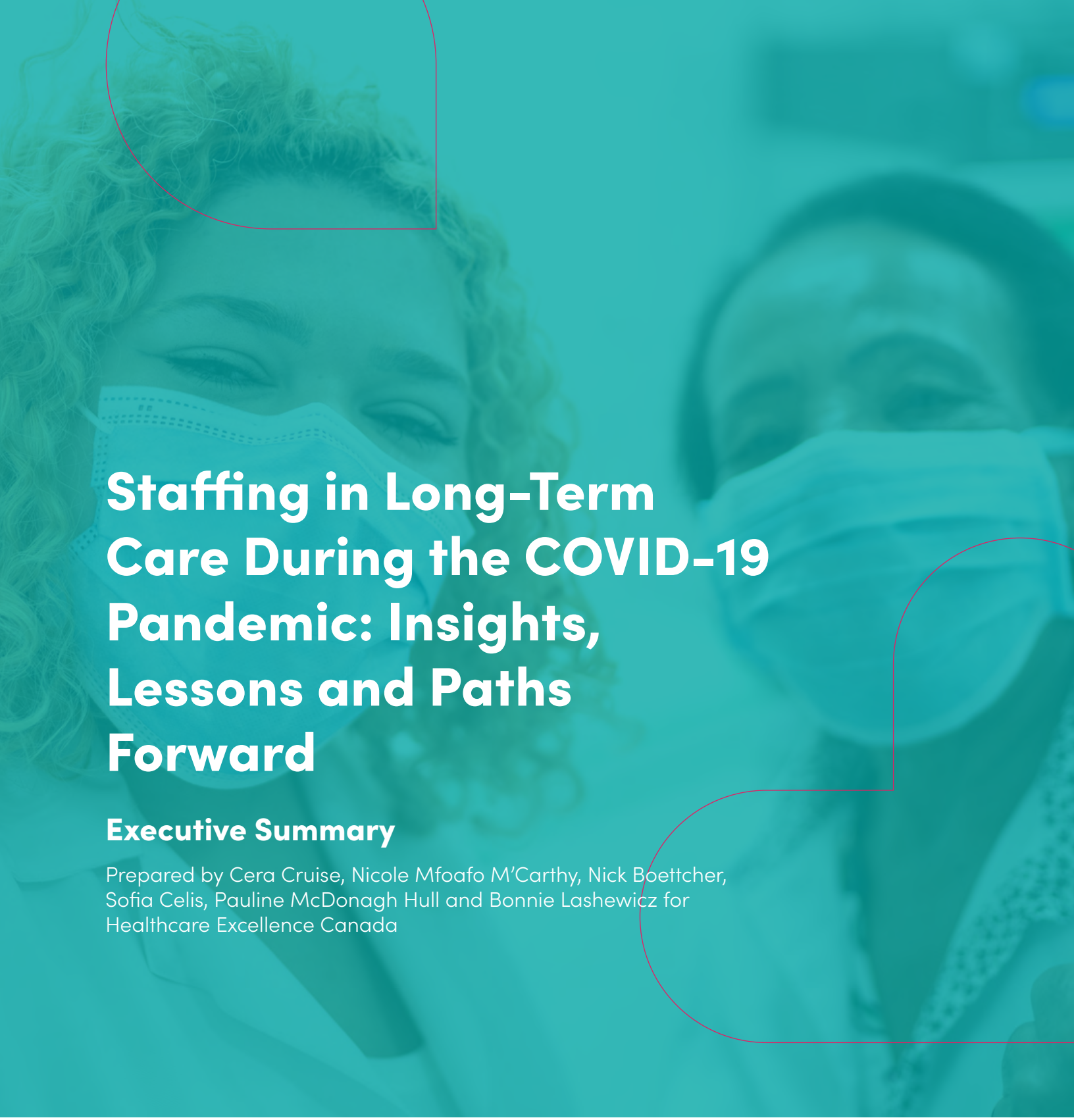

Staffing in Long-Term Care During the COVID-19 Pandemic: Insights, Lessons and Paths Forward

Executive Summary

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Healthcare Excellence Canada

CaRER Lab

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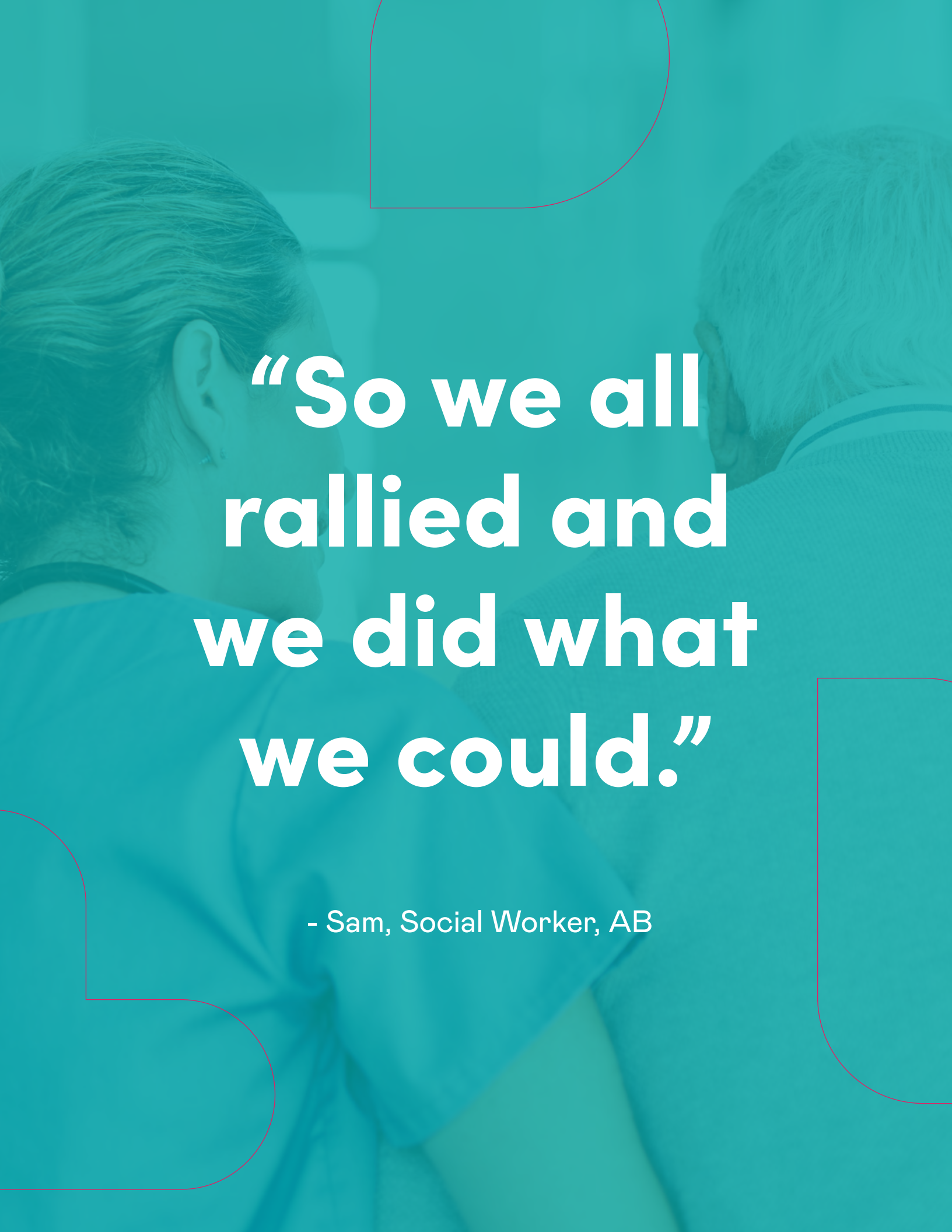


“So we all rallied and we did what we could.”

