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Practices of Interest to Support In-Person Family Presence and Communication with Families

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Introduction

Globally, COVID-19 threatened to devastate long-term care (LTC) homes, where the age and health status of people living in LTC put them at an increased risk of contracting and dying from the virus. Government and LTC providers acted quickly to protect people living and working in long-term care from the virus, often shuttering homes to anyone but essential staff. Initially during the first wave of the pandemic (spring of 2020), there was a widespread shutdown of in person access to those living in the homes. This action resulted in reports of isolation and family members speaking out against restrictions. From the outset of the pandemic, communication with families was of paramount concern as regular access was restricted and their concerns about their loved one's care and safety escalated. LTC providers were faced with managing a high volume of requests and inquiries from families, often having to redirect staff resources to this work. Family interactions occurred through window visits, drive by visits, and were enabled through telephone calls or through technology (e.g., FaceTime, Skype). As the pandemic progressed, jurisdictions introduced directives enabling some in person access to those living in homes; initially outdoors while maintaining social distancing. Then there was more in person contact within the care home after the introduction of provincial directed initiatives assigning the role of "essential caregivers" or "designated caregivers" to essential care partners. Across the country, various other approaches were adopted to support family as well. There is an opportunity for numerous lessons from these experiences to be learned and shared widely for ongoing management of this pandemic in LTC as well as for preparing for future viral outbreaks.

This report, based on interviews with LTC homes, reveals new or updated practices initiated during the pandemic. The following are insights into two practice of interest areas:

1. Strategies adopted by homes to keep families and essential care partners informed about the care of those living in LTC homes, policy changes and ongoing response and recovery during the pandemic; and

2. Strategies adopted by homes to increase in-person presence of essential care partners and visitors (i.e., family, friend, volunteer) during public health restrictions.

During June and July of 2021, interviews with select LTC providers were conducted to learn about practices that were different or innovative and which others can benefit. To help identify a pool of potential settings of interest, we contacted leaders of provincial LTC associations, family council organizations and health authorities to identify settings in their respective jurisdiction where the approach aligned with this work's objectives. These sources were supplemented with contacts through the researchers' networks, contacts from Healthcare Excellence Canada,

results of a literature search conducted by CADTH on Strategies Used by Long-Term Care Facilities to Maintain Communication With Essential Care Partners During a Pandemic or Infectious Disease Outbreak and a literature search conducted by the researchers (specific to family presence strategies). We followed up with recommended LTC homes and asked contacts to answer a brief screening questionnaire to identify unique practices they used. Based on responses and with attention to variety in terms of jurisdiction and type of setting, we chose to book interviews with settings where practices presented us with new or innovative approaches. In a few instances, a provider was selected because their strategies of interest covered both areas – communications and increased presence. Interviews took place by telephone or videoconferencing (i.e., Zoom or Teams) and were led by two research team members. Eleven interviews with providers were completed (see Appendix A)[1]. Interviews lasted between 30 and 60 minutes.

At the outset a few overall findings from this work include the following:

- While we had a framework guiding our selection, for the most part the homes selected are not based on a rigorous process.
- No initiatives emerged that were empirically tested or researched, despite an interest in reporting on evidence-informed practices.[2]
- Evidence on outcomes/benefits for families is anecdotal.
- LTC homes had different starting points in terms of existing practices (e.g., well established with social media, comprehensive webpages, up-to-date email distribution lists, active and engaged Family Council), especially in relation to communications with families.
- Generally, providers described initial phases of pandemic as ‘crisis management’ or ’survival mode’ with no planned approach for communications especially since a pre-pandemic common way for communicating about the care of those LTC was with families in-person. A tool box of varied strategies would be a valuable resource for the sector.
- Provincial directives in terms of access/visitation and interpretation of such directives varied.

[1] In some jurisdictions we were unable to identify a setting of interest or received no input.
[2] Of note, two providers interviewed indicated they are currently doing research to assess outcomes.

- Providers commented on the challenge with changes in visitation directives being made at news conferences without advance notice to the sector or clarity in terms of a date when such order would come into effect. This created expectations for families that LTC providers were unable to meet and increased communication activity.
- Providers commented on the challenge of balancing safety with quality of life for people living in LTC (and families). Many felt restrictions were too harsh, but it was not within the homes' control and restrictions did not help with relationship building work and having families truly recognized and integrated as partners in care. There was also some discussion about need to better distinguish/clarify between family as partners in care and family as visitors.
- Several participants shared that practices adopted during the pandemic will be maintained.

Note on language: We use the term "families" to note close relations (relatives or non-relatives) of the person living in LTC.

Strategies Developed to Enhance Communications with Families and Essential Care Partners

During the pandemic, LTC homes needed to update or adopt strategies to communicate with families about policy changes, outbreaks, recovery information, vaccine rollout, and care practices. In many instances, common communication approaches were new to a LTC home, while others were able to build on existing frameworks. Approaches such as websites, social media (Facebook in particular), newsletters, and email lists were commonly reported and relied upon to keep families updated throughout the pandemic. Telephone and video-conferencing communication were often used as needed for communication about individual care and to connect with families one-on-one.

The following are examples of homes that undertook new or different approaches to how they kept families informed. These examples also include insights into the extent of family input/involvement in developing strategy as well as resources needed for implementation.

Ocean View

Strategies used: Pre-recorded telephone messages, video message and virtual Town Hall meetings

Ocean View is a community-governed 176-bed nursing home in Dartmouth, Nova Scotia. During the pandemic, Ocean View took a multi-pronged approach to keeping families updated and connected. Early on, they realized that it was necessary to provide alternatives to email for those with lower technological access and/or literacy levels. The CEO video-recorded a message that was posted on their website and released through social media. In this message, the CEO spoke to a few key messages providing assurance to families about what was happening and why certain directions were being taken. Feedback about this approach was positive and this strategy will be used again if the situation warrants. In addition, there was a central email address established that was monitored by the communications manager. This generated quite a bit of activity. They found many of their family members preferred to use the phone rather than email, so a simple but effective solution of pre-recorded phone messages was implemented. These messages were recorded by the communications manager and included basic updates on visitation policies and status of COVID-19 in the facility. After the message played, the phone line allowed callers to leave a message if they still had specific questions. The communications manager would triage the calls and forward them to the appropriate staff/management member(s). This line was well-received by family members and the facility saw a marked decrease in daily calls asking for these basic updates. For more sensitive or personal updates, staff/management called family members directly. Ocean View also held a few virtual Town Hall meetings, via Zoom, which they promoted during visitation screenings, on phone calls and through social media. On average, 15 to 20 family members attended with members of the leadership team (e.g., Client Engagement Lead, Acting Director of Care, Medical Director) and topics such as vaccine hesitancy were covered. These town halls provided an opportunity for family members to connect with one another, share feedback and ask questions. Ocean View recognized that the virtual meetings broadened their reach to families who may otherwise not be able to attend on site due to distance or scheduling. A combination of virtual and in-person Town Hall meetings will continue as needed.

Family engagement/feedback on their strategy: Informal feedback showed the video message and pre-recorded messages were well received by family.

Resources required for implementation: Ocean View has a dedicated communications manager and an information technology (IT) professional who were key to supporting these activities.

Langley Care Lodge

Strategies used: Email and blog updates, auto-attendant phone system, and virtual Town Hall meetings

Langley Lodge is a 139-bed non-profit care home in Langley, British Columbia. Prior to the pandemic, they typically communicated with families through newsletters, their website, and during in-person informal conversations. Families were highly connected through a family council and frequent social events families attended on-site. During the pandemic, management asked families for feedback on the content and style of updates they wanted to receive which helped them tailor their approaches and decreased the volume of calls made to management. Frequent updates were sent via direct email and a COVID-19 blog is on their public website. Their email distribution list grew from the initial primary contact person to include additional family members. At some points during the pandemic, the communications updates were daily. These updates addressed what was happening, actions being taken, any relevant information from the health authority as well as a great deal of assurance. In addition to this broad communication approach, an auto-attendant telephone system was created to divert calls going to respective units as the volume of calls was already overwhelming the staff. This phone system was monitored, and messages addressed within 24 hours. They also kept families engaged and connected through regular Town Hall meetings. These hour-long Zoom meetings attracted between 30 and 45 family members. Key members of the leadership team including the CEO, Social Worker, Director of Care, and Support Services Manager participated in these meetings. The leadership team presented information and then took questions from families. Although the first Town Hall meeting was held to update families during an outbreak. After receiving positive feedback they decided to continue with monthly meetings. The meetings have evolved with families' needs and are now a source of family connection and support. This has become especially important for families new to the home; it is an opportunity to meet the leadership team, learn about the home, and connect with other families. To support a variety of families to attend, they held these meetings at varying times of day. An important learning for this home was to provide information in a variety of ways and frequently.

Family engagement/feedback in strategy: family members helped to tailor the approach. Positive feedback was received from families about Town Hall meeting.

Resources required for implementation: reassign tasks to existing staff, including the CEO and administrative staff. Langley Lodge also has an information technology specialist who supported the telephone and website work.

York Care Centre

Strategies used: Mass text message notification, webpage pop-up and family portal

York Care Centre is a not-for-profit organization, located in Fredericton, New Brunswick which includes a campus with 218 long-term care beds. During the pandemic they initiated a 'buoy-up' framework to direct communications efforts for their stakeholders (those living and working in the home, and their families). The framework includes phases focused on: what can be done for the people served; what actions can be taken in the next quarter; what was learned from the feedback received; and how can the actions taken be reported adequately back to the stakeholders. Part of their work was to conduct quarterly surveys involving those living and working in the home, and their families. These surveys let the organization know whether they were on the right track with their communications and recalibrated approaches as appropriate. Two specific strategies were adopted as a way to alert families to new information: mass text message notifications and website pop-ups. Families could sign up to receive text message updates and the home reported a high uptake for this method. The pop-up feature which provided an information update on the website meant that the user could not proceed past the initial screen until the pop-up was closed. The home also had an online Family Portal that families could register for and access information not available to the public such as more specific details on activities and care. In addition to these approaches, regular emails went to family (and staff), and for those who did not use email, paper copies were made available on-site. York Care Centre has a robust family advisory board which was involved in their pandemic response. Board members are mostly aged 70 years and above and did not adapt to Zoom/virtual meetings, but they continued informal contact through phone calls.

Family engagement/feedback in strategy: Feedback was received from quarterly surveys and through engaged family council.

Resources required for implementation: York Care Centre has a full-time communications and marketing person and the CEO was also engaged in communication efforts. A specific COVID Leadership Team was created that helped with ideas, messaging, etc. IT staff were available to

support quarterly online surveys, mass text notification, family portal and website features such as the pop up. There is a fee for each mass text. Funding available through the Federal-Provincial-Territorial Safe Restart Agreement helped with some of the additional staffing costs.

Western Regional Health Authority

Strategies used: Telephone calls

Newfoundland and Labrador's Western Regional Health Authority (WRHA) is responsible for multiple government-owned LTC facilities. WRHA is in a rural setting with homes ranging from very small attached to hospitals to stand alone homes. They needed communications strategies that would work in communities with limited internet access and with older family populations who do not use email or social media. Information was posted on their webpage, but the main approach this region relied on was the telephone. However, WRHA had outdated communications infrastructure that could not manage the volume of incoming calls associated with the pandemic. The system was not able to transfer calls and did not have multiple lines at the nurse's stations. The telephone system was upgraded and staff were delegated to make phone calls to essential caregivers, family and friends. There was communication issued by email but contact lists were not current, and many families were not email users. As a result, communications were centralized at WRHA. Individual administrators would tailor the communication to their community. Indicative of the small community nature of the region, the administrators also relied heavily on word-of-mouth; families are strongly connected in this region and it was noted that simple solutions, such as this, worked more effectively. The regional Resident-Family Advisory Council gained momentum by meeting virtually throughout pandemic. This group also met virtually with site social workers and management to discuss policy changes so the council could provide feedback and bring ideas forth. This approach was very successful and will continue.

Family engagement/feedback in strategy: Feedback was received through the Resident-Family Advisory Council.

Resources required for implementation: Investment in telephone infrastructure was required. Existing staff including social worker, care managers and care coordinators were delegated for direct calling to families.

Loch Lomond Villa

Strategies used: Email, Family Partnership Council, and virtual Town Hall meetings

Loch Lomond Villa is a not-for-profit organization with a campus including 190 nursing home beds in Saint John, New Brunswick. During the pandemic, they used email to communicate directly to families on a regular basis, leveraging their well-established distribution list. The CEO prepared COVID-19 updates and ensured that each email had the name and contact number of someone at Loch Lomond Villa so that, if needed, a family member could more easily follow up. Information shared through the email was also posted on the webpage and mailed out directly if technology was a barrier. Loch Lomond also harnessed the capacity of their existing Family Partnership Council to engage families. This Council met via Zoom and later in person. The Council includes family members of people living in the home as well as those who wished to stay engaged after their relatives passed. As pandemic response policies were drafted (e.g., visitation policies), they were shown to the Council for feedback. Members of this Council volunteered to visit older people living in the home and teach them how to use technology to stay in touch with family. Loch Lomond also held several virtual Town Hall meetings to discuss updates; this format was found to be effective in responding to families' questions and concerns. Communication strategies such as email updates, virtual and in person Town Hall meetings used during the pandemic will continue. The Family Partnership Council will be considering using technology more given their experience during the pandemic.

Family engagement/feedback in strategy: Family Partnership Council was invited to provide input and families had direct opportunity during Town Hall to offer feedback. Family shared that the Town Hall meetings were helpful.

Resources required for implementation: No specific information available.

Saul & Claribel Simkin Centre

Strategies used: Email and Facebook

The Simkin Centre is a not-for-profit government funded 200-bed personal care home in southern Winnipeg. The home honours Jewish values and traditions while welcoming seniors of all backgrounds. Prior to the pandemic, the webpage, Facebook, and Instagram were well established, but were used more strategically during the pandemic. When changes were announced by the government, families felt they would be immediately be in effect, which was not always feasible for the Center. This expectation created a lot of frustration amongst families

and resulted in additional enquiries to the home. Communications became an important part of the pandemic response and multiple strategies were used. The principles of communication adopted were truthfulness and timeliness. Emails were released daily, sometimes multiple times a day. The messages were written by the CEO and over time a template for the message evolved. Simkin Centre's email list increased from approximately 200 to 900 as more family members signed up. The communication issued through email was also posted on the Simkin Centre webpage. They noted that Facebook became a very effective communication tool for them with followers increasing from 100 to 1,000 during the pandemic. The Facebook page became a common place for people to go for information and allowed a broader range of family members to access information, especially for families who were geographically dispersed. While Facebook was used to share information about the pandemic, Simkin Centre also posted images and content that would stay in people's feeds, thereby building followers. Media outlets also began following the Centre on Facebook and picked up on several initiatives for which the care home received local and national media attention.

Family engagement/feedback in strategy: A lot of positive comments and evidence of engagement received through Facebook.

Resources required for implementation: Existing staff were delegated to manage email and the webpage. The CEO did a lot of content development for emails. Facebook was managed by staff.

Communication Takeaways

The following are key takeaways regarding the communication strategies collected from the interviewees:

- Providers shared that at the outset of the pandemic, the communications approach was more of a crisis response than a strategic organized approach; however, the importance of a coordinated communications was soon recognized.
- Several facilities experienced an increase in meaningful dialogue with families during the pandemic that they plan to carry forward and build upon after the pandemic.
- Town Hall meetings or other means of enabling discussion amongst families and facility staff/management allowed families to receive updates and education, offer input and feedback and become more involved in the pandemic response.

- Town Hall meetings and Facebook provided a valuable opportunity for families to connect with one another.
- Multi-pronged communication approaches should be used to ensure that family members' diverse needs are met (high and low-tech options).
- Communication approaches should build on the home's existing frameworks.
- Simple strategies, such as pre-recorded phone messages, can have a high impact.

Increasing in-person presence of essential care partners and visitors

From the outset, researchers recommended that policymakers avoid blanket visitor restrictions (Low et al., 2021).[3] To enable this, researchers made broad recommendations for safely re-opening or increasing family presence. They recommended that essential care partners should be designated by every person living in the LTC home, or a substitute decision maker (Low et al., 2021; Stall et al., 2020). Stall and colleagues[4] note that the definition of "essential" is to be determined by the person receiving care, and their family, not authorities. Other recommendations include having essential care partners trained in the same infection prevention and control (IPAC) practices as staff and granted access to hands-on contact with loved ones (Low et al., 2021). Beyond these broad recommendations which matched many provincial-territorial policies and facility practices, evidence about innovative approaches was lacking in the literature.

One area of note is the work of the Ontario Caregiver Organization (OCO) which is working to promote and enhance the engagement of family caregivers across the health system. Pre-pandemic, building on the work of the Change Foundation, OCO adopted their tools and were promoting resources across the health system such as an e-learning module for care providers about family engagement. With the challenges the pandemic introduced, OCO created the

[3]Low, L.-F., Hinsliff-Smith, K., Sinha, S., Stall, N., Verbeek, H. Siette, J., Dow, B., Backhaus, R., Spilsbury, K., Brown, J., Griffiths, A., Bergman, C., & Comas-Herrera, A. (2021). *Safe visiting at care homes during COVID-19: A review of international guidelines and emerging practices during the COVID-19 pandemic* [White paper]. International Long-Term Care Policy Network. https://ltccovid.org/2021/01/19/safe-visiting-at-care-homes-during-covid-19-a-review-of-international-guidelines-and-emerging-practices-during-the-covid-19-pandemic/

[4]Stall, N. M., Johnstone, J., McGeer, A. J., Dhuper, M., Dunning, J., & Sinha, S. K. (2020). Finding the right balance: An evidence-informed guidance document to support the re-opening of Canadian nursing homes to family caregivers and visitors during the coronavirus disease 2019 pandemic. *Journal of the American Medical Directors Association*, *21*(10), 1365-1370.e7. https://doi.org/10.1016/j.jamda.2020.07.038

Partners in Care: Pandemic Tool Kit - Ontario Caregiver Organization with resources aimed to support the engagement of family caregivers in a safe and meaningful way. The Kit includes:

- Caregiver ID Badge
- Caregiver Pledge
- Communications Tool template

During COVID-19, the Ontario Caregiver Organization (OCO) increased emphasis on the Kit's resources and its alignment with public health directives regarding the presence of essential caregivers. The organization also supported a learning collaborative for adopters of the resources to share learning and experiences (see entries in this section about peopleCare and County of Grey for their experience with the OCO resources)[5]

Below are examples of homes that undertook new or enhanced approaches to increase in person presence of families in context of their jurisdictional public health guidelines. Insights into the extent of family input/involvement with the development of the strategy as well as resources needed for implementation are also noted.

York Care Centre

Strategies used: Advanced training program with self-screening entry

York Care Centre is a not-for-profit organization in Fredericton, New Brunswick which includes a campus with 218 LTC beds. York Care Centre increased family presence during the pandemic by developing a program for essential caregivers. They approached this from the standpoint that families should be trusted to protect those living in LTC. To support this, they implemented a training program for essential caregivers to learn personal protective equipment (PPE) protocols, self-screening procedures, and lowering transmission risk while in the community. This was undertaken prior to the provincial directive regarding Designated Support People. The program is approximately two hours long and was delivered in person, in small groups by various staff (e.g., Director of Care, Activity Coordinator). Once they completed the program, families were given electronic access cards to the facility that were programmed to allow entry during the caregiver's scheduled access times. Upon entry, the caregiver self-screened by

[5] See also Huddles hosted by HEC which featured these care homes: https://www.healthcareexcellence.ca/en/what-we-do/what-we-do-together/essential-together/essential-together-huddles-connecting-for-peer-to-peer-learning-and-support/

answering a few questions on an iPad. During times of higher community transmission, staff-led screening replaced this self-screening process.

Family engagement/feedback in strategy: Feedback received informally has been very positive.

Resources required for implementation: Existing staff were assigned to offer components of the program. There is an information technology specialist on staff responsible for the programming of electronic access cards and self-screening system.

Tideview Terrace

Strategies used: Phased in approach to on site access

Tideview Terrace is a not-for-profit organization located in Digby, Nova Scotia with 90 LTC beds. The home is designed with 10 self-contained households with separate entrances and private resident rooms. Nova Scotia public health officials announced directives for designated caregiver access in September 2020, with this care home adopting a slow, staged approach to implementation of on site family visitation. Initially, the home identified a select group of family members initially to introduce the process to them. It was noted that many of their family members were older so increased attention was given to ensure clarity and comfortability with the process. The home had to find the balance for the information shared regarding safety protocols but not to the extent of full fledge inflection control protocols. Information included the process for coming into the household including where coats were placed, hand washing regime, replacing masks, and wayfinding. Because of this setting's physical design (e.g., independent household entrances, private rooms), once families were initially screened and understood the process, they were approved to come and go. This process was opened first to one designated caregiver (DCG) per resident before rolling out the program to an eligible second DCG that the Nova Scotia's public health directive allowed for.

Family engagement/feedback in strategy: Family were not involved in developing the process, but their presence on site helped with the care of their loved one living in the LTC home.

Resources required for implementation: Existing staff were involved in the development and implementation of the screening process.

Loch Lomond Villa

Strategies used: Advanced training program

Loch Lomond Villa is a not-for-profit organization with a campus including 190 nursing home beds in Saint John, New Brunswick. They implemented a program early on in the pandemic for essential care partners. The response to the program resulted 176 of the 190 people living in their home having an essential care partner. As Loch Lomond has some larger event/meeting spaces, they were able to hold two-hour in-person training sessions on IPAC and safe visiting with 10-25 family members at a time, training approximately 300 family overall. Essential care partners were required to sign a document that outlined their responsibilities and confirmed their adherence to public health guidelines. The CEO heard from staff and family members alike that they felt safe opening their doors to family members again with the program in place. In addition, the home had, prior to the pandemic, seven different households of 20-35 residents per household which was helpful in terms of cohorting, making families feel safe, and thereby increased their presence. The Family Partnership Council was an asset in increasing the number of essential care partners. Some Council members whose own relatives had passed requested to become the essential care partners for people in the home that they knew had no family of their own available for the role.

Family engagement/feedback in strategy: Family Partnership Council was invited to provide feedback.

Resources required for implementation: Existing staff were reallocated as needed (e.g., administrative staff processed applications, organized scheduling and screening) and they hired additional staff and summer students for screening. Funding provided from the New Brunswick Government supported the additional resources needed. Sessions were delivered by existing staff depending on topic (e.g., health and safety coordinator).

Menno Place

Strategies used: Employed family as cleaning staff

Menno Place is a faith-based non-profit society in Abbotsford, British Columbia with 347 LTC beds, 95 assisted living suites and 258 Supportive Living suites for a total of 700 older adults on the campus. When the region went into outbreak status, the health authority implemented an enhanced protocol for care homes related to cleaning. Because staff were no longer able to work on different units during a shift, and the single site order that was implemented in the province, there was staffing challenges. After considering other options to secure cleaning staff (e.g., hotels, schools), they posted a call to their family members inviting them to apply for positions as casual cleaning staff. They received more than 200 responses and hired 9 family

members who, depending on the schedule, were able to interact with their family member by cleaning their relative's household and taking lunches and/or breaks with them. The standard organizational hiring protocols were followed for these family members (e.g., references, criminal checks, orientation/training). The individuals hired were integrated into the respective union or employee association. Initial concerns by the health authority were alleviated by assuring that hires were following standard protocols. Some of these individuals were also hired as screeners as the need increased for this role. This practice is expected to continue, especially given the staffing challenges while the single site order is in place.

Family engagement/feedback in strategy: Family hired in this role were able to see and engage with their relative when on their shift (e.g., lunch and breaks). The Globe and Mail coverage featured a family member's story of their positive experience in this role.

Resources required for implementation: Existing staff managed the hiring and training process.

Elim Village

Strategies used: Dedicated Visitation Centre

Elim Village is a senior living community located in Surrey, British Columbia. It offers various living settings from independent living to assisted living to full care in a 193-bed setting (the Harrison and Harrison West). To support in-person family visits, senior management considered options and identified an indoor chapel area and outdoor gazebo as possible solutions. These areas were adjacent to one another and could meet entrance/exit protocols, allow sufficient space, and not interrupt existing operations. These areas were re-purposed into the Visitation Centre that resembled six living room areas (three indoor, three outdoor) for private and comfortable family visits during pandemic restrictions. Staff were creative in making the space attractive and inviting. Additional staff were hired to support the operations of the Centre: scheduling visits, transporting people to/from the Centre, ensuring protocols were followed. Access to the Centre was available Monday through Saturday with families booking times in advance. More than 4,000 visits in the Centre were supported.

