry partners to mitigate risk of psychological harm by using evidence-based tools to identify the demands of the job, design work to reduce cognitive, psychological, and physical load, and where necessary – modify jobs and job tasks to meet worker abilities.

- Use evidence-based tools to identify and communicate the cognitive and psychological job demands required in each clinical and non-clinical job position.
- Document the "invisible work" being done by workers in LTC homes, which is necessary yet not within job descriptions or daily task lists.
- Document and communicate expectations related to changes in scope of practice as they relate to increased job demands.
- Design work rotations to reduce cognitive & physical load.
- Modify jobs and job tasks to meet worker cognitive and physical abilities.

WORKPLACE POLICIES AND PROCEDURES

A general lack of formal workplace policies and procedures in LTC homes were identified as a contributor to psychological harm to workers. The LTC home can work collaboratively with the LTC Association(s), MLITSD and (where relevant), their health and safety association to develop and institute workplace policies and procedures to create safe environments for healthy workers. It is particularly important to consider the integration of psychological health and safety policies, procedures and programs into existing workplace health, safety and wellbeing policies, programs, and management systems. Identification of workplace factors that may cause psychological harm, ensuring psychological incidents and injuries are reported and investigated appropriately, and post-exposure supports/recovery are in place to prevent further harm or recurrence is critical to prevent psychological harm.

Health and Safety (Psychological Health and Safety) Policies and Procedures

- Provide appropriate psychological debrief after exposure to situations with the potential to cause psychological harm (e.g., resident death or substantial responsive behaviour).
- Develop and implement standard procedures for operational pauses following exposure or secondary exposure to potentially traumatic events such as a resident death.
- Incorporate psychological health and safety in monthly joint health and safety committee workplace inspections.
- Share psychological health and safety-related staff and resident incident reports and data with the joint health and safety committee.
- Identify and action solutions to minimize resident responsive or offensive behaviours. Involve the appropriate care team members and conduct a root cause analysis to understand and mitigate the root causes of the behaviour leading to the incident/exposure. Ensure that staff are aware of the right to refuse unsafe work process and limitations.
- Stop normalizing resident responsive behaviours; increase health and safety injury and incident reporting, including psychological incidents, injuries, and illnesses.
- Clearly communicate resident history and established care processes to staff.

Communication and Knowledge transfer

- Develop standard communication protocols (means, method, and frequency of communication to workers) related to organizational change.
- Ensure systems are in place to support knowledge transfer from leaders to workers.
- Use small huddles to transfer information and education more efficiently to team members.

- Develop and institute formal processes for knowledge transfer between generational (and experienced/new) workers in long term care homes.

Other

- Provide leaders with education and tools for psychologically safe conflict resolution to support inter team dynamics, manage conflicts, and mitigate toxicity.
- Develop and communicate procedures to ensure leadership accountability and timely support.
- Explore standardizing informal processes used by staff to meet organizational need and resident care need.

COMMUNITY INTERACTION

Many opportunities were identified for better interaction with LTC Home communities, including enhancing public facing communication to increase visibility, awareness, and decrease stigma associated with working in long term care. Creating collaborative community partnerships to increase volunteer recruitment and student-involvement in LTC homes was also brought forward. Enhanced community interaction supports recruitment and retention and may lead to reduced staff turnover.

Public facing communication.

- Develop and launch public media campaigns on working in LTC, the value of LTC to society and communities, and why LTC roles are meaningful/fulfilling.
- Ensure transparent communication to the public on established health and safety policies, procedures, practices, and data to combat perceptions that work in LTC results in contraction of communicable diseases and health risks to staff.
- Increase public education and awareness of LTC contributions to the healthcare system and the community.
- Explore opportunities to change commonly used language in LTC to promote inclusivity, decrease stigma and positively shift public perception of LTC.

Community programs and partnerships

- Create structured volunteer programs. Include volunteer work in LTC as a standard option for high-school students.
- Create partnerships between LTC homes, employment centers and government entities to promote LTC as a meaningful and impactful employment opportunity and a great place to work.
- Sponsor high school/post-secondary co-op programs and other opportunities (in the LTC home) to promote career options in LTC.
- Expand resident care beyond the LTC home and into the community to normalize the LTC care experience and decrease stigma associated with working in LTC.

5.0 DISCUSSION AND CONCLUSIONS

Data presented in this report are condensed and consolidated. Opportunities exist for a full analysis of data related to potential stakeholder collaborations and partnerships, direct impact to the LTC Home and enhanced System-level processes and resources. Readers are encouraged to engage in a detailed review of findings available on the PSHSA website with consideration to their unique challenges and opportunities.

Findings presented in this report align with the findings of Ontario's long term care staffing study suggesting that the LTC staffing crisis can be directly and positively impacted by creating a psychologically healthy and safe place to work. Key areas of overlapping findings relate to:

- revising provincial processes and/or resources with a focus on the funding model and legislative/regulatory framework.
- understanding the resident population and staffing with the appropriate skill mix to support need.
- identifying the unique skillsets of clinical and non-clinical staff and adjusting workload and task assignment to increase the amount of direct care provided to residents.
- taking a team-based approach to care.

These shared findings underscore the interconnectedness of staff wellbeing and quality resident care. Implementing solutions in the LTC home and across the System to reduce or prevent psychological harm to workers will undoubtedly lead to holistic, high-quality resident care.

Many solutions to reduce risk of psychological harm to workers in LTC can be implemented at the system and workplace levels with limited focus at the individual (worker) level. Many solutions can be actioned by LTC homes through collaborative partnerships and external support. Collaborators include the Ministry of Long-Term Care, Ministry of Education, Ministry of Labour, Immigration, Training and Skills Development, LTC Associations, health and safety associations, professional regulatory bodies, labour groups, academic and research institutes and industry/community partners.

LTC Homes are encouraged to use the methodology and findings presented in this report to conduct root cause analyses on a smaller scale (in-home) to understand causal factors for psychological harm unique to their workplace and create tailored solutions for measurable impact to staff. Long-term care collaborators are encouraged to continue to explore and address psychological harm across the long-term care sector to support staff wellbeing and high-quality resident care.

6.0 WORKSHOP EVALUATION

Participant feedback on workshop preparation, delivery and outcomes was overwhelmingly positive. In a workshop evaluation survey completed by 20 participants (5 workers, 6 employers, 9 subject matter experts) all *agreed* or *strongly agreed* that:

- The orientation session adequately prepared them for the workshop.
- The workshop provided opportunities to connect with LTC workers, employers and subject matter experts.
- After participating in the workshop they had enhanced knowledge of psychosocial factors in the workplace.
- After participating in the workshop they had enhanced understanding of the root causes of psychological harm in LTC.
- They gained a deeper understanding of how to prevent psychological harm in LTC.
- The workshop succeeded in identifying root causes of psychological harm in LTC, and
- The workshop facilitators were well prepared, responsive to questions, effective at moving discussions forward and created a safe space that enabled all participants to contribute equitably.

Participants gained most value from:

- Facilitated, open and honest discussions.
- Shared experiences from a variety of diverse perspectives and roles.
- Networking, collaboration and knowledge sharing with peers and colleagues from across the LTC sector.

"Hearing various perspectives from differing levels/roles, really helped me to think about things in a different way!"
"The way the RCA was facilitated and the tools used were very well done. It helped people to learn how to assess the factors to get to the solutions."
"Learned how to conduct a root cause analysis for psychological safety. I've done university level certification and I feel these two days have been more effective."

CHALLENGES AND OPPORTUNITIES

Securing participation from geographically diverse locations across Ontario was initially challenging given the time commitment and cost required for travel and participation, especially for workers. Workshop organizers were able to offset the cost to workplaces by offering reimbursement for travel, meals, and hospitality (> 100km) in line with Ontario's Management Board of Cabinet Broader Public Sector Expenses Directive, 2011. Participation from indigenous LTC homes (worker and employer) was initially secured but inclement weather leading up to the in-person workshop impeded travel from indigenous and remote communities and those participants were unfortunately unable to attend.

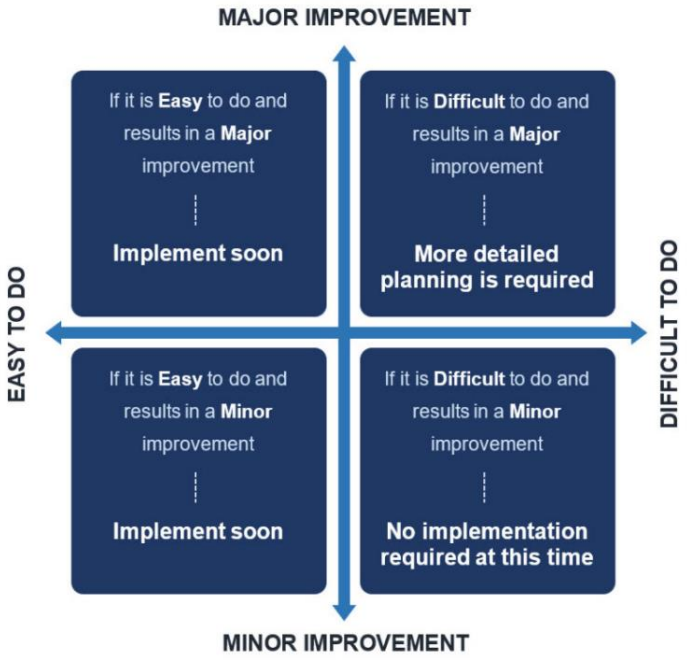
The sensitive nature of discussions surrounding worker mental health and psychological harm required additional time to allow participants to share sometimes emotionally traumatic experiences and exposures making it difficult to fit all the activities into two days. Allocating additional time (a third day) for discussions would have been difficult given the health and human resources challenges experienced by LTC Homes across the province.

Although participants reported that workshop orientation was well organized, opportunities exist for future workshops to prepare a condensed or consolidated orientation package for participants who joined at the last minute. Additional opportunities would be to tailor the information in the orientation package to the role of the type of participant (employer vs worker vs SME).

7.0 NEXT STEPS

Following the publication of this report, findings will be shared widely with stakeholders who participated in the workshop and all stakeholder groups who were identified as collaborative partners for supporting implementation of identified solutions to prevent psychological harm. A knowledge mobilization plan will be developed based on the results of this report, keeping in mind the relevant stakeholders.

PSHSA will review solutions where they are identified as a collaborator and develop an action plan identifying key roles and responsibilities of all collaborators and associated timelines. PSHSA will continue to support the long-term care sector with focused activities to prevent psychological harm to staff.



Long-term care homes are encouraged to review this report and collectively identify applicable solutions where the workplace has a large level of influence in reducing risk of psychological harm.

Workplaces and collaborative partners may consider using an impact vs effort approach when prioritizing solutions. For example, if the solution is easy to do and results in a major improvement, implement it soon. If a solution is difficult to do and results in only a minor improvement, no implementation may be required as this time. Action planning is most successful when actions are prioritized, assigned to the appropriate workplace party and a completion date is identified. Ensure that the solution is evaluated for effectiveness on a regular, ongoing basis.

8.0 ACKNOWLEDGEMENTS

PSHSA would like to acknowledge the support of our funder and prevention system partner, the Ministry of Labour, Immigration, Training and Skills Development.

PSHSA would like to express our appreciation to the worker, employer, Ministry and LTC Association representatives and subject matter experts for their participation in the RCA. We appreciate the perspectives that the participants brought to the project and the thoughtful and passionate discussion on workplace psychosocial factors that impact Ontario's long-term care team members and leaders. This project would not have been possible without the contributions of representatives from the following sector and industry organizations (in no particular order):

Brockville General Hospital	Region of Peel Long Term Care	AdvantAge Ontario
Bruyere Continuing Care	Responsive Management Group	Ontario Centres for Learning, Research and Innovation in Long-Term Care
Dundurn Place Centre	Yee Hong	Mental Health Commission of Canada
Golden Lodge	Newmarket Health Centre and Maple Health Centre	Ministry of Long-Term Care
John Howard Society		Ministry of Training, Immigration and Skills Development
Lancaster Long Term Care Home	Parkview Home	Ontario Long Term Care Association
	Ontario Tech University	Public Services Health and Safety Association

APPENDIX A: WORKSHOP AGENDA

DAY 1 – WEDNESDAY, NOVEMBER 1, 2023

Time	Activity	Location
7:30 - 8:30 AM	**Breakfast and Networking** *Participants are invited to enjoy breakfast and networking in the Alderwood room prior to the start of the workshop*	Alderwood Room
8:30 - 9:00 AM	**Welcome and Introductions** Introduction to the workshop • *Henrietta Van hulle – VP, Health Safety and Wellbeing (PSHSA)* • *Sherri Bastos – Director, Health Safety and Wellbeing (PSHSA)* Introduction of workshop facilitators and workshop agenda • *Tegan Slot – Manager, Workplace Wellbeing (PSHSA)*	Alderwood Room
9:00 - 9:30 AM	**Review of workshop materials and flow** *Definition of Psychological Harm* *Introduction and review of the fifteen (15) Psychosocial Factors* *Overview of root cause analyses*	Alderwood Room
9:30 – 10:00 AM	**Exercise 1: Group discussion *'What workplace factors contribute to psychological harm?"*** *Guided discussion on identification and categorization of workplace factors that may contribute to worker psychological harm.*	Alderwood Room
10:00 - 10:15 AM	**Exercise 2: Prioritization of Psychosocial Factors** *Prioritization of six (6) psychosocial factors for further discussion and identification of secondary and tertiary causal factors leading to psychological harm in LTC.*	Alderwood Room
10:15 - 1030 AM	BREAK	**Alderwood Room**
10:30 - 120:0 AM	**Exercise 3: Identification of Root Causes.** *Facilitated small group discussion identifying secondary and tertiary causal factors of psychological harm in LTC. Group discussions are led by a PSHSA facilitator, and each comprise two workers, two employers, and two subject matter experts.*	Aspen Room Birch Room Beech Room

12:00-12:45 PM	LUNCH	**Alderwood Room**
12:45 – 1:15 PM	**Exercise 3: Identification of Root Causes Continued** *Continued facilitated small group discussions to review identified causal factors and prioritize information to share back to larger group.*	Aspen Room Birch Room Beech Room
1:15 - 2:45 PM	**Exercise 4: Group Collaboration** *Participants are invited to rejoin the main session and present their findings of secondary and tertiary causal factors. Opportunity for collaborative sharing of knowledge from the broader group to enhance the breadth and depth of identified causal leading to psychological harm in LTC.*	Alderwood Room
2:45 - 3:00 PM	BREAK	**Alderwood Room**
3:00 - 3:45 PM	**Exercise 5: Causal Factor Prioritization.** *Prioritization of ten (10) secondary causal factors most likely to contribute to psychological harm in LTC. Solutions for the identified causal factors will be identified during day two of the workshop.*	Alderwood Room
3:45 - 4:00 PM	**Wrap Up** *Wrap up of day one and introduction to day two agenda and activities.*	Alderwood Room

DAY 2 – THURSDAY, NOVEMBER 2, 2023

Time	Activity	Location
7:30 - 8:30 AM	**Breakfast and Networking** *Participants are invited to enjoy breakfast and networking in the Alderwood room prior to the start of the workshop*	Alderwood Room
8:30 – 9:00 AM	**Welcome** *Introduction and review of the agenda for the day.* *Review of the six Psychosocial Factors selected as the greatest contributors to psychological harm in LTC. Review of the ten (10) secondary (level-2) causal factors prioritized for identification of solutions to mitigate risk of psychological harm in LTC workers.*	Alderwood Room

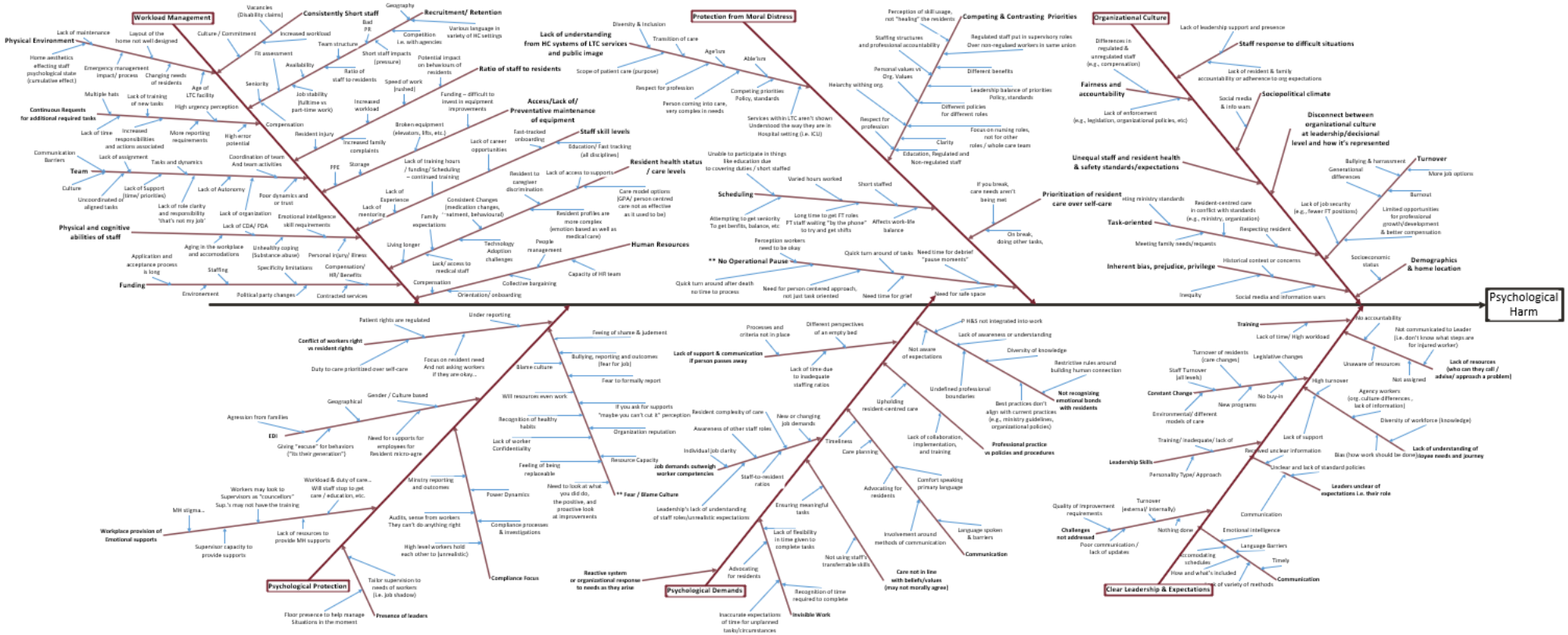
9:00 – 10:00 AM	**Exercise 1: Large Group – identifying solutions** *Guided group discussion identifying solutions for <u>one</u> (1) secondary causal factor leading to psychological harm. Participants are invited to collaboratively brainstorm solutions to mitigate risk of harm.*	Alderwood Room
10:00 - 10:15 AM	BREAK	**Alderwood Room**
10:15 - 12:00 PM	**Exercise 2: Small Groups – identifying solutions** *Participants are invited to rejoin their small groups from day one and continue to brainstorm solutions to mitigate risk of psychological harm for each of <u>three</u> (3) assigned secondary causal factors.*	Aspen Room Birch Room Beech Room
12:00- 1:00 PM	LUNCH AND NETWORKING	**Alderwood Room**
100 – 2:30 PM	**Exercise 3: Group Collaboration** *Participants are invited to rejoin the main session and present findings of solutions to mitigate risk of psychological harm for their <u>three</u> (3) causal factors. Opportunity for collaborative sharing of knowledge from the broader group to enhance the breadth and depth of identified solutions.* **Thirty minutes allocated per group (ten minutes per causal factor solution)*	Alderwood Room
2:30 – 2:45 PM	BREAK	**Alderwood Room**
2:45 – 3:30 PM	**Wrap Up** *Participants are invited to participate in a short survey to support continual improvement and evaluate knowledge sharing and achievement of identified workshop objectives.* *Information is provided on next steps, opportunities for continued involvement to support MH in LTC and knowledge mobilization across the LTC sector.*	Alderwood Room

APPENDIX B: WORKSHOP GROUPS

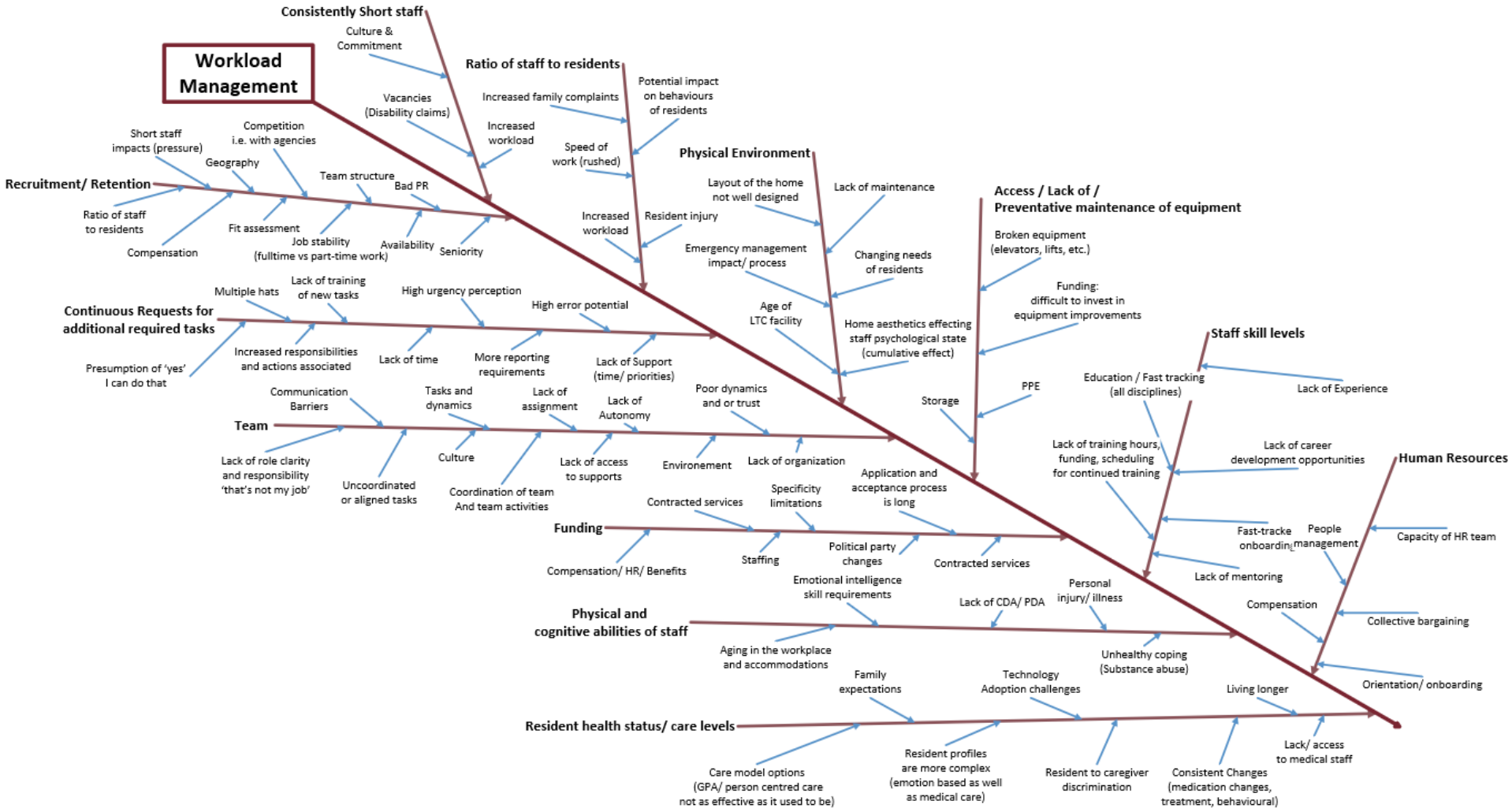
WORKSHOP GROUPS Lead Facilitator: Tegan Slot, PSHSA		
PARTICIPATING ORGANIZATIONS		
GROUP 1 Facilitated by Sherri Bastos - PSHSA	GROUP 2 Facilitated by Jeremy Holden - PSHSA	GROUP 3 Facilitated by Nathan Kolar - PSHSA
PSHSA	PSHSA	PSHSA
MHCC	CLRI/RIA	Ontario Tech
MLTC	MLITSD	MLITSD
CLRI/RIA	AdvantAge Ontario	OLTCA
Lancaster LTC	Brockville General Hospital	Newmarket Health Centre
Region of Peel	Responsive Group	John Howard Society
Yee Hong	Lancaster LTC	Bruyere Continuing Care
Golden Lodge	Dundern Place Centre	Parkview Home

APPENDIX C: CAUSE AND EFFECT DIAGRAMS

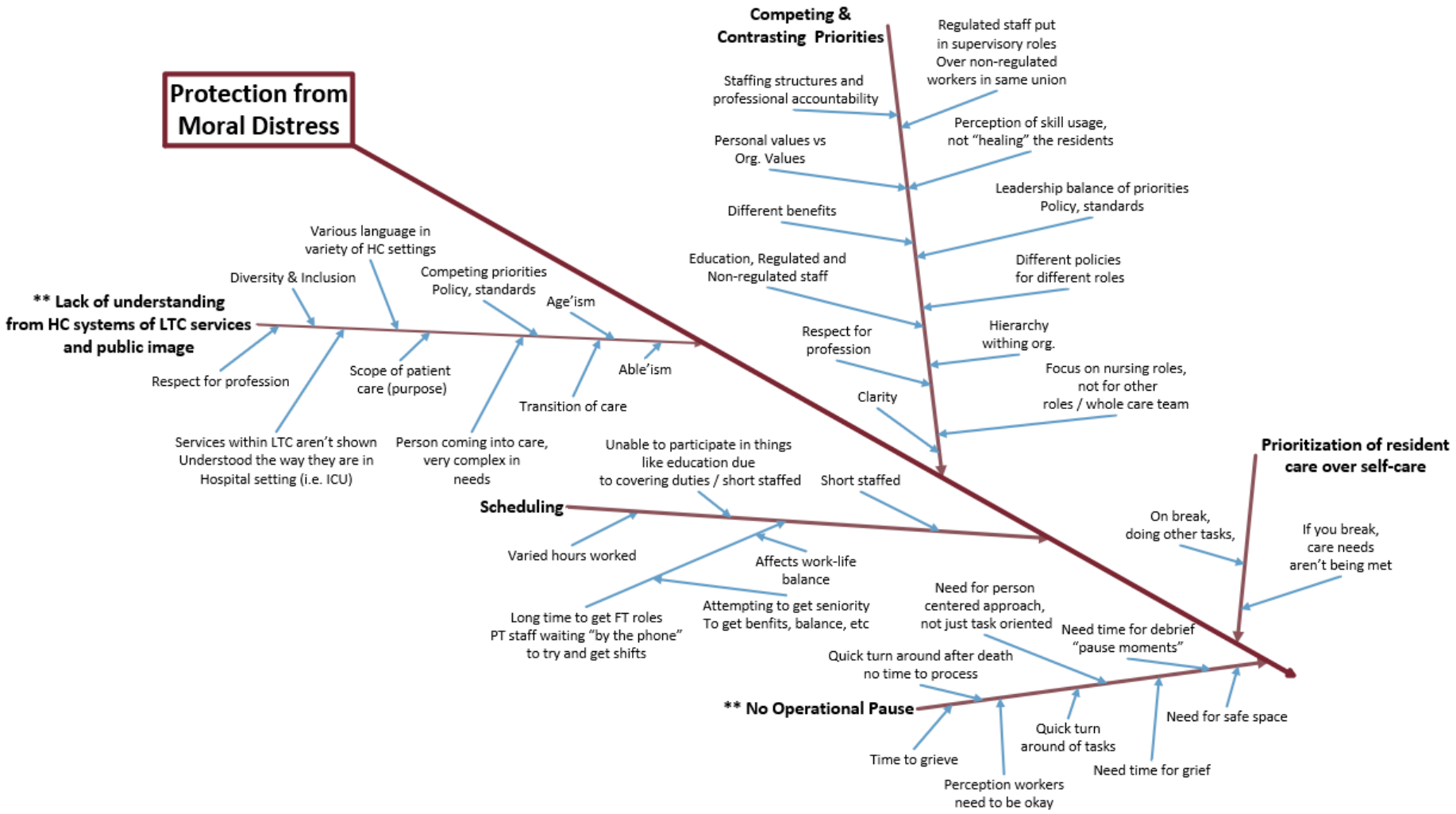
PRIMARY AND SECONDARY CAUSAL FACTORS



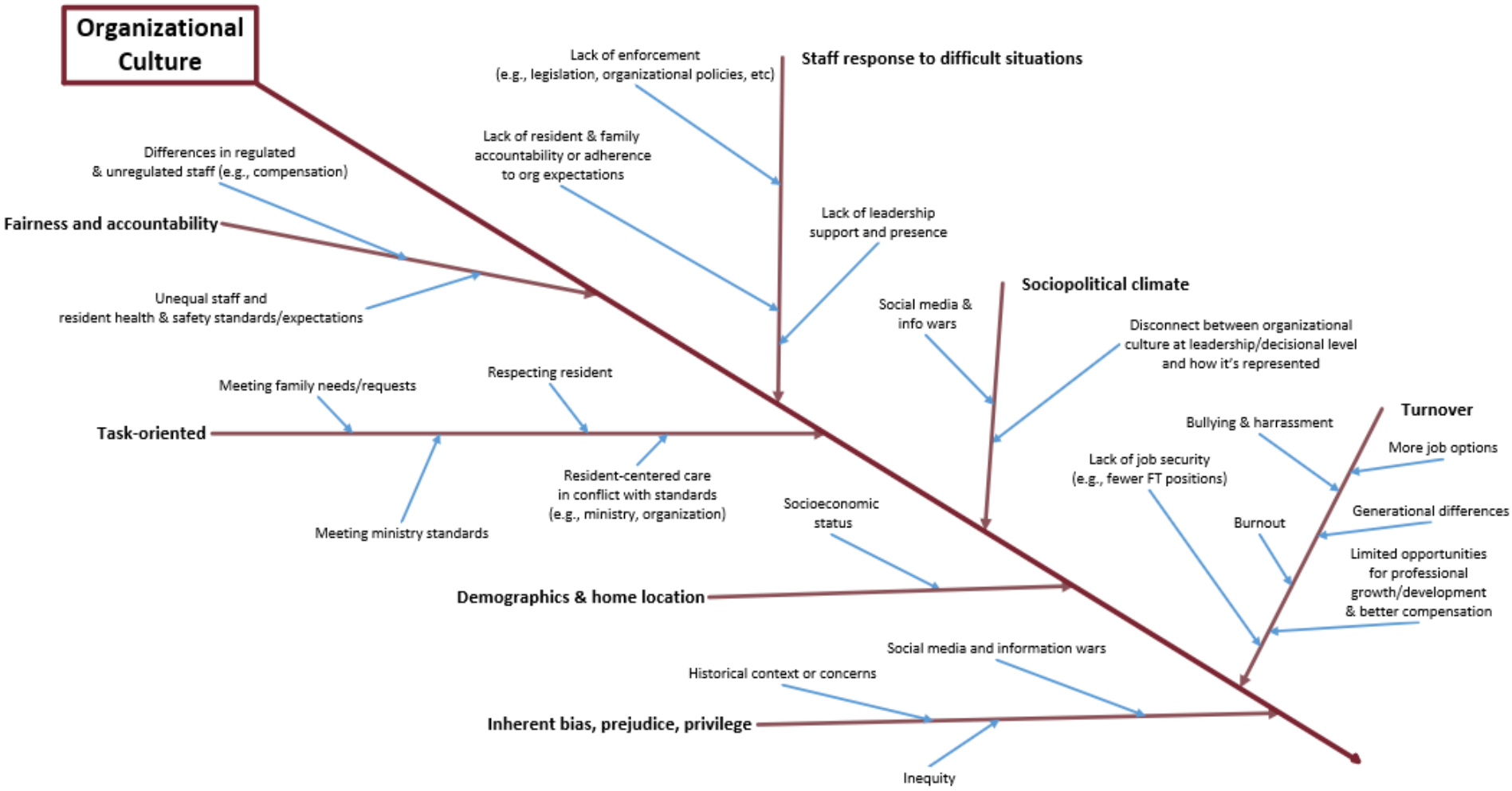
WORKLOAD MANAGEMENT



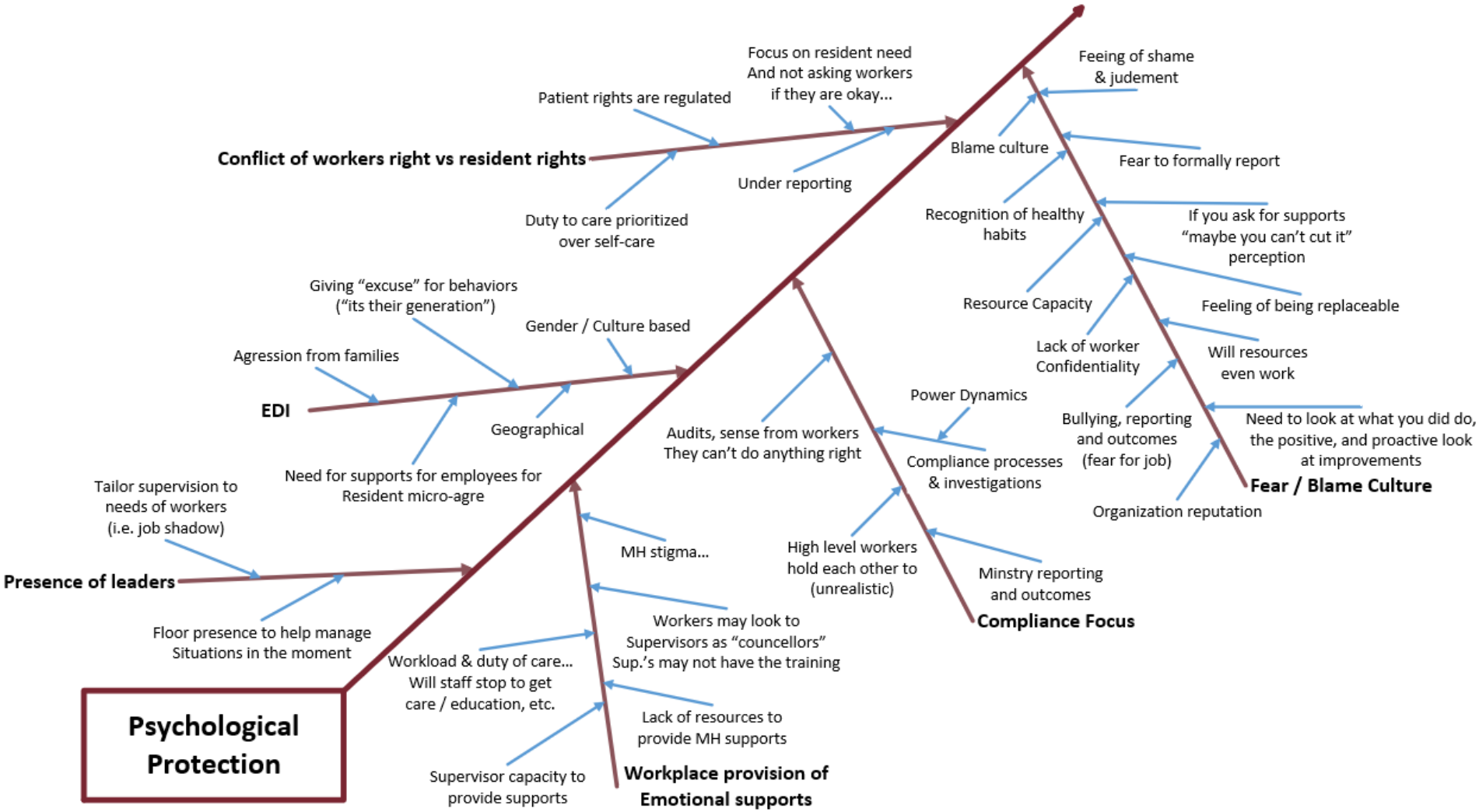
PROTECTION FROM MORAL DISTRESS



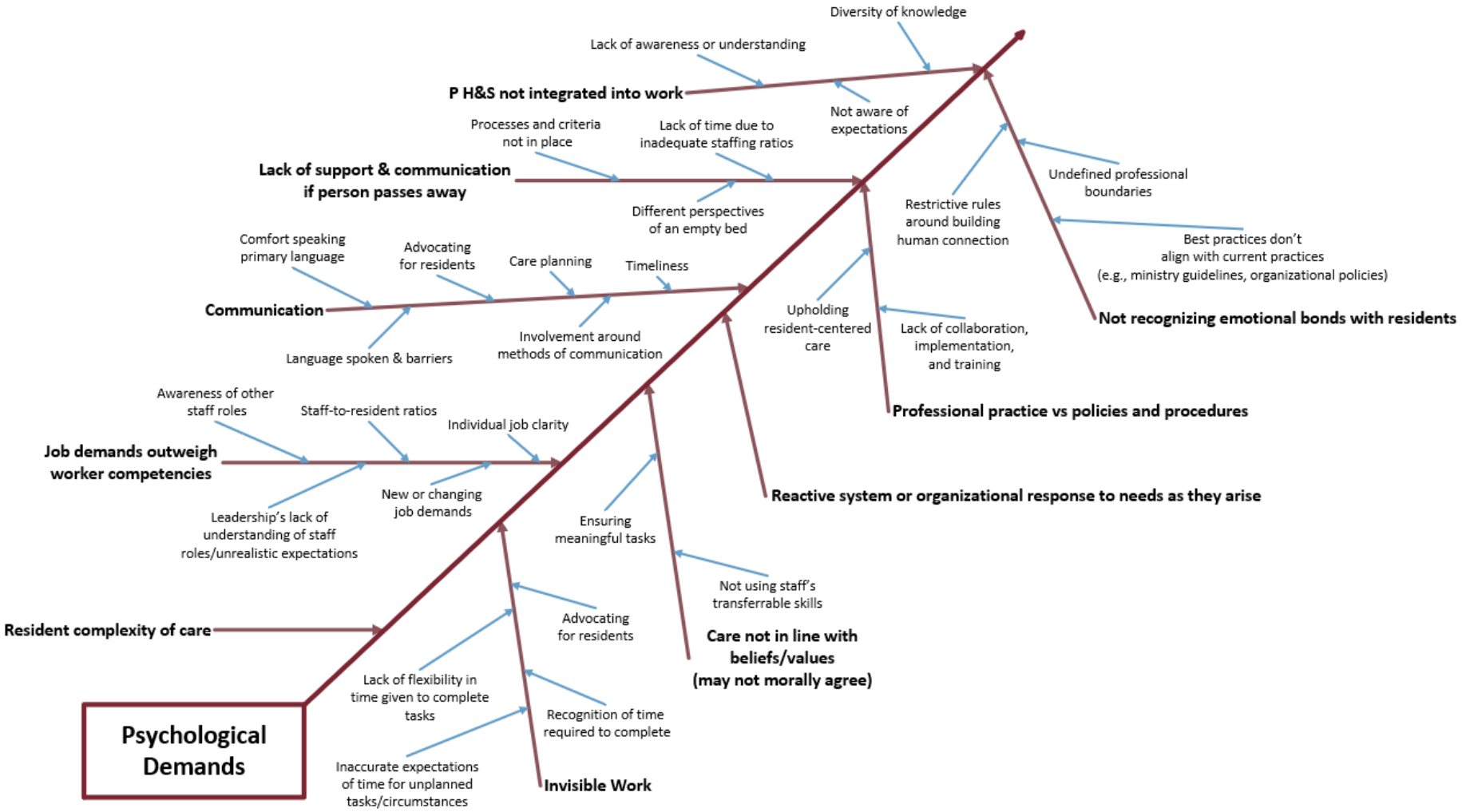
ORGANIZATIONAL CULTURE



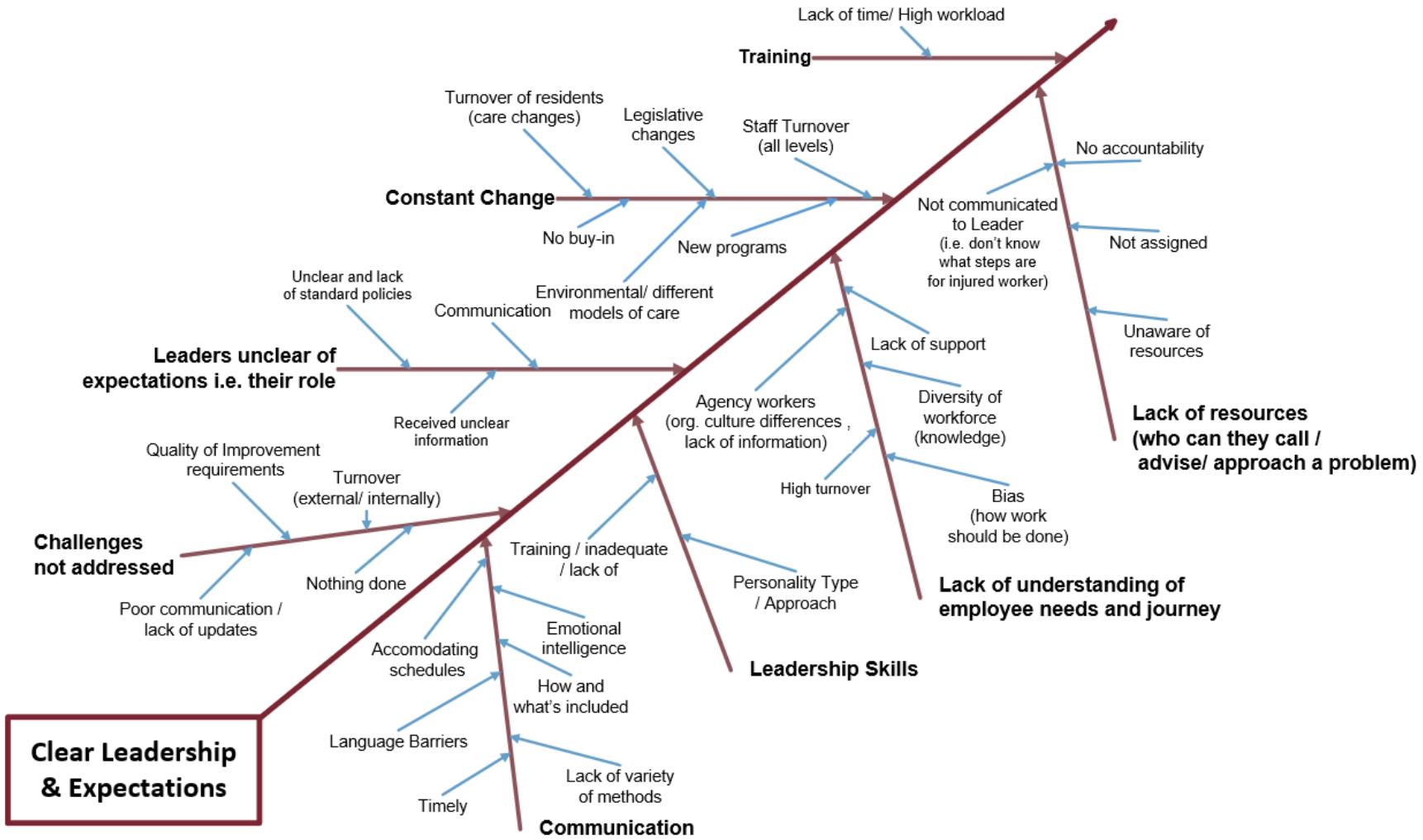
PSYCHOLOGICAL PROTECTION



PSYCHOLOGICAL DEMANDS



CLEAR LEADERSHIP AND EXPECTATIONS



APPENDIX D: CAUSAL FACTOR PRIORITIZATION BY GROUP

