The Canadian Long-Term Care Sector Collapse from COVID-19: Innovations to Support People in the Workforce

Effondrement du secteur canadien des soins de longue durée à cause de la COVID-19 : des innovations pour soutenir la main-d'œuvre

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Key Takeaways

- On top of the long-standing lack of resources, including the ever-existing staff shortages, long-term care (LTC) workers experienced an unprecedented increase in their workload during the pandemic without justifiable compensation – including a lack of sufficient time off and absence of communication to promote work–life balance.
- All categories of LTC staff experienced immense moral distress, burnout and compassion fatigue due to high rates of COVID-19 cases and deaths of residents and staff, policy changes and staff turnover. A preventative approach where staffing is optimized and supports are readily available is necessary to prepare the LTC sector for another health crisis.
- Decades of research have shown that strong evidence is not sufficient to change LTC policies and practices. A rejuvenation of the LTC sector urgently requires adequate staffing with access to competitive benefits, compensation and mental health supports to allow workers to effectively care for residents and effectively implement changes to improve LTC in Canada.

Abstract

The COVID-19 pandemic rattled Canada's long-term care (LTC) sector by exacerbating the ingrained systemic and structural issues, resulting in tragic consequences for the residents, family members and LTC staff. At the core of LTC's challenges is chronic under-staffing, leading to lower quality of care for residents and higher degrees of moral distress among staff. A rejuvenation of the LTC sector to support its workforce is overdue. A group of diverse and renowned researchers from across Canada set out to implement innovative evidence-informed solutions in various LTC homes. Their findings call for immediate action from policy makers and LTC decision makers.

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Résumé

La pandémie de COVID-19 a secoué le secteur canadien des soins de longue durée (SLD) en exacerbant les problèmes systémiques et structurels enracinés, ce qui a eu des conséquences tragiques pour les résidents, les familles et le personnel des SLD. Au cœur des défis propres aux SLD se trouve le manque chronique de personnel, ce qui entraîne une moindre qualité des soins et des degrés plus élevés de détresse morale parmi le personnel. Un rajeunissement du secteur des SLD en soutien de la main-d'œuvre se fait toujours attendre. Un groupe de chercheurs diversifiés et renommés, provenant de tout le Canada, a entrepris de mettre en œuvre des solutions novatrices fondées sur les données probantes dans divers établissements de SLD. Leurs conclusions demandent une action immédiate de la part des décideurs politiques et des décideurs des SLD.

Introduction

The long-term care (LTC) sector provides around-the-clock services and care to people whose health needs prevent them from living independently. This care and service is provided by a workforce whose historic marginalization has been highlighted by researchers dating back to the 1970s (Linn et al. 1977), yet little has changed in Canada over the last half century (Badone 2021; Estabrooks et al. 2020). The COVID-19 pandemic illuminated historic under-investment in LTC. The LTC sector is inadequately resourced to care for an aging population that has increasingly complex needs due to high levels of frailty and multiple health conditions, including dementia. An integrated palliative approach with chronic disease management is needed as many residents die within two years of admission (Ayalon et al. 2020; Vossius et al. 2018).

The LTC workforce is characterized by limited overall staffing levels and too many residents for workers to care for adequately. The resulting workloads leave little time to complete essential care, coupled with scant support from experts and specialty clinicians, low pay and poor access to mental health resources. Accordingly, the LTC workforce is at a high risk for burnout, occupational stress, physical injury and job precarity (Hunter et al. 2020). Pervasive under-recognition and undervaluing of care work helps create less than desirable working conditions that go unaddressed by policy makers and decision makers (McGilton et al. 2020). The devaluation of the LTC workforce's hard work is compounded by the composition of the workforce being predominantly racialized immigrant women, whose needs and value to society are systemically overlooked (Gahwi and Walton-Roberts 2022). Moreover, negative systemic ageist stereotypes have contributed to policies, suboptimal budgets and resource allocation and institutional practices that resulted in Canada's inevitable COVID-19-related death rate of 81% in LTC, compared to the global average of 38% (Badone 2021).

We must not wait for another public health crisis to address the glaring needs of LTC; the workforce has been overburdened and the sector needs immediate intervention. This paper is a collaborative effort by research teams across Canada and calls on policy and decision makers to stop studying and start implementing often-repeated, evidence-informed recommendations that address the marginalization of LTC workers and, subsequently, the marginalization of those under their care.

Context

The COVID-19 pandemic has had a profound impact on the health of older adults, particularly those living in congregate care settings, with over 80% of COVID-19 deaths occurring in LTC homes across Canada (Hunter et al. 2020). Patients diagnosed with COVID-19 were treated differently because of their age with regard to decisions on receiving the limited supply of life-sustaining treatments and equipment, such as ventilators (Montero-Odasso et al. 2020). As such, LTC homes were discouraged from transferring residents to hospitals at the onset of the pandemic, while a large number of older patients from acute care were discharged to LTC and other settings to create more space for the younger COVID-19 patients (Sibbald 2020). At the same time, LTC staffing and medical resources were limited, leading to suboptimal care for in-house residents (Stall et al. 2020). Also, the increase in patients transferred from acute care led to an increase in outbreaks in LTC and burdened the staff because of the care required by additional residents. Furthermore, because of public health restrictions aimed at preventing the spread of the COVID-19 virus, several categories of staff were deemed non-essential to LTC, thus compromising the delivery of day-to-day recreational, rehabilitative, primary, acute, episodic and palliative care to residents (Vellani et al. 2022).

LTC was consistently underrepresented by government officials and policy makers in public addresses about Canada's healthcare system during the pandemic, leaving individual LTC organizations and workplace leaders struggling to interpret new policies and regulations. The resulting gaps in care and inconsistencies across LTC sites had devastating consequences. Inconsistent standards of care not only put residents at risk but also created morally distressing choices for LTC staff

to either follow directives or provide the quality of care that they knew they should (Stall et al. 2020). Moreover, years of governments deprioritizing the sector rendered LTC workers more vulnerable to being infected with COVID-19 (Armstrong et al. 2020) and the associated moral distress.

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The Strengthening Pandemic Preparedness in Long-Term Care Project

In November 2020, the Implementation Science Teams (ISTs) – Strengthening Pandemic Preparedness in LTC initiative was launched by Healthcare Excellence Canada (HEC 2022) in partnership with Canadian Institutes of Health Research, New Brunswick Health Research Foundation, Saskatchewan Health Research Foundation, Centre for Aging + Brain Health Innovation and Michael Smith Health Research BC. The goal was to generate evidence and determine promising practices and policies that are effective in optimizing the safety of residents, families and other essential care partners, as well as staff, during and beyond the COVID-19 pandemic in LTC facilities across Canada. Six ISTs identified challenges experienced by LTC workers, some unique to the COVID-19 pandemic and some extending beyond pandemic conditions. The teams came together to share their findings and inform policy and decision makers in LTC on the accomplishments and challenges of the pandemic on the LTC workforce. As part of their projects, each team developed an evidence-based innovation to implement in LTC (Table 1). The findings are promising; however, implementation is challenging and requires immediate attention by policy makers, administrators and decision makers. We linked findings from each of the six projects to construct key themes that represent the relationships among the findings (Popay et al. 2006).

We Need More Long-Term Care Workers and to Fully Value Them

Amid the unprecedented pandemic conditions, LTC workers adapted to rapidly changing policies and working conditions as best as they could with limited supports. While the pandemic has highlighted many areas of need, the most urgent has been staffing. The LTC workforce has been stretched thin, and often understaffed workers interviewed by ISTs emphasized the severe consequences of inadequate staffing, which included longer working hours and irregular schedules. Time needed to care for each isolated resident multiplied while workers missed

TABLE 1.
Summary of Implementation Science Teams and projects

Teams	Goal of project	Innovation
Katherine McGilton, KITE-UHN	To improve staff resiliency and mental health while reducing moral distress in the LTC workforce	Developed a toolkit to empower nurse practitioners to facilitate team huddles to share relevant information and conduct regular check-ins with staff
Bonnie Lashewicz, University of Calgary	To better support LTC staff in managing moral distress	Developed an application to enable LTC organizations to support workers in managing moral distress
Andrea Iaboni, KITE-UHN; McMurray, Wilfrid Laurier University; Grigoravich, Brock University	To improve moral resilience among staff and support the compassionate and effective isolation of residents and address moral distress in LTC workforce	Created DIT to help staff balance decisions related to infection prevention and control measures with principles of person-centred care (DIT n.d.)
Sharon Kaasalainen, McMaster University	To provide easily accessible educational resources to build staff confidence to take a palliative approach to care	Developed a virtual palliative toolkit (SPA-LTC 2020) to supply staff with educational modules and information on integrating a palliative approach to care
Joanie Sims-Gould and Farinaz Havaei, University of British Columbia	To describe the process and impact of the implementation of the single-site employment order in LTC on residents and staff To generate a roadmap to effectively implement future policies in LTC	Used the Consolidated Framework for Implementation Research (CFIR 2022), which outlines a five-step process by which researchers can translate findings into realistic outcomes, to describe the implementation and impact of the single-site employment order
Idrissa Beogo, University of Ottawa	To create a community of practices among residents to reduce isolation and loneliness during and after the COVID-19 pandemic	Focused on the importance of linguistic minorities – namely, the presence of relatives as key partners in providing care and reducing social isolation and loneliness

DIT = Dementia Isolation Toolkit; KITE = Knowledge, Innovation, Talent, Everywhere; LTC = long-term care; UHN = University Health Network.

shifts due to a COVID-19 infection or fear of contracting it. LTC staff worked extra shifts and longer hours to avoid feelings of guilt stemming from leaving residents isolated and without care, resulting in consecutive weeks and even months without a single day off. Consequently, the quality of resident care declined as staff burnout climbed. Immense workloads carried during pandemic conditions did not match the compensation staff received from governing bodies and LTC organizations. Yet LTC workers continued to show up and adapt to dynamic working conditions.

When asked what their organization and supervisors could have done better, workers highlighted the importance of leaders recognizing the increased workload and offering greater compensation, including offering sufficient time off and providing a communication-based environment that promotes work–life balance. Workers shared that having LTC leaders more available on the floor to support front-line staff and answer questions would have increased worker comfort. LTC leaders also shared that they were strained as they tried to regularly communicate with families while keeping up-to-date on the latest policies and procedures to implement in their facility, leaving little time to fulfil their regular duties. Some managers had to transition roles when their facility experienced a COVID-19 outbreak and assist with resident care to compensate for exceptional staff shortages. Conversely, some novice workers were thrown into leadership roles at the onset of the pandemic and struggled to adapt to the intense workloads. Consequently, an unprecedented number of workers are now leaving the LTC sector, either because of extended stress leave or to transition to work in other healthcare sectors with less distressing work environments. In all, LTC workers essentially pleaded for more resources to alleviate their workloads.

Moral Distress in Long-Term Care Staff Was a Prominent Finding across All Projects

Disproportionately high rates of COVID-19 cases and deaths in LTC homes among residents and staff combined with acute or chronic insufficient staffing, high rates of staff turnover and ever-changing policy mandates served to drive staff burnout, compassion fatigue and moral distress. Workers expressed feelings of guilt as they enforced visitor restrictions in accordance with COVID-19 protocols. Workers vividly described the emotional distress of watching residents' mental and physical health decline despite workers' persistent efforts to provide adequate care. Workers also felt guilty for neglecting their personal responsibilities and relationships as a result of spending so much of their time at work. Young members of the LTC workforce (under 30 years) experienced an extraordinary emotional burden due to being new in the field with less ability to cope amid ever-changing rules imposed by the pandemic, leading to greater moral distress. While staff often felt unsupported by their management teams, who were not present to answer their questions and support resident care, managers themselves were exceptionally exhausted working unreasonable hours in their office responding to concerns from families and listening to staff concerns. Managers were unprepared for their increased workload and desperately needed mental health supports to mitigate burnout. Workers felt they had limited abilities to affect change or easily access information related to resident care without the help and approval of their managers. The COVID-19 pandemic deepened long-standing divides between different categories of staff and affected communication and task performance.

Pandemic-Imposed Policies Led to a Decrease in Person-Centred Care

To ensure the health and safety of staff, residents and their families, the Public Health Agency of Canada mandated several rapid redesign and resource redeployment practices, such as strict visitation policies, COVID-19 screening, use of personal protective equipment and the single-site employment order. Emerging pandemic evidence shows that despite important contributions to limit the spread of infection, these policies were complex and had many unintended consequences for LTC homes, the residents and caregivers (Chen et al. 2020; Havaei et al. 2022). Furthermore, depending on the funding structure and accountability (i.e., municipal run, for profit or not for profit), there were differences in how these directives were interpreted and executed.

Given the increasingly high level of frailty and complexity of LTC residents, what we need is a workforce that is prepared to care for them in a competent and dignified manner with opportunities to uplift their own capacity, grow professionally and feel valued and supported by their institutions. The principles of person-centred care were all but abandoned as pandemic-related directives contributed to the LTC sector taking a task-oriented approach to care that overlooked resident needs and had staff focus on risk aversion instead. LTC homes also had few opportunities to train staff to care for residents with dementia who have complex and dynamic care needs, integrate a palliative approach to care that transitions into end-of-life care and effectively deal with multiple losses within a short period. All combined, this led to compromised resident care; grief among residents, staff and families that was more fully felt than in the wider society; and an exhausted workforce (Kaasalainen et al. 2021; Maben and Bridges 2020).

Chronic Staffing Crisis Is a Barrier to Implementing Change

During implementation activities, each IST faced barriers related to staff availability to take part in the projects.

Iaboni's and Kaasalainen's respective teams provided LTC staff with easily accessible virtual educational resources to build confidence and competence but found that staff lacked the time and energy to meaningfully engage with the resources provided.

McGilton's and Lashewicz's respective teams dedicated their projects to improving the mental health and resiliency of staff experiencing high moral distress. The teams reported that LTC workers had excessive workloads, leaving no time to incorporate huddles on the floor. There was little willingness to commit their free time to using an app that focused on their mental health because of limited days off work, which the largely feminized workforce has to dedicate to housework and trying to spend time with friends and family. These ISTs adapted by shortening the script for staff members facilitating the huddles and reconceptualizing the app to require less time and effort from staff. Staff submitted a short checklist that put the onus on employers to aggregate results and provide corresponding supports, to which staff and employers were more receptive.

Sims-Gould's team reviewed the impacts of the single-site employment order and found the implementation of this order challenging, given limited human and material resources, including less competitive employee compensation. Likewise, the single-site employment order itself exacerbated staffing inadequacies, resulted in an increased use of staff overtime and overburdened staff and compounded burnout. Researchers found that policy implementation effectiveness could be improved through (1) clear and timely communication within and between organizations, (2) effective leadership, (3) more human and non-human resources to support policy implementation, (4) use of standardized data systems to track employment information of LTC staff and (5) increasing staffing levels to address the loss of staff caused as a result of the policy implementation.

Finally, Beogo's team aimed to develop a user-friendly digital platform for connecting residents with family members that could be used without the additional support of LTC workers, who spent a large portion of their workdays facilitating video and phone visits with resident family members. The implementation of the virtual platform resulted in more time for LTC workers to dedicate to other care-related tasks while still reducing the social isolation and loneliness experienced by residents.

A Call to Action

LTC staff experience high levels of moral distress, yet they typically wait until their mental health has deteriorated to alarming levels before seeking help. At the same time, there is a lack of readily accessible mental health resources for staff and management, especially to help them manage their own grief and bereavement from enduring many resident deaths during the COVID-19 pandemic. This raises concerns about the future of the LTC workforce that has been working under threadbare conditions. A preventative approach would be valuable and is urgently needed, where staffing is optimized, staff is supported by their supervisors and internal and external resources are readily available. Current mental health supports are underutilized, and decision makers need to reallocate resources to invest in solutions that workers will engage with and benefit from. Then workers may be able to provide person-centred care that is tailored to residents' comprehensive needs.

Each IST received positive feedback on their innovation from advisory groups, LTC partner sites and LTC workers interviewed, and we found promising data that staff were receptive to using the innovations. While all ISTs want to continue and expand their innovations, we feel that help from policy and decision makers is urgently needed to intervene on the chronic staffing issue that prevents other changes from being successful. Furthermore, we need continued efforts to strategize how best to implement innovations, given that strong evidence is not sufficient to change practice. In most implementation science models, facilitators are key to assessing and responding to the characteristics of the innovation and the recipients within the settings. LTC leaders must support workers in facilitating the implementation of new innovations and addressing barriers as they emerge.

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Moving Forward

One after another, researchers and subject matter experts over the past 50 years have called on decision makers to address the malignant cocktail of deficiencies plaguing the LTC sector in Canada in the domains of standards of care, funding, infrastructure, workforce and staffing, and the need for person-centred care. The frailest and most medically complex individuals enter LTC homes, yet their care providers are insufficient and lack the skills, time and equipment to care for them. The chronic staffing crisis is crippling the LTC sector as overworked, underpaid and burned out staff struggle to provide basic care to residents. Innovative practices that might better educate and prepare workers or provide tools to mitigate moral distress experienced at work are abandoned in the face of these stressors.

It is critical that LTC homes re-evaluate and reallocate Employee Assistance Program funds so that LTC workers can easily and equitably access and benefit from supportive services. We also need to institute policies and measures that help retain the existing workforce and attract highly qualified and passionate workers to this challenging yet fulfilling environment, including through competitive remuneration (regardless of ownership of the LTC home), continuing education and professional development opportunities. Policies implemented during emergency situations must be guided by person-centred care that incorporates residents' values, wishes and preferences. The essential role of families, informal care partners and volunteers in care provision needs to be explicitly acknowledged as crucial to residents' overall well-being throughout their stay in LTC.

Researchers, professionals and LTC staff have been calling for change for half a century, and it took a global pandemic to magnify the evidence to prove that the current system is broken. The quality of the LTC sector reflects the quality of care provided to residents, and it starts with a well-resourced workforce. It is time to adequately staff the LTC sector and provide appropriate benefits, compensation and mental health supports to the workforce to allow workers to effectively care for residents and reshape Canada's LTC system into a sustainable and high-quality healthcare field. HQ

Disclaimer

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