Long Term Care Pandemic Response **Policy Recommendations**

Evaluation of rapid redesign and resource deployment pandemic response in one long-term care facility in British Columbia during COVID-19.

LOUIS BRIER
HOME & HOSPITAL

UBC THE UNIVERSITY OF BRITISH COLUMBIA

Table of Contents

CONTRIBUTING MEMBERS

PRINCIPAL INVESTIGATOR

Farinaz Havaei, RN, PhD
Assistant Professor
UBC School of Nursing
2211 Wesbrook Mall, RM T25
Vancouver, BC, Canada V6T 2B5
farinaz.havaei@ubc.ca

CO-INVESTIGATORS

Sabina Staempfli, RN, MN, PhD Student
UBC School of Nursing

Maura MacPhee, RN, PhD
Professor
UBC School of Nursing

David Keselman, RN, PhD
Chief Executive Officer
Louis Brier Home & Hospital

Alison Phinney, RN, PhD
Professor
UBC School of Nursing

STEERING COMMITTEE MEMBERS (of Louis Brier Home and Hospital)

Vicki Anderson
Resident Representative

Mirsad Dragic
Resident Representative

Dan Galzka
Family Representative

Keren Gertsman
Family Representative

Jennifer Belen
Clinical Nurse Lead

Carol Bucknor
Executive Director

Leonora Calingasa
Licensed Practical Nurse

Audrey Castro
Care Aide

Katrina Cerrado
Occupational Therapy

Lunadel Daclan
Manager IPAC and QRM

Nicole Encarnacion
Nurse Manager

Edy Govorchin
Manager, Recreation

Megan Goudreau
Quality/Safety Specialist

Balpreet Nijjar
Registered Nurse

Alex Portnik
Nurse Manager

Melissa Tadeson
Manager, House-keeping and Laundry

Loren Tisdelle
Director HR

ACKNOWLEDGEMENTS

We would like to acknowledge the funding received by Michael Smith Foundation for Health Research COVID-19 Research Response Fund and BC SUPPORT UNIT (Grant ID # COV-2020-1086). We are also grateful for the contribution of the Louis Brier Home and Hospital staff and residents as well as our steering committee members who have been informing the direction of this research.

Study Overview

Evaluation of rapid redesign and resource deployment pandemic response in one long-term care home in British Columbia during COVID-19.

In April 2020, nursing researchers at the University of British Columbia (BC) obtained a research grant to study the unintended consequences of rapid redesign and resource deployment (RR) in one BC long-term care (LTC) home, Louis Brier Home and Hospital Affiliated with Vancouver Coastal Health, Louis Brier is a private not-for profit care home with over 400 staff who care for 215 residents with varying acuity (physiological) and dependency (activities of daily living) needs. In Fall 2020, the care home experienced a COVID-19 outbreak among its staff with no confirmed cases among its residents to date.

RR strategies refer to practices and policies that were introduced in the LTC sector to slow the spread of COVID-19. Examples of RR strategies include the single site employment order, increased capacity for staffing; equipment and supplies; flexible sick leave policies and other occupational health considerations; training; identification and management of ill residents and/or workers; and considerations of visiting policies.

To evaluate the impact of RR strategies on staff, residents and families, we obtained qualitative and quantitative data from multiple sources. We conducted 53 interviews with the care home leadership (n=5), staff (n=27), residents (n=10) and their families (n=11). We also administered a longitudinal survey to staff in October 2020 and again in February 2021. Finally, we collected monthly quality and safety data (pertaining to residents and staff) from the care home administrative database for six months before and for six months after COVID-19 was declared a pandemic in March of 2020.

Study Overview

This study was conducted in collaboration with a steering committee of 15 key actors, including leadership, care providers, support workers and family and resident representatives, who informed the direction of the research, from the beginning to the end, through monthly meetings. The following report is intended for LTC home leadership, LTC decision-makers, and LTC policy-makers, and provides an overview of key findings and evidence-based recommendations that were developed in partnership with the study steering committee.