- Sam, Social Worker, AB

Background

The LTC+[1] (long-term care and/or assisted living) workforce in Canada is in crisis and this crisis is characterized as the pivotal challenge for those determining the future of LTC+ in Canada (Estabrooks et al., 2020). The initial stages of the pandemic were accompanied by widespread and often insidious devaluing of elderly bodies, particularly those bodies who were institutionalized and/or reliant on caregivers (Cruise & Lashewicz, 2020). The excess morbidity of elderly LTC+ residents due to infection with coronavirus was normalized by many, as reflected in early medical triage protocols (Rueda, 2021). While many media reports criticized workers for the disastrous and fatal outcomes brought on by COVID-19 outbreaks in some LTC+ facilities, there are limited accounts of LTC+ workers experiences of working during the COVID-19 pandemic in Canada including about how staffing practices influenced workers' mental health. Levels of burnout in healthcare workers in general are high, causing additional strains on care provision services (Maunder et al., 2022). As a matter of public health promotion, significant and rapid responses to the mental health needs of healthcare workers are needed if the Canadian healthcare system is to recover from the toll taken by the COVID-19pandemic.

We believe the experiences of Canadian LTC+ workers are distinct given the proportionately high vulnerability of LTC+ residents to COVID-19 associated deaths as compared with Canadians not living in LTC+ facilities, and with LTC+ residents in other Organisation for Economic Co-operation and Development (OECD) countries such as Australia, the United Kingdom (UK), and Spain (Canadian Institute for Health Information, 2020). According to the National Institute on Aging (2022), 17,120 LTC+ residents and 32 LTC+ workers had died in Canada of Covid-19 since the pandemic began. Nationally, 63% of LTC+ facilities had had an outbreak of Covid-19, and occurrences of outbreaks were notably high in Alberta (92% of LTC+ facilities), Ontario (89% of LTC+ facilities), and British Columbia (BC) (71% of LTC+ facilities) (https://LTC+-covid19-tracker.ca). The devastation of the pandemic in LTC+ facilities was so severe that the Canadian military was deployed in 47 LTC+ facilities in Québec and seven LTC+ facilities in Ontario (Badone, 2021; Mialkowski, 2020). Within this context, we studied LTC+ worker experiences of moral distress. Moral distress is the pain or anguish of knowing what is needed but being unable to do it owning to constraints outside one's control (Dean et al., 2020) and from our evidence, we remain troubled with the presence of moral distress and how such distress can contribute to moral injury and burnout.

This report summary is built on research funded by the Canadian Institutes of Health Research (CIHR)/Healthcare Excellence Canada (HEC) and that provided a rapid response mixed-methods project titled "Supporting mental health and preventing moral injury among LTC+ workers." This summary encompasses highlights from: (1) a realist literature review on staffing models in LTC+ around the world; (2) a secondary analysis of interview and survey data from our study of LTC+ workers' experiences and insights into LTC+ delivery during the COVID-19 pandemic; (3) a brief policymaker perspective overview from interviews during which we discussed the priorities of LTC+ policymakers and inquired into how decisions are made about LTC+ staffing; and (4) a stakeholder dynamics model where we

[1]LTC+: Long-term care and/or assisted living.

LTC+ facilities provided living accommodation, supervised and personal care including professional health services, meals, laundry, and housekeeping, to those who require it.

LTC+ workers include those working in, or on behalf of an LTC+ home, on one or more teams, including those who are salaried and hourly-paid, in temporary, term or contract positions, clinical and non-clinical roles, regulated and non-regulated health care professionals, and all support personnel who are involved in delivering care and services for the LTC+ home and its residents.

highlighted the goals of various actors in LTC+ and hypothesized the impact that interventions would have on actors. Taken together, this summary encapsulates findings that are significant to current practice within LTC+. We prioritized these findings prompted by the LTC+ staffing crisis Canada is currently facing, but we caveat that in order for the LTC+ sector to be sustainable as Canada's population continues to age, increased investment and overhaul of the LTC+ system is required.

What does the literature tell us about staffing models in LTC+?

Several studies found an association between higher staffing levels in LTC+ and improved quality of care for residents (Harrington et al., 2000). Others argue that the staffing levels must be considered in conjunction with staffing ratios, especially ratios of registered nurses (RN's) and nurse practitioners (Munroe, 1990; Hungsoo et al.,2009). When measuring the outcomes of different staffing models in LTC+, most studies focus on the health outcomes for residents and often overlook or omit the experience of workers in navigating the new models of care. (Farell & Frank, 2007; Rahman et al., 2009). Consistent assignment remains one of the most common staffing models; however, studies show contradictory findings as to whether this model reduces worker turnover, absenteeism, and improves quality of care for residents (Farrell & Frank, 2007; Burgio et al., 2005). In qualitative interviews where worker perspectives were recorded, workers reported boredom and increased burnout due to repetitive tasks that accompany consistent assignment (Casper, 2020). Innovative staffing models include managing smaller units and incorporating nurse practitioners and clinical assistants; these models promise positive outcomes for both residents and workers (Harrison et al., 2019; Venturato & Drew, 2010).