Top ten secondary causal factors by participant group were as follows:

Rank	Worker	Employer	Subject Matter Expert
1	Psychological Demands *Communication*	Workload Management *Lack of funding*	Workload Management *Short staffed*
2	Psychological Demands *Resident complexity of care*	Workload Management *Short staffed*	Psychological Demands *Resident complexity of care*
3	Workload Management *Short staffed*	Psychological Demands *Job demands outweigh worker competencies*	Workload Management *Lack of funding*
4	Psychological Demands *Job demands outweigh worker competencies*	Workload Management *Ratio of staff to residents*	Clear Leadership & Expectations *Communication*
5	Clear Leadership & Expectations *Communication*	Workload Management *Physical and cognitive abilities of staff*	Organizational Culture *Turnover*
6	Workload Management *Lack of funding*	Clear Leadership & Expectations *Training*	Psychological Demands *Job demands outweigh worker competencies*
7	Workload Management *Ratio of staff to residents*	Workload Management *Resident health status*	Psychological Demands *Communication*
8	Workload Management *Physical and cognitive abilities of staff*	Psychological Demands *Resident complexity of care*	Workload Management *Recruitment and retention*
9	Organizational Culture *Turnover*	Psychological Demands *PHS not integrated into work*	Workload Management *Ratio of staff to residents*
10	Workload Management *Team*	Workload Management *Human resources*	Psychological Demands *PHS not integrated into work*