Staffing and Workload

Findings

At this LTC home, the direct care staff include registered nurses (RNs), licensed practical nurses (LPNs), unregulated care aides (CAs), and allied health personnel (e.g,. physiotherapists, recreational therapists, dietitian, social worker). Staff survey results showed on average each CA was assigned to 11 residents; each LPN to 28 residents; and each RN to 30 residents per shift. In both survey times, October 2020 and February 2021, the most inadequate RR practices during the pandemic were "flexibility of sick leave" (at Time 1, 48% of staff rated the practice inadequately vs. at 41% at Time 2) and "staffing levels" (Time 1: 38%; Time 2: 36%). Over 70% of respondents indicated that the pandemic had a high impact on their workflow.

Administrative data showed there was a sharp decrease in direct care staffing levels (full time equivalent [FTE]) between March and April 2020 with the sharpest decline for RNs (more so than LPNs and care aides). The data also showed a decline in RN FTEs and an increase in CA FTEs between March 2019 and Aug 2020.

Leader, staff and family interviews revealed significant concerns with staffing inadequacies and subsequent heavy workloads during the pandemic:

Staffing and Workload

- The **leadership** team described staffing levels and skill mix as inadequate to meet the additional demands of the pandemic "*When we do admissions, residents have to be isolated in their rooms for 14 days. Can you imagine keeping a resident in the room for 14 days without being able to leave the room*?"
- **Leaders** also raised concerns about the dilution of allied healthcare and ancillary services on weekends, noting, "*It seems like there are no resident needs on the weekends*."
- **Leaders** stated a dedicated infection prevention and control officer facilitated effective pandemic management while mitigating staff workload noting "the care home has a dedicated infection control officer, and many pandemic management practices were put in place before outbreaks occurred in BC."
- **Staff** stated "*[The] number of residents to take care of is overwhelming*."
- They also noted a change in work demands as a result of the pandemic. "*In regards to workload, when we have someone in isolation or someone's been swabbed it does add to the workload, because you have to go through the extra steps of donning and doffing and that does take time for sure.*" (RN)
- **Staff** also described the mental health implications of the pandemic. "*It's very hard for us, it's really hitting us hard. I guess that's one of the reasons why care staff are calling in sick because they intend to do overtimes and they get burnt out and overworked and all of the sudden they get so weak*." (CA)

Staffing and Workload

- **Residents** and **families** also voiced concerns about staffing and workload. A resident noted "*The covid needs, really did impact the staff a lot because of the amount of work it meant for them. Different kind of hair coverings, and the changing, the different clothes and that sort of thing. The hours were very intensive and so I think it was really hard on them but it didn't show through. From my perspective it didn't show through in terms of the kind of care they gave me.*"
- One **essential visitor** (a visitor deemed by provincial guidelines as paramount to resident health who is given permission to enter the care home) noted "*The staff are wonderful, it's just there's not enough.*"
- Another **essential visitor** described "*I think the nurses are really really really stretched. They don't have time to call.*"

During the pandemic, Louis Brier staff members ranked the facility **very highly** for quality of services provided, and on quality of teamwork.

96% stated they were **very satisfied** with their job. Yet…

32% of Louis Brier staff members reported **high** levels of emotional exhaustion, and

20% of Louis Brier staff members reported **high** levels of depression, PTSD, or anxiety.

Staffing and Workload

Recommendations

It is not clear if the current hours per resident per day (HPRD) guidelines in BC LTC sector are data-driven or based on convention or resource availability. Effective HPRD guidelines must depend on an accurate, objective assessment of residents' priority care needs. Evidence from LTC research and standardized administrative data is required to identify HPRD guidelines that optimize resident outcomes.

- HPRD guidelines must be driven by resident care needs as care needs highly influence workload and staffing requirements.
- HPRD guidelines must distinguish between direct care providers, including different nursing designations: RN, LPN, CA.
- HPRD guidelines must be flexible and adaptable: to address changing workload demands, including the current pandemic.
- Standardized administrative data including human resource data (e.g., staffing levels, skill mix), and quality/safety data on resident outcomes (e.g., falls with injuries, pressure ulcer development, restraint use) must be collected by all provincial LTC homes for evaluation purposes.
- Given the rise in workload and global shortages of nursing staff, there is an urgent need to support the existing LTC workforce—to avoid further adverse mental health outcomes (e.g., burnout) and turnover.

Staffing and Workload

- LTC homes must increase baseline staffing to deal with increasing resident needs and demands associated with the pandemic.
    - More specifically, LTC homes must have a full-time staff dedicated to Infection Prevention and Control.
    - Additionally, LTC homes must have a full-time staff dedicated to meeting the communication needs of residents and families. For more information, see Communication with Family.
    - Resident care needs must be operationalized using real time patient needs assessment tools that are valid and reliable and can be utilized by an interdisciplinary care team.

Care Home-Specific Plan

Louis Brier is the first LTC home in Canada to develop a resident needs assessment profile, in partnership with researchers, using an internationally known patient needs assessment tool, the Synergy Tool. The resident needs assessment profile will objectively identify and operationalize the acuity and dependency needs of this LTC resident population. Objective resident needs assessments are required to determine appropriate staffing levels and skill mix (HPRD per designation)—to ensure the right staff are available at the right time to care for residents. This tool will support effective workload management based on resident needs.

Sick Time Policy

Findings

During the pandemic, LTC homes were asked to institute sick time policies that were flexible and non-punitive. Sick time policies grant paid sick leave to staff posing a potential risk to the health and safety of residents and coworkers. Staff survey results in October 2020 (Time 1 survey) and February 2021 (Time 2 survey) showed that nearly half of the respondents rated the sick time flexibility as inadequate. At Times 1 and 2 respectively 11% to 18% of the staff reported calling in sick at least 3 to 4 times. We found a statistically significant rise in staff reported frequency of sick calls from Time 1 to Time 2.

The most important predictors of sick calls were the visitation policy, staffing levels, and cleaning supplies. Staff who perceived these pandemic management strategies as more adequate were less likely to report calling in sick compared to their peers who identified these strategies as inadequate.

Administrative data showed a sharp decline in paid sick time between March and April 2020 followed by an increasing trend since April 2020. This suggests that more staff requested and were granted paid sick time during early months of the pandemic.

Similarly, interview data revealed tensions between staff and leadership related to the sick time policy and its implementation. Staff wanted a more flexible policy to better manage personal and professional needs; while leadership wanted a stricter policy to fill unmet staffing needs in the care home.

Sick Time Policy

- One **staff** member noted "*It was quite frustrating in a sense because every single week we get an email about how many people have called sick, how much money does this cost, and saying how they're going to have to make really tough decisions in the future because of spending.*" (Allied Health)
- One **leader** described "*Between the single site order [where staff can only work in one care home] and people really getting sick, we cannot afford people calling in sick [with no justification] because there is no way to replace them. Now, every time you call in sick…you don't get paid until you complete the appropriate documentation and bring in a doctor's note. This is not new to BC, it's just that many organizations don't enforce it.*"

Recommendations

With increased workloads and occupational stress, sick time policies must balance the staffing needs of the organization and the psychological health and well-being of LTC staff.

- Key actors, including LTC staff and organizational leadership must have input into the sick time policy.
- Sick time policy communications from leadership must be frequent, transparent, clear, and consistent.
- To improve staff and leadership relations, sick time requests must be objectively evaluated by a third-party regulator such as WorkSafeBC.
- Training workshops about the sick time policy and practices are necessary for LTC staff and leadership both at a care home and provincial level.
- More effective workload management, improved mental health support and better access to necessary equipment and supplies are important strategies for reducing staff sick time.

Staff Mental Health

Findings

In this study, mental health was measured through validated scales of PTSD, anxiety, depression and burnout. Staff survey results showed that in October 2020 nearly one in five respondents reported PTSD symptoms, anxiety and depression and one in three staff members reported high emotional exhaustion, a key indicator of burnout. In February 2021 there were subtle mental health outcome improvements. We believe this finding may be explained by increasing rates of staff turnover particularly among staff hardest hit by the stresses of the COVID-19 pandemic and the pandemic policies. The most important predictors of staff mental health were the sick time policy, the visitation policy, the single site employment order, and leadership communication with staff. Staff members who perceived these policies and practices as more adequate were more likely to have better mental health compared to their peers who identified them as inadequate. The impact on staff mental health was also recognized by residents and their families.

- **Staff** interviews demonstrated that staff mental health and wellbeing deteriorated during the pandemic. One staff member noted "*I feel lonely, and some of the residents feel that way too, they're so lonely.*" (Nursing)
- Another **staff** member stated "*since the restrictions and all the rules have begun in March, I think in terms of delivering care to residents it is a bit more, let's say I get sort of burnt out a bit easier compared to pre-pandemic. You come to work and then you have to deal with the daily stresses of work on top of that, so I think the burnout is much higher now than it was before the pandemic started.*" (Nursing)

Staff Mental Health

- Another **staff** member noted "*there was an initial surge of anxiety of course because we do want to provide good care, but we're going into a different role all together… I think the anxiety comes from a place where yes we know the precautions for Covid, but how to implement tasks from these new roles for us has been quite challenging.*" (Allied Health)
- **Leadership** representatives in the steering committee also expressed feelings of loneliness, fatigue, and burnout among administrators

Recommendations

Mental health is especially taxed during the pandemic, as evidenced by rises in anxiety, depression and PTSD.

- Mental health strategies must be inclusive for direct care staff, ancillary staff and leadership.
- Immediate mental health interventions such as regularly held formal check-ins with staff members (e.g., daily 5-minute mindfulness practices with a small team) would be beneficial to reduce stigma and raise awareness of mental health issues.
- Long-term mental health interventions must address LTC homes' workplace conditions such as staffing and workload.
- Evidence-based guidelines, tools and resources, such as the Canadian Standard for Psychological Health and Safety in the Workplace, must be implemented to address workplace conditions, promote mental health and prevent work-related psychological injury.
- Pandemic management policies and practices may inadvertently cause potential or actual mental harm and should therefore be adapted for each care home with input from key actors including the affected staff.

Visitation Policy

Findings

During the pandemic, a strict visitation policy was introduced in the LTC sector where families and visitors were prohibited from entering LTC homes unless in exceptional cases, such as end of life. This policy became the target of public scrutiny and was subsequently modified several times during the pandemic. Overall, the policy classifies LTC visits as 'essential' or 'designated'. Essential visits are visits for compassionate care paramount to the physical and mental wellbeing of the residents. Essential visitor status is at the discretion of the health authority or the home staff. Designated visits are non-essential family and social visits. Compared to designated visitors, essential visitors have significantly more flexibility in the frequency and duration of LTC visits.
Specific details about the most recent policy are available here.

The study findings about the visitation policy were mixed. According to the staff survey results, only 20% and 8% of the staff at Times 1 and 2 respectively perceived the policy as inadequate. This policy was found to be the most important predictor of staff mental health, job satisfaction and sick calls. Staff who perceived this policy as more adequate were less likely to report PTSD, burnout, job dissatisfaction and sick time.

Staff interview data showed while most staff appreciated the importance of the policy for infection control and prevention, they were emotionally distraught by witnessing the pain and suffering of the residents and families who were negatively impacted by the policy. Furthermore, families were described as informal care givers in LTC homes and their absence was recognized by staff as an important factor contributing to heavy workloads.

Visitation Policy

- One **nurse** noted the emotional impact of the policy "*This afternoon I was looking out the window when waiting for our meeting and I overheard a daughter crying and telling her mother "I love you Mom I love you Mom" and it broke my heart because she was at the window and the resident was inside, and she was outside, and I was watching them by the window, and I was in tears.*" (LPN)

- Other **staff members** described the implications of the policy for staff workload "*I think the change has impacted the staff… I can see a lot of the residents being more isolated, being more restless, being more demanding and bored*" (CA) and *[Family restrictions] was something that was really different and hard for families to adjust to and even staff because [before COVID] a lot of times families would come help with the care. So, staff were kind of having to step up and also provide more care because we didn't have the support from a family or other source."* (RN)

Similarly, the visitor policy was a source of emotional tension for many families. In interviews, family members described the turmoil of battling many conflicting emotions; while all family members understood the need for restricting visitors to limit transmission to residents, many suffered greatly from not being able to care for and have contact with their loved one in the home.

- One **family member** reflected on the near miss of transmission *"I personally had Covid, and very fortunately the place had been locked down and I couldn't go in that Friday that I was supposed to go in. Had I gone in, I would've given it to [resident]."*

Visitation Policy

- Another **family member** expressed frustration with the policy *"I wish they could just revisit it and understand that locking families out does not really serve the purpose. And I think besides a lot has been said about residents being lonely and dying of loneliness or not eating because they're so depressed"* and *"… my number one wish is that families should be considered essential visitors. They have to really trust that the families don't want to bring in Covid."*

Family members viewed their role as advocates for their loved ones in the care home, especially those family members who has residents at the care home with cognitive limitations. After implementing the visitation policy, families' advocacy role was, to a great extent, delegated to companions who were allowed into the LTC home during the pandemic and acted as a communication channel between residents, families and the care team.

- One f**amily member** noted "*I'm sure [having a companion is] really genuinely the single thing that has been keeping my mom alive this long: having somebody come 4 days a week for an hour just to spend time with her"*

- Another **family member** described *"When the families were asked no longer to visit, the companions were allowed to come in. ...I begged to be an essential visitor... and they said no you can't. Then I requested to be registered as a companion. I thought well I'll become a companion, please.... I said I'll pay you for hiring myself no problem, but I was refused."*

Visitation Policy

Recommendations

- When strict visitation policy is in effect, additional support and resources must be put in place to mitigate the negative impacts of the policy on residents, families and staff.
- There must be clear communication of BC Ministry of Health guidelines on designated versus essential visitor status to visitors and families. Families and visitors must be provided with clear and transparent rationales for accepting or declining their requests for essential visitor status.
- Families and visitors must be given access to user-friendly scheduling systems for booking designated family visits in advance.
- A private space—indoor or outdoor— must be available for in-person one-on-one designated visits.
- Staff must have access to additional resources and supports to assist with increased workloads associated with strict visitation (e.g., increased staff requirements to facilitate virtual communication, establish safe spaces for distanced visits, coordinating visits etc.)
- The LTC volunteer community could be utilized more effectively to support staff with their increasing workloads and residents and families with their psychosocial care needs.
- There should be systematic tracking of family support and paid companion hours implemented at the individual resident level, care home level, health authority level, and provincial level. This is essential to understand the full extent of these practices to meet residents' needs.

Communication with Family

Findings

Communication was a central issue that heavily affected families, residents, and staff members. Some aspects of communication eased anxiety and stress that family members experienced, particularly the weekly email updates sent by the executive leadership. Updates included visitation policy changes, outbreak status, descriptions of infection prevention and control measures implemented, modified programs that were implemented, and pictures of residents and staff. Family members found the updates informative and comforting.

On the other hand, families found it difficult to get specific and individualized information regarding the health and well-being status of their loved ones at the care home. Due to the change from in-person communication (aka 'bumping' into the care providers in the hallway) to virtual communication, many families were unable to establish a point of contact and relied on either calling the nursing station or emailing care providers who were already burdened by numerous care demands. The overworked staff were unable to establish lines of communication with family members, leaving them feeling helpless and frustrated due to limited or lack of specific information about their loved one at the care home. Care home leadership did send out notifications about off-times to call the nursing station (e.g., not during shift change team debriefing or medication distribution times), but even then, family members had difficulty getting a hold of care staff.

Communication with Family

- One **family member** reflects *"I think the nurses are really really really stretched. They don't have time to call. … The problem is that you call, and no one answers. I know that they are probably out there feeding or doing some medications…Sometimes I will call at three o'clock and they will tell me they are busy doing the shift change briefing, can you call back in 30 minutes. …I call at night no one answers, there's no voicemail you can leave. There's no email you can send to."*

Family interviews revealed that family members felt specifically that they had no way to communicate unique resident care needs due to lack of in-person contact with nurses and CAs. They felt this lack of input negatively impacted the care that was being provided to the residents.

- One **family member** stated "I *can't communicate basic things like [the resident] is resisting having his dentures cleaned- can you try to come in when he's not got his dentures in and do a cleaning. You know something like that- that I would coordinate with a care aide when I see them in the hallway. I can't do that right now.*"

Conversely, family members that had existing or established lines of virtual communication with care providers pre-pandemic did not experience the communication issues described above. They found the care providers promptly responded to their requests via email and were able to fulfill all individual communication needs.

Communication with Family

Family members with companions (uncertified personal support workers hired directly by the family who continued their duties during the pandemic) relied heavily on them for communicating the resident's status to the family members which families felt also reduced their anxieties and increased feelings that residents had their needs met. Similarly, companions played an integral role in communicating family's knowledge of resident care needs with the care team.

- A **family member** reflects *"A lot of my contact is with [companion] … and if I need to hear from the nurses about mom having a [medical issue], they do contact me via phone and I find out what's going on."*

Recommendations

- A communication plan must be developed for each resident. This is especially valuable for residents living with cognitive impairment.
- The communication plan must identify at least one point of contact among the care team and one point of contact among family/visitor.
- The contacts must work together to transfer important resident information and updates between the care team and the family.
- The plan must also provide mutually agreed-upon and feasible boundaries regarding preferred modes of communication (e.g., email, telephone) and time (e.g., specific day of the week), frequency (e.g., weekly, monthly) as well as the duration.
- Communication regarding residents to family members must be acknowledged as contributing to workload.
- When strict visitation is in effect, additional resources and support (e.g., a communication officer) must be put in place to assist staff with addressing the increased needs for individualized communication (with family or visitors).

Resident Experiences

Findings

The pandemic management strategies had a large impact on the health and well-being of the residents, particularly the strict visitation policy and infection prevention and control practices.

Although residents expressed gratitude for efforts from the care home to keep them safe, visitation restrictions caused both emotional and physical distress in residents. Residents experienced increased loneliness, isolation, anger, and even weight loss and decreased cognitive capacities due to restrictions. Residents felt a loss of a 'sense of home' without being able to touch, see, and interact with loved ones, and this impacted their quality of life.

- One **Resident** reflects *"It seems silly to sit so far apart, I can't hug [my daughter] goodbye. But you have to accept the fact that it's being done for our benefit. [With all] the restrictions they have, they're trying to keep us safe, it has been an advantage so far because nobody in the residence has got [COVID-19] yet. I think they're doing the best they can."*

Although staff members made a conscious effort to increase interactions with residents (via e.g., increased recreational programming) and maintain social connections (via e.g., facilitating video calls, sitting down and chatting with residents), both increased workload and infection prevention and control (IPAC) policies impeded staff's ability to fill the gap made by visitation restrictions. IPAC practices including distancing requirements impacted structured activities and programs (e.g., concerts, art classes, afternoon tea) inside the home. When activities were reduced or absent, residents' mental health was compromised.

Resident Experiences

- A **Resident** reflects *"Some of these programs aren't allowed anymore to keep by the rules. I'm not in favour of the rules, but I have got to go by them. Don't I?... I'm 88 years old now. It stands to reason that I'm not going to be here all that long. … I would rather take that chance now, on catching something, than have the whole bit taken from the group."*

IPAC practices also slowed down resident care due to constantly putting on and taking off personal protective equipment and disinfecting equipment and surfaces.

- One **resident** described the effort needed to prepare their power chair for medical transport: *"The covid needs really did impact the staff a lot because of the amount of work it meant for them. Different kind of hair coverings, and the changing, the different clothes and that sort of thing. The hours were very intensive and so I think it was really hard on them but it didn't show through. From my perspective it didn't show through in terms of the kind of care they gave me" [Resident]*

Residents suffered particular mental duress from the restriction of movement around and outside of the facility, especially during total lockdowns. Residents felt immense stress in these times and paralleled their experiences to being incarcerated or institutionalized.

- One **Resident** states *"For me, it was really hard to be restrained to the building. In fact, when we get in lock down and couldn't go from floor to floor even. … I wasn't able to [go for a walk] and it did eventually really get to me. I just really felt like a prisoner, and I was."*

Resident Experiences

65% of Louis Brier staff found there was an **increase** in resident isolation and loneliness

51% of Louis Brier staff found there was a **decrease** in resident levels of physical activity

In terms of communication, residents with limited access and/or capacity to use technology struggled to get facility-specific and pandemic-specific information, whereas their peers with these capacities appreciated the regular communications sent by the care home.

- One **Resident** with access to email reflects *"…between the provincial government and Dr. Bonnie Henry and her staff, and then the [care home] staff, more information has been made available and that calms a lot of people down. Whether it goes to the family member or it goes to the [resident] who has internet access, that helps an awful lot. You can't believe the improvement that has made."*

One positive unintended consequence of IPAC practices and the single site order was an increase in continuity of care. Staff at the home were assigned to stay on specific units with the same residents to cut down on infection risk, increasing consistency of staff and consistency of care.

