



Lessons on COVID-19 from Home and Community: Perspectives of Nursing Leaders at All Levels

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Abstract

The initial focus of the COVID-19 pandemic was on the surge capacity of hospitals. Moving forward, however, the attention needs to shift toward keeping people healthy at home. In this paper, we discuss critical insights from the home and community care sector, which shed light on pre-pandemic fault lines that have widened. The paper, however, takes a positive look at how a better future can be built, particularly for those most vulnerable in society. We offer three key insights and analyses as well as examples of how one national homecare organization in Canada, SE Health, is facing the pandemic. We discuss the following key insights: (1) pre-pandemic systemic biases and barriers were exasperated during the pandemic, which impacted the most vulnerable; (2) nurse leaders were faced with unprecedented fear and anxiety from both patients and their staff colleagues; and (3) the pandemic provided an opportunity for significant learning, innovation and capacity development. The pandemic is far from over – we are in a marathon, not a sprint. The paper concludes with how nurse leaders can lead the way in navigating through the pandemic and build a better “new normal.”

Introduction

The major preoccupation of the healthcare system in preparation for the COVID-19 pandemic was with the surge capacity of hospitals (specifically

critical care) and later with long-term care when it was apparent that congregate living settings were hit hard. While about 13% to 14% of those confirmed with a COVID-19 infection were hospitalized (Government of Canada 2021), the remaining majority were at home, where they looked after themselves or received support through virtual or in-person health services by formal or informal caregivers.

The home and community care sector is uniquely situated in the broader healthcare ecosystem. Although homecare services are not protected under the *Canada Health Act*, provincial and territorial governments have established different mechanisms of governance, funding and access to homecare services (Government of Canada 2016). There were three unique features of the COVID-19 pandemic and the response to the pandemic that shaped its impact on people living at home with healthcare requirements for a myriad of conditions:

1. *Fear of the unknown*: There was much that was not known about this coronavirus. The uncertainty, along with a lack of clear and consistent information, stoked fear and panic. When the World Health Organization (WHO) declared COVID-19 a global pandemic, public health and government agencies directed people to remain at home and only leave for essential activities (e.g., groceries, healthcare, child care). Homecare patients and their families became anxious about having nurses, personal support workers and therapists conduct home visits. Patients frequently declined homecare services even when such services were important to their well-being.
2. *Homecare service reductions*: The experiences of countries such as Italy and Spain, where hospitals were overwhelmed with the influx of patients infected by the virus, influenced other countries around the world to focus on creating surge capacity in hospitals. Hospital-based treatments and surgeries were cancelled, and in Ontario alone, 2,200 older adults occupying hospital beds were transferred to long-term care facilities (Grant and Ha 2020).
3. *Non-essential services*: In Ontario, as in other jurisdictions, such as the US, much of homecare service was treated as non-essential, leading to large-scale cancellations (Reddy et al. 2020). In addition, in the first few months of the pandemic, priority access to the limited stock of personal protective equipment (PPE) was reserved for acute-care settings (Ontario Health 2020). This created significant challenges in providing safe services elsewhere.

The overall impact was a reduction of 20% to 60% of various homecare services. This instigated a significant workforce destabilization in the home and community care sector. Sizeable front-line staff either did not have adequate hours of work or had to commit to working in one setting or sector (an infection control measure), or they saw opportunities to work elsewhere, with higher pay and

predictable work. Many front-line staff also went on leave of absence and applied to receive government aid (i.e., Canada Emergency Response Benefit). Overall, the result was a significant reduction in homecare workforce capacity.

In this paper, we discuss key insights gathered during the initial months of the COVID-19 pandemic in Canada from the perspective of nurse leaders working in different roles at SE Health, a large, national homecare organization with partnerships and projects in several continents. These perspectives were initially collected within SE Health through several processes: discussions at our COVID-19 command centre, a nursing leadership forum and a virtual global village gathering with representatives from home and community care organizations in seven countries (Virani 2020). The paper also includes implications for moving forward and discusses how nurse leaders can lead the way.

What Did Homecare Nurse Leaders Learn from the Pandemic Experience?

Nurse leaders identified three key insights. Each insight gives hope that the pandemic is a catalyst to “build better” for the future while overcoming the challenges of the “old normal.” The goal is not about getting through the pandemic but rather getting better through the pandemic. It is also about creating a better “new normal,” not just for the healthcare system but for a more resilient society.

Insight 1: Pre-pandemic systemic biases and barriers were exasperated during the pandemic, with particular impact on the most vulnerable in society, particularly older people.

Three key biases came to bear on the initial response to the spread of COVID-19:

1. First, the biases threaded into the tapestry of our society, and reflected in our healthcare system, privilege hospital-based or curative models of healthcare delivery while underutilizing the potential of primary care, home care and technology-based solutions.

Besides the public health measures that focused on curbing the spread of the virus, much of the healthcare system was concerned about how hospitals may get “overwhelmed” with sick patients. These fears were particularly compelled by the experiences in other jurisdictions where hospital resources, such as ventilators, had to be rationed. We believe this approach to pandemic planning is based on a predominant medicalized model that privileges clinical settings, such as hospitals, rather than considering a holistic impact of the pandemic on people’s overall health. Asking people to remain in their homes and limiting physical contact were appropriate public health measures, as were hand sanitization and wearing face masks. However, many people outside the hospitals who relied on home and community care supports

had their services either deprioritized or cancelled outright. Such supports included providing personal care, monitoring physical and mental health, addressing social isolation, monitoring medications and providing timely treatments (e.g., infusion treatments, wound and ostomy care, pain management, catheter changes, tracheostomy care and more). Imagine an elderly man living at home with his wife who has her own health needs. He has a diabetic foot ulcer that is slow in healing, and he relies on a nurse to change dressings, assess wound healing, monitor diabetes complications and assess other co-morbidities. In this scenario, delays, interruptions, or cancellation of care can lead to fatal outcomes in a matter of days. During a pandemic, such as the current one, this couple would require even greater support to navigate their life-care needs, such as food, access to medications and supplies (dressings, incontinence pads) and addressing the worries and anxiety stemming from the uncertainty caused by the pandemic.

To respond to this inherent bias toward clinical settings, nurse leaders in the home and community sector had to “band together” across agencies and bring a collective voice to various ministry and regional planning tables and advocate for the vast population that receives healthcare services outside the hospital walls. This has been a long-standing activity of home and community care leaders. At the start of the pandemic and every step of the way since, this activity has taken significant energy and resources to ensure that people outside of hospitals who require healthcare services were not forgotten. Such advocacy has resulted in some positive outcomes, such as having greater numbers of people receiving palliative care at home and legitimizing virtual care options where appropriate.

2. A second systemic bias was a propensity toward short-term crisis management frameworks that have previously guided responses to crises such as inclement weather, floods, ice storms, small-scale outbreaks during the flu season or labour strikes. Protocols for such short-term crises have involved the use of “emergency response levels” or ERL codes that support the prioritization and cancellation of services that are not based on individual assessments made in discussion with clients and families. In this instance, nurse leaders quickly identified that this model of emergency assessment was not only inappropriate in this context but also had a significant impact on the care needs and quality of life of vulnerable people living at home as well as their family members who were impacted by caregiver stress and burnout. In addition to cancellation of homecare services and decreased access to primary care, older people were discouraged from and fearful of using hospital emergency care services. These examples demonstrate a substantive blind spot in the healthcare system in which vulnerable people paid a heavy price.