Context is important in understanding the successes of organizational models or structures given that LTC+ tends to operate under circumstances of perceived resource scarcity. Therefore, there is recognition that interventions and programs must be shaped and adjusted to the needs of the facilities and specific units.

What lessons can be learned from LTC+ workers?

From interviews with LTC+ workers, we identified eight "lessons learned" that ought to guide both current workplace practises in LTC+ settings as well as future pandemic response plans.

1. **Leadership and management can influence workers' mental health experiences in a crisis**
   Leaders who are on the ground, accessible, and act as advocates for their workers positively impacted workers' experiences.

2. **Cooperation can be a source of strength in the most tenuous of times**
   Working under intense strain can provoke appreciation for co-workers but can also propel tensions in the workplace.

3. **Care isn't only a physical act; emotional and spiritual care matter greatly and require inclusion of family members in care**
   Residents suffered from isolation protocols, and this negatively impacted the mental health of some LTC+ workers. Every effort should be made to include family members in care during outbreak/crisis conditions.

4. **LTC+ workers need to feel appreciated by society and by their workplaces**
   Appreciation takes many forms but workers especially value recognition of their skills and sacrifice, and encouragement to look after their own mental health.

5. **Communication is constantly changing, and this demands an atmosphere of understanding and cooperation rather than policing.**
   As knowledge was gained about the nature of the coronavirus, care protocols changed rapidly. Communication delivered repeatedly and in multiple formats creates more learning opportunities for workers as part of an atmosphere of mutual teaching rather than of policing.

6. **Peer support is important to LTC+ workers but can also constitute additional labour; enhancing peer support resources should be a priority**
   Workers often felt that other healthcare workers were the only people who understood what they experienced at work and preferred to confide in these individuals rather than in family and friends. Many workers described engaging in extensive peer support activities during and after work.

7. **Resources available for LTC+ workers need to be transparent and equally accessible**
   Frontline nursing workers did not always have the same information, or access to, resources as management or allied health professionals.

8. **LTC+ facilities need the resources to hire more workers and to pay their workers well if burnout and moral distress are to be prevented**
   Limited staffing and personal protective equipment (PPE) resources caused significant distress for workers and created conditions that increased facilities' vulnerability to widespread COVID-19 outbreaks and a reduction in standards of care.

These themes provide insight into how LTC+ workers experienced working during the COVID-19 pandemic and the practices that supported and strained their mental health. While the pandemic created new stressors that impacted the provision of care in LTC+, it also exacerbated pre-existing issues. As pandemic restrictions decline and policymakers reflect on the factors that contributed to Canada's high COVID casualty rates in LTC+ facilities, it is important that workers be placed at the centre of these discussions and subsequent actions.

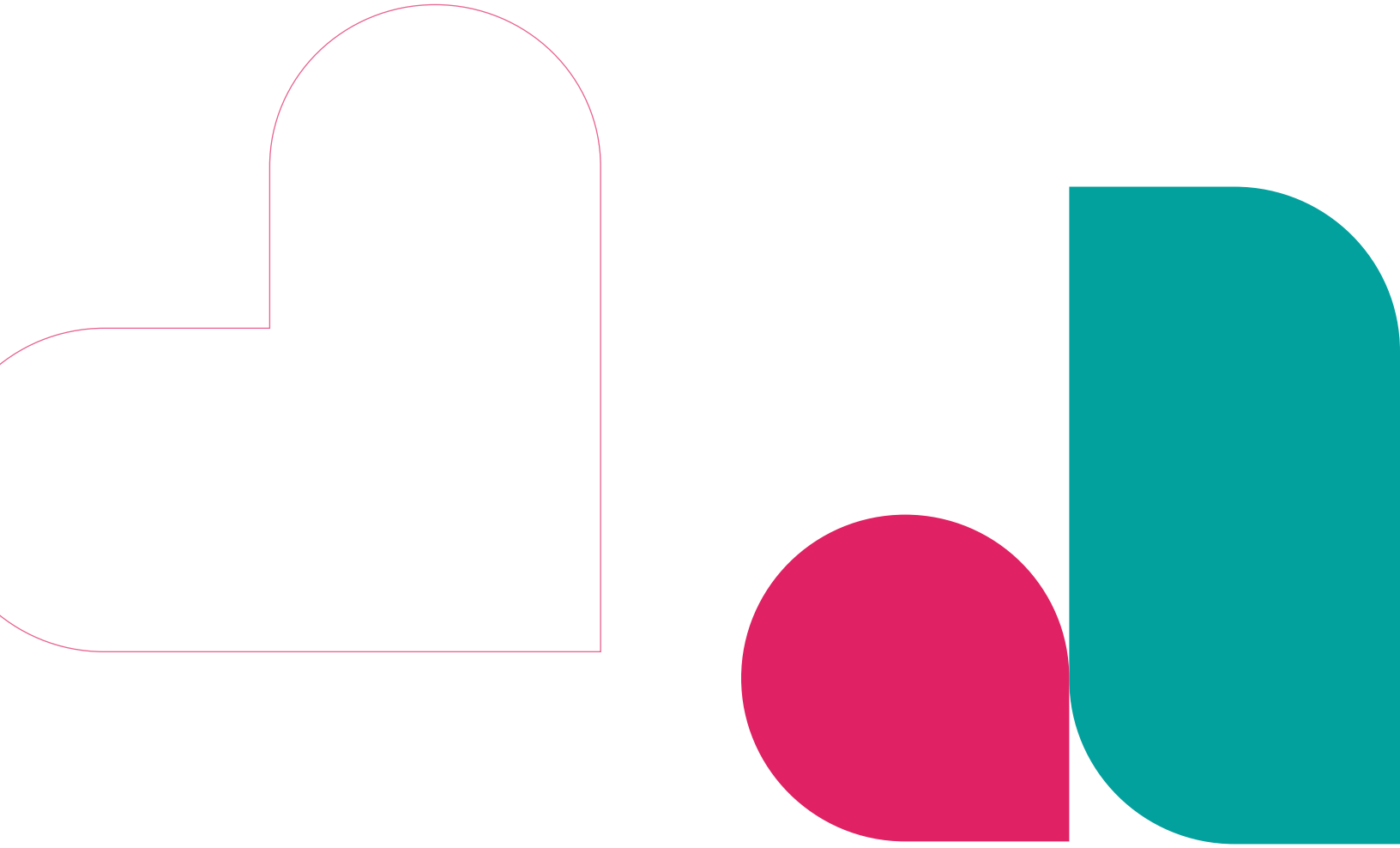
How do stakeholders make decisions regarding LTC+ policy and what are their priorities?

Government policymakers use academic research to make policy decisions. Researchers need to increase LTC+ worker and resident participation in studies and increase research project focus on knowledge translation activities. Like the perspectives from LTC+ workers, perspectives from policymakers for provinces, organizations, and facilities emphasized the need for the LTC+ system in Canada to better meet the needs of workers and residents. Innovating models of care that facilitate responsive communication between policymakers and workers is the desired state. The province of BC responded to under availability of frontline nursing staff by creating a subsidized health care assistant and health care aide training program. This training program adopted a work-integrated learning approach to train more than 3,000 frontline workers during the pandemic. This program compels further research to evaluate its impact.

Understanding the workings of policymaker decisions is critical in imagining and planning the future of LTC+ in Canada.

How do the goals of stakeholders complement and conflict with each other?

Using a stakeholder dynamics model, we identified a critical need for public and political priorities to be better aligned with the priorities of LTC+ residents if well-being of all of those interacting with, and impacted by, the LTC+ system is to be improved. Cost-containment and dignified care are inherently conflicting priorities. Short-term interventions might sustain LTC+ through the current staffing crisis but significant long-term investment in system improvement is needed.



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