- One **Family member** reflects *"When it's the nurses that have known dad for a long time they know his medication, they know the time to give the medication, they even know when his behavior changes to call my mom and say this is what's happening how can we adjust it. But when you have different people all the time it's definitely, the care is just not as good."*

Resident Experiences

Recommendations

Many of the recommendations outlined in above categories address concerns raised by residents. Examples include the need for a private space for visitation, more effective workload management and mental health support for staff as well as optimized utilization of volunteer services. **Appendix A** provides examples of strategies implemented in our partner care home to improve resident experiences.

Additional recommendations to improve resident experiences include:

- Visitor policies should be discussed in conjunction with families and residents (e.g., with established family and resident councils) to make sure that they include holistic care needs.
- Care homes must continue to offer programs and recreational activities during lock downs to minimize resident isolation and loneliness.
- Recreational programs and activities must be modified with an eye to enable resident engagement and minimize risk to resident safety.
- Program modification must be accomplished through collaborative efforts of the recreational team and infection control and prevention experts. The care homes must provide the required resources and supports, as described in section D (visitation), to enable resident and family connection and engagement during lock downs.

Resident Experiences

- Additional staff must be put in place to support the extra demands associated with sustaining recreational programs and activities as well as resident-family connection and engagement.
- The LTC volunteer community is a possible source of support for managing additional demands in relations to the recreational programs and activities as well as resident-family connection and engagement. Therefore, the LTC volunteer community must be utilized more effectively during lock downs.
- The care homes must use various modes of communication to share information and updates with residents and families depending on their capacity and needs. For example, residents and families with limited technological skills should receive facility updates in hard copy.
- The care homes must implement care delivery models that maximize staffing consistency. While the single site employment order was perceived to facilitate staff consistency, it created challenges in relation to securing adequate levels of staff required to meet accelerating resident needs during the pandemic.

Appendix A

Strategies by Louis Brier to Increase Quality of Life for Residents

Category	Strategy
Communication	• During strict lockdowns (no visitors, no movement in facility), recreation staff increased efforts to help families communicate with residents by organizing and assisting with video calling; care home leadership requested donations of iPads/tablets, or donations with which to purchase technology • Leadership team increased frequency (to once per week) of bulletins sent out to emailing list (including families and residents) with care home updates
Visitation	• Accepted and vetted application for essential visitor status based on resident need; hired an employee to conduct this process and discuss with healthcare team about resident status; screener trained essential visitors on proper PPE use at entrance to facility • Scheduled and facilitated outdoor (via two designated outdoor visitation stations) and window visits (weather permitting); trained visitation assistants to give more space and privacy to residents and families • Scheduled and facilitated indoor visits (in a converted computer lab) with two sections separated by partitions; residents were brought to and from visits by visitation assistants
Infection Prevention and Control	• Introduced a screener at the main entrance of the building and closed off all other access points, to screen all staff and essential visitors for symptoms and prevent restricted visitors from entering premise; decreased resident stress about visitors bringing in the virus • Allowed residents to eat meals inside their own rooms if had anxieties about exposure; family representatives signed waivers if resident was unable to consent • Re-designed existing spaces to enable distanced programming and activities
Companion Program	• Leadership identified all companions as essential workers thus enabling them to enter the home even during lockdown to provide one-on-one supplemental care to residents; companions received immunizations concurrently with other care home staff • Families who previously did not use the companion program were allowed to hire available companions allowing residents to benefit from increase supplemental one-on-one care when visitors were restricted • The charity that supports the care home continued to fund a certain portion of companion fees each year for residents/families who cannot afford to pay for a companion

Category	Strategy
Programming	• Adapted recreational programming to allow for distances activities and programs where possible; smaller groups gathered for musical activities, games, and discussion groups • During lockdowns, recreation therapists visited resident rooms for individual programming (e.g., card games, playing music • Procured animal therapy when restrictions allowed • Procured a scheduled food truck to arrive at care home for residents and staff to use when wish • Performers were organized to perform outside the facility (when raining, under awnings), and performances were live streamed into the facility where residents could sit socially distanced
Staffing	• Redeployed staff within the facility to help with e.g., dining room when kitchen staff had to quarantine due to potential exposure; ensured all facilities were fully functional for residents