Family engagement/feedback in strategy: Families did not provide input into the design of the space for the Centre. Families expressed positive reviews initially about the Centre because it supported in-person interactions but then some mixed reviews were received as people wanted more interaction and wanted free/open access for visits.

Resources required for implementation: Expense to repurpose existing space. With funding from the British Columbia Government, additional staff were hired to manage the operations (e.g., 3-4 full time positions).

Saul & Claribel Simkin Centre

Strategies used: Volunteers to support care

The Simkin Centre is a not-for-profit government funded 200-bed personal care home in southern Winnipeg. The home honours Jewish values and traditions while welcoming older adults of all backgrounds. In September 2020 Manitoba's public health directive provided for a designated caregiver to be present on site with those living in LTC homes. During this time, Simkin Centre also issued a call out to families and the broader community for volunteers who could provide assistance with feeding, hydration, supporting virtual visits, and laundry (e.g., folding of isolation gowns). This extra help was particularly needed during the home's outbreak and approximately four to six weeks later when staffing resources were further strained. There was an overwhelming response to this call; approximately 200 people offered to volunteer. Interested people participated in an education session, led by the Volunteer Coordinator, with topics covered including personal protective equipment (PPE), risks and screening protocols. Some individuals who initially expressed interest, including designated caregivers, decided not to proceed with the role due to their comfort level, however about half continued. Some of the volunteers were family members who really appreciated the opportunity to go into the setting and contribute. While initially not all the designated caregivers chose to be on site as they became willing to come back into the building, they were required to participate in education session. Simkin Centre noted that an increasing presence of volunteers was an initiative of interest pre-pandemic but did not have the opportunity to develop. Given the response from the community during the pandemic, the involvement of volunteers will be a practice that will be sustained post-pandemic.

Family engagement/feedback in strategy: Family input was received through various ways including communications to CEO, administrative assistant and Director of Care and this informed subsequent activities.

Resources required for implementation: Summer students supported various family visitation activities (in-person or virtual). The Volunteer Coordinator's time was focused on education session and working with unit nurse managers to assign/schedule volunteers to a specific unit/person.

peopleCare Communities

Strategies used: Survey, adoption of Partners in Care: Pandemic Tool Kit

peopleCare Communities is an organization with eight care homes in southwestern Ontario, with about 1,000 people living in their homes. Efforts to increase family involvement pre-pandemic were in the works, but these efforts intensified with the onset of the pandemic. Early in the pandemic they conducted a specific survey with families to understand what was needed for families feel supported and to welcome them into the site. Responses from approximately 200 families indicated they wanted outdoor visits and access to PPE. At about the same time, the organization learned about Ontario Caregiver Organization's Partners in Care: Pandemic Tool Kit and felt these resources could offer some options to support the safety concerns of family and staff. For example, peopleCare adopted the Pledge as part of their "at the door" screening process. The home used a digital screening app at the site entrance and the Pledge would appear on the screen for people to read and sign. The organization found that the Pledge provided screeners with the script to engage with families about the measures and protocols in place and helped families assume responsibility for resident and staff safety. The Caregiver ID Badge was also adopted to elevate and convey the importance of the families' role in the home. Consistent with the organization's philosophy, the symbolism of the Badge recognized family as a care partner. However, because of Ontario's directives and designations, they modified the Badge to identify whether a family member was on site as a Caregiver or as a Visitor. With each designation, there were specific rules to follow which at times caused confusion for families and staff. The Badge was a helpful tool for staff because it enabled staff to identify the role of the family member while on site (social or care) and who they should speak to regarding care plans. In some cases, caregivers were responsible for specific care tasks and this was identified in the care plan, helping to build a sense of trust between families and staff. There is research underway to assess the impact of the Partner in Care resources in one of the peopleCare's home from the perspectives of family, and those living and working in the homes. The use of the Partners in Care resources during the pandemic helped the organization with efforts to foster family inclusion and these efforts will be continued.

Family engagement/feedback in strategy: Family survey was done in April/May 2020 with responses that helped to inform the organization's practices. Another survey is underway as well as research study which includes a family perspective.

Resources required for implementation: Ontario Caregiver Organization's resources are available at no cost and can be customized as needed.

County of Grey

Strategies used: Training program, rapid testing on site and adoption of Partners in Care: Pandemic Took Kit

The County of Grey in rural Ontario runs three municipal, public LTC facilities each ranging from 66 to 150 beds. The organization is very committed to person-centred care and authentic family engagement. Before the province issued its visitation policies, the organization piloted a designated care partner (DCP) program adapted from practices in chronic care hospitals. The facility staff would identify people living in the home they felt could benefit from family presence based on indicators such as weight loss and withdrawing socially. This work was shared with the Minister of Long-Term Care shortly before visitation guidelines were released by the province. DCPs were trained through an online platform consisting of modules taking 3.5 hours and cover IPAC and shared responsibilities for keeping COVID-19 out of the facilities. Family members could alternatively complete the training in paper workbooks that were mailed to them or that they could be picked up at the homes. County of Grey adopted Ontario Caregiver Organization's Partners in Care Pandemic Took Kit resources such as the ID Caregiver Badge. DCPs wore the Badge allowing staff to identify them while on site and the Pledge, renamed as "shared responsibility" document, was adopted as well. The modified Pledge document included statements about what the family and organization were committing to respectively. There was also an appeal process developed that managed situations in which families were denied access due to safety concerns and identified solutions to ensure families would be reintegrated. To ensure transparency, if a DCP developed COVID-19, the facilities followed the same outbreak measures as they would for staff. The intention of the program was largely to include DCPs as part of the care team. Once approved, their access was more open. On site testing was available for DCPs, which further enabled their presence. Across the settings, a total of 320 DCPs were trained and are considered active in the role. The organization is involved in evaluation research to understand their response to the pandemic and more generally their approach to family engagement. They are committed to ensuring that the Partners in Care

program is not just a response to the pandemic but rather supports a culture change within their organization regarding the role of family.

Family engagement/feedback in strategy: Input was invited from Family Council on policy for access. DCPs wanted opportunity for on-site screening and this was acted upon. Surveys with family were done and the input received was used to shape the training program and communications. They have also partnered with local researchers to study the value of the Partners in Care resources in one of their homes.

Resources required for implementation: Existing staff were used to implement these activities (e.g., resident and family services manager). A local retired health care professional volunteered to help with orientation and assisting family with process.

Presence of Essential Care Partners and Families Key Takeaways

The following are key takeaways regarding strategies to increase in-person presence of families collected from the interviewees:

- Jurisdictional guidelines regarding family as a “care partner” and family as “social visitor” varied contributing to different responses and considerations by providers.
- Robust training for family was a worthwhile investment to ensure that family members understood importance of protocols and how to follow them.
- Physical design of the care setting (e.g., dedicated space, households, private entrance) was a factor in family presence.
- Developing a shared sense of responsibility for the safety and well-being of people living (and working) in the LTC home was key; mutual trust was a key factor; activities include involving essential care partners in care plans, stating a pledge, signing a contract, involvement in planning/evaluating the initiatives.
- Different styles of care partner training worked for different sites (in-person, online, paper workbooks) but elements of the programs were similar (e.g., IPAC, safety protocols).
- Scheduling approaches varied based on infrastructures (e.g., technology or not) which may be linked to families’ experience and increased presence (e.g., self-directed, or not).

Appendix A – Interviewees

- County of Grey (Ontario) - Jennifer Cornell, Director of Long Term Care
- Elim Village (British Columbia) - Ron Pike, CEO
- Langley Care Lodge (British Columbia) - Debra Hauptman, CEO (to June 30, 2021)
- Loch Lochmond Villa (New Brunswick) - Cindy Donovan, CEO
- Menno Place (British Columbia) - Karen Biggs, CEO
- Ocean View (Nova Scotia) - Laura Karahka, PR & Communications Manager
- Ontario Caregiver Organization - Alison Kilbourn, Project Lead, Strategic Partnership and Innovation
- peopleCare Communities (Ontario) - Jennifer Killing, Vice President, Quality and Innovation
- Simkin Centre (Manitoba) - Laurie Cerqueti, CEO & Alana Kull, Director of Care
- Tideview Terrace (Nova Scotia) - Debra Boudreau, CEO
- Western Health (Newfoundland & Labrador) - Paul Biffett, Regional Director of Long Term Care
- York Care Centre (New Brunswick) - Tony Weeks, President & CEO