3. A third bias in society that has been exposed is ageism.

Pandemic planning, in general, did not sufficiently anticipate or consider the impact of COVID-19 on older people living in the community or on their health and life-care needs. Older adults, in general, are faced with vulnerabilities in several areas: life and death, mental health, economic well-being, abuse and neglect and potential loss of shelter or housing. Vulnerable older adults, such as those living in congregate settings, those who have low income, those who may have language and/or other barriers and those who have cognitive impairment, are of concern (Schröder-Butterfill and Marianti 2006; United Nations 2020). Although less than 1% of homecare patients were affected by COVID-19 (Bayshore Healthcare 2020), they were impacted in other ways. Many older adults, particularly those who are frail, were lonely and fearful and suffered from physical and mental health decline, while others had to find sources of strength from family, friends and community-based organizations. In addition, family caregivers experienced exhaustion, with reduced resources and support for their caregiving roles.

Several months into the pandemic, the United Nations (2020) put out a policy brief on the impact of COVID-19 on older adults. This brief identified important considerations in developing a planned approach that protects the human rights and dignity of older adults while acknowledging the diversity of impact that the pandemic has had in different subsegments of the older adult population.

The policy brief identified four key priorities:

1. Ensure that difficult healthcare decisions affecting older people are guided by a commitment to dignity and the right to health.
2. Ensure “physical distancing,” which is crucial but needs to be accompanied by social support measures and targeted care for older persons, such as increasing their access to digital technologies.
3. Fully integrate a focus on older persons into the socio-economic and humanitarian response to COVID-19.
4. Expand participation by older persons, share good practices and harness knowledge and data. This includes broadening partnership with civil society and tackling ageism and stigma against older persons.

As nurse leaders, it is imperative that we understand the broader biases and forces that impact our patients and communities. We need to highlight these fault lines and engage in the development of creative solutions that specifically address the needs of vulnerable groups. In the context of older people living in the

community during the pandemic, specific attention is needed to address consistency and continuity of care providers to reduce the risk of infection spread, and provide access to basics such as food, masks and social stimulation. One specific project that SE Health was engaged in, with the support of the Saint Elizabeth Foundation, involved partnering with individuals and groups in local communities to sew masks for patients. Over 30,000 masks were collected and distributed to patients so that they could protect themselves and the healthcare providers coming into their homes.

Insight 2: Nurse Leaders Were Faced with Unprecedented Fear and Anxiety from Both Patients and Their Staff Colleagues

Amid unparalleled fear and anxiety, homecare nurses at the front line stepped up to address these fears using science-based decision making, compassion and an orientation to action. These staff were the bridge between family members and primary care doctors and nurse practitioners. They organized food/groceries, arranged medication deliveries and addressed a myriad of life-care needs while continuing to provide health assessments, treatments and activities of daily living in a safe and effective manner. In addition, with the ever-changing information on the transmission of the virus, on public health recommendations and directives and on government and other non-government supports, nurses became the translators of such information to patients and their families while ensuring that care planning and supports were appropriately organized.

Nurse leaders, at all levels, used leadership best practices that were previously established by SE Health as a Best Practice Spotlight Organization to (1) build relationships and trust; (2) create an empowering environment; (3) create a culture that supports integration of the latest science; (4) lead and support staff in making rapid practice changes; and (5) balance the complexities, values and priorities related to the pandemic (Registered Nurses' Association of Ontario 2013). The leadership team quickly shifted the power structures by having greater engagement with front-line staff and supervisors, supporting team work, creating mechanisms for swift decision making and empowering staff by setting a tone of agility and autonomy to "make it happen." The leadership team also implemented structures and tools to support staff by leveraging the most current science, reducing uncertainty, enabling use of various technologies and providing practical solutions while unleashing creativity. The following are examples of strategies that helped provide structure, consistency and confidence:

- a) *Three-factor framework*: SE Health's professional practice leaders developed and integrated all clinical decisions using a framework that focused on (1) the patient; (2) the provider; and (3) the environment (College of Nurses of

Ontario 2018). This three-factor framework provided a common, principle-based decision-making tool while addressing the concerns and perspectives of all three in their decisions. For example, at the early stage of the pandemic, the three-factor framework was used to make decisions on which PPE to use under different circumstances. It was also used to establish a real-time pandemic dashboard to track key metrics that supported rapid and effective decisions. These metrics included patient and provider screening, patient/family COVID-19 status, infection prevention and control (IPAC) competency achievement of staff, etc.

- b) *COVID-19 professional practice priorities framework*: The COVID-19 priorities framework provided consistent direction and a set of activities for the entire organization. The priorities included (1) identifying science and evidence to support decision making (e.g., science related to the need for physical distancing and IPAC practices); (2) developing and using client and employee screening (e.g., development of digital screeners and supporting staff to integrate these practices in their day-to-day procedures); (3) developing and implementing training programs for IPAC practices; (4) establishing processes to project the need for PPE and developing effective distribution channels across all our service delivery sites; (5) establishing digital and virtual care (e.g., training staff in providing effective virtual care interventions); and (6) knowledge translation (e.g., leveraging best practices in knowledge translation to implement new protocols and supporting their uptake and compliance). Work streams were quickly created for each of the six priorities and in most cases were led or co-led by nurse leaders. Quick access to the latest science, critical review of the evidence, decision making based on the evidence and translation and implementation of protocols were led by nurse leaders working in harmony.
- c) *Customized care approach*: Home and community care nurses are well equipped to provide a person- and family-centred care approach because entering people's homes requires a mindset where the patient has full control of who comes into the home, when they come and if they come in at all. An example of innovative use of existing technology included the use of an integrated voice response application ("robocalls") to identify patients' preference for an in-home visit or a virtual visit and, in some instances, a patio or curbside visit.
- d) *Leveraging the full scope of nursing practice*: The scope of nursing practice has always included patient teaching, family engagement, supporting self-care management and improving overall quality of life. These elements of the nurses' practice took on a greater imperative. Nurses spent considerable effort in teaching, addressing questions and engaging family members to provide the direct care that patients required when in-person visits were not appropri-

ate. For example, nurses taught family members to provide intermittent catheterization, change simple dressings, take vital signs, etc. Operationally, visits were scheduled based on the needs of the clients rather than a predetermined allocation of time.

- e) “*Communication x 10*”: Senior nurse leaders in home and community care spent much valued time on advocating for patients in the community. Key areas of advocacy included prioritization and deployment of resources such as PPE, compensation for virtual care practices, inclusion of front-line home and community staff for the pandemic pay and COVID-19 testing to be available for healthcare providers working in the community. To be effective in advocacy, nurse leaders had to be well informed on current research, guidance, government policies and public opinion as well as have real-time information from front-line staff. Nurse leaders were required to participate in various discussion forums both within the organization as well as externally, including various global forums. Some of these forums included a synthesis of information generated by dozens of sources into daily briefing summaries; the chief executive officer’s (the most senior nurse leader) engagement in daily discussions with other home and community leaders and participation in numerous working groups set up by the ministry; various briefing meetings at different levels in the organization, including daily COVID-19 command centre huddles; weekly virtual town hall meetings; and weekly COVID-19 leadership meetings, as well as practice meetings and training sessions.

Insight 3: The Pandemic Provided an Opportunity for Significant Learning, Innovation and Capacity Development

Historians will judge the COVID-19 pandemic as a moment in history when significant change and innovation came to the foreground. The pandemic, to date, has provided two important moments for the home and community care sector, where nurse leaders have played an important role in innovation, conceptual work, design and implementation.

1. *Reclaiming the importance of healthcare in the home*: Across the globe, a strong recognition of the importance of accessing healthcare services in the home has taken hold (Smith 2020; Tumlinson et al. 2020). In addition, there are opportunities to integrate many of the disparate healthcare services using virtual platforms blended with support provided by in-home caregivers. For example, “primary care@home” models have been developed, whereby home-care providers work closely with primary care providers to meet patient care goals. Similarly, “LTC@home” models have been developed, wherein patients waiting for a long-term care bed can reimagine receiving safe, 24/7 care in the home with a combination of in-person care, technology-assisted care and

family caregivers. These models are ready to be deployed with the appropriate policy and funding levers.

2. *Legitimizing virtual care as an important mechanism for providing services:* When the WHO declared COVID-19 as a global pandemic, SE Health corporate and service delivery centre (administrative) staff began remote working arrangements the next day. Fortunately, most of the tools required were already in place, such as the use of Microsoft Teams, all staff having laptops and mobile phones with the required software, secure channels for accessing the SE Health servers and files, remote technology supports and the “Clinical Practice Resource Team.” Clinical care, however, was largely provided using in-person channels, although a virtual care model had been tested and deployed for programs such as “The H.O.P.E Model,” a neighbourhood model of care (Sharkey and Lefebvre 2017). Once virtual care compensation was approved – in a decision time frame that was unprecedented (Ontario Ministry of Health 2020) – the work of spreading and scaling virtual care became the focus, with much attention on developing tools and skills and supporting implementation and change management. This has been a significant change in practice for both the nurses and patients.

The Way Forward

The health and social care sectors must work together, with a sharp focus on keeping people healthy and at home. This requires a systems approach to planning and interventions. Along with promoting public health measures, attention must be given to the ongoing health needs of older adults, those with chronic illnesses as well as other vulnerable populations, such as Indigenous peoples, those living in poverty, those who are homeless and those living in remote and isolated communities. A holistic approach is recommended, where five domains of well-being are considered in the planning and delivery of healthcare services (Sharkey et al. 2020): (1) personal (e.g., living arrangements, family status, intergenerational connections, thinking skills); (2) social (e.g., neighbourliness, friendships, personality attributes); (3) health (e.g., physical, mental, disability, chronic conditions); (4) resources (e.g., employment, finances, material); and (5) local (e.g., satisfaction with medical, leisure, public transport and shopping services). The systems approach should reach neighbourhoods, families and the community resources that can support well-being. Ontario Health Teams could be the right platform to address community-focused approaches and a measure to keep people out of the hospital. These Ontario Health Teams have a mandate to be “clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population” (Ontario Ministry of Health 2020). Nurse leaders must inform themselves of the many available models of care and advocate these for their communities.

It is more important than ever during this pandemic to have personalized responses to patients and their families. Nurse leaders must build systems that provide greater autonomy to front-line healthcare providers along with the flexibility and tools to meet the needs of patients using a blended model of in-home visits, virtual care and remote consultations with family or other informal caregivers. Front-line staff need to be equipped with standardized protocols but also armed with a decision-making framework that empowers them to respond with nimbleness, agility and creativity.

For home and community care to respond well during the pandemic and beyond, there needs to be an immediate focus on workforce stabilization. This includes a fundamental shift in terms of human resource planning, including the hiring of full-time positions at competitive salaries and benefits. This sector must not be the “poor cousin” in the healthcare system, particularly when we need people to stay healthy and at home.

Conclusion

COVID-19 has caused upheaval globally; however, it has also presented the opportunity to build better for the future. Nurses have taken on the responsibility of getting homecare services reinstated, have put in overtime to ensure that patients are safe and their needs are addressed and have looked for creative ways to keep families engaged with their loved ones. We applaud their heroic efforts and commitment in helping patients and communities. The insights and implications from the experiences of home and community care nurse leaders can support the strengthening of our home and social care systems and ensure that those who are the most vulnerable have the protections they need. A quotation from Mahatma Gandhi summarizes this sentiment well (Volunteering Matters 2016):

The true measure of any society can be found in how it treats its most vulnerable members.

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References

Bayshore Healthcare. 2020, June 17. In-Home Seniors Healthcare Is the Safer Alternative Especially during COVID-19 Pandemic. *Cision*. Retrieved August 27, 2020. <<https://www.newswire.ca/news-releases/in-home-seniors-healthcare-is-the-safer-alternative-especially-during-covid-19-pandemic-804165233.html>>.

- College of Nurses of Ontario. 2018. *RN and RPN Practice: The Client, the Nurse and the Environment*. Practice Guideline. Retrieved August 27, 2020. <<http://www.cno.org/globalassets/docs/prac/41062.pdf>>.
- Government of Canada. 2016, April 13. Home and Community Health Care. Retrieved August 27, 2020. <<https://www.canada.ca/en/health-canada/services/home-continuing-care/home-community-care.html>>.
- Government of Canada. 2021, January 13. Coronavirus Disease 2019 (COVID-19): Epidemiology Update. Retrieved January 15, 2021. <<https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html>>.
- Grant, K. and T.T. Ha. 2020, 21 May. How Shoring Up Hospitals for COVID-19 Contributed to Canada's Long-Term Care Crisis. *The Globe and Mail*. Retrieved August 27, 2020. <<https://www.theglobeandmail.com/canada/article-how-shoring-up-hospitals-for-covid-19-contributed-to-canadas-long>>.
- Ontario Health. 2020, 25 March. Priority Setting of Personal Protective Equipment – Within Health Care Institutions and Community Support Services. Retrieved March 26, 2020. <https://www.wrh.on.ca/uploads/Coronavirus/Ethics_Table_Policy_Brief_3_PPE_Within_Health_Care_Institutions_Community_Support_Services.pdf>.
- Ontario Ministry of Health. 2020, 18 March. Supporting Expansion of Virtual Home Care Delivery [memorandum]. Retrieved August 27, 2020. <http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/memos/MOH-OH_Memo_Virtual_Visits_March_18_2020.pdf>.
- Reddy, M., N. Stall and P. Rochon. 2020, May 18. How Coronavirus Could Forever Change Home Health Care, Leaving Vulnerable Older Adults without Care and Overburdening Caregivers. *The Conversation*. Retrieved August 27, 2020. <<https://theconversation.com/how-coronavirus-could-forever-change-home-health-care-leaving-vulnerable-older-adults-without-care-and-overburdening-caregivers-137220>>.
- Registered Nurses' Association of Ontario. 2013, July. *Developing and Sustaining Nursing Leadership Best Practice Guidelines: Second Edition*. Retrieved August 17, 2020. <https://rnao.ca/sites/rnao-ca/files/LeadershipBPG_Booklet_Web_1.pdf>.
- Schröder-Butterfill, E. and R. Mariani. 2006. A Framework for Understanding Old-Age Vulnerabilities. *Ageing & Society* 26(1): 9–35. doi:10.1017/S0144686X05004423.
- Sharkey S., Z. Khayat and P. Holyoke. 2020, January 15. *The Future of Aging*. Idea Couture and SE Health.
- Sharkey, S. and N. Lefebvre. 2017. Leadership Perspective: Bringing Nursing Back to the Future through People-Powered Care. *Nursing Leadership* 30(1): 11–22. doi:10.12927/cjnl.2017.25110.
- Smith, K. 2020, August 19. The Post-Pandemic Future: Home Care Will Ease the Burden on Hospitals. *Toronto Life*. Retrieved August 19, 2020. <<https://torontolife.com/city/the-post-pandemic-future-home-care-will-ease-the-burden-on-hospitals/>>.
- Tumlinson, A., W. Altman, J. Glaudemans, H. Gleckman and D.D. Grabowski. 2020. Post-Acute Care Preparedness in a COVID-19 World. *Journal of the American Geriatric Society* 68(6): 1150–54. doi:10.1111/jgs.16519.
- United Nations. 2020, May. *Policy Brief: The Impact of COVID-19 on Older Persons*. Retrieved August 27, 2020. <<http://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2020/05/COVID-Older-persons.pdf>>.
- Virani, T. 2020, September 22. Seven Lessons during COVID-19 from across the Globe: Perspectives of Home and Community Healthcare Organizations. Retrieved November 1, 2020. <<https://www.linkedin.com/pulse/seven-lessons-during-covid-19-from-across-globe-home-community-tazim/>>.
- Volunteering Matters. 2016, September 15. The True Measure of Any Society Can Be Found in How It Treats Its Most Vulnerable Members. Retrieved January 19, 2021. <<https://volunteeringmatters.org.uk/true-measure-society-can-found-treats-vulnerable-members/>>.