



ST. MICHAEL'S  
UNITY HEALTH TORONTO

# Identifying Barriers, Facilitators and Recommendations to Long-term Care COVID-19 Infection Prevention and Control Preparedness and Response

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This document was jointly created by the Canadian Patient Safety Institute and the Canadian Foundation for Healthcare improvement which have now amalgamated to become Healthcare Excellence Canada. There may still be references to the former organizations as well as their logos and visual identities.

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## Abbreviations

CAPES	Canadian Alliance to Protect and Equip Seniors Living
CFHI	Canadian Foundation for Health Improvement
CPSI	Canadian Patient Safety Institute
EMS	Emergency medical services
IPAC	Infection prevention and control
KFL&A	Kingston, Frontenac, Lennox, and Addington
KTP	Knowledge Translation Program
LHIN	Local Health Integration Network
LTC	Long-term care
LTCH	Long-term care home
NIA	National Institute on Aging
PPE	Personal protective equipment
PSW	Personal support worker
RH	Retirement home

# Executive Summary

## Introduction

Long-term care homes (LTCH) have been at the epicenter of the COVID-19 pandemic in Canada with residents accounting for more than 80% of the country's deaths. The Canadian Foundation for Healthcare Improvement (CFHI) and Canadian Patient Safety Institute (CPSI) identified promising practices and policy options for future infectious disease outbreaks in a recent report. These six practices (preparation, prevention, people in the workforce, pandemic response and surge capacity, plan for COVID-19 and non-COVID-19 care, presence of family) are further broken down into a series of questions to ask when assessing preparedness and response capacity.

To build on this original report, CFHI engaged the Knowledge Translation Program (KTP) at St. Michael's Hospital to perform a secondary analysis of 25 interviews with LTCH and RH stakeholders from across Canada.

## Objectives

The objectives of this analysis were to:

1. Identify barriers and facilitators to, as well as needs/ recommendations to, COVID-19 preparedness in LTCHs and RHs
2. Map relevant tools and resources from the IPAC+ Resource Repository that can be leveraged to support identified barriers, facilitators, and needs/recommendations

## Methods

Interviews were analyzed through a rapid qualitative analysis approach, due to 1) the nature of the data being provided (i.e., detailed notes rather than formal transcripts), and 2) the need to analyze this data quickly to identify appropriate strategies to support LTCHs and RHs throughout the second wave of COVID-19.

## Key Findings

There are many resources available to support barriers, facilitators and identified needs/ recommendations to COVID-19 preparedness in LTC. As the pandemic endures, these findings can be leveraged to inform the development of new strategies and allocation of resources to support LTCHs and RHs through these difficult times.

## Summary of Results

### 1. PREPARATION:

#### BARRIERS

- Health system focus on acute care, not LTC
- IPAC implementation challenges in LTCHs

#### FACILITATORS

- Pre-established partnerships and plans between hospitals and LTCHs
- Access to and management of PPE

#### IDENTIFIED NEEDS & RECOMMENDATIONS

- Ongoing focus on IPAC training and assessments
- Develop PPE supply chain
- Development of individualized outbreak response plans

### 2. PREVENTION

#### BARRIERS

- LTCH admissions from acute care
- Inconsistent public health guidance
- Poor adherence to IPAC best practices

#### FACILITATORS

- Early implementation of IPAC measures
- Use of mobile assessment centres
- Geographic advantages

#### IDENTIFIED NEEDS & RECOMMENDATIONS

- Routine testing, surveillance and contact tracing in LTCHs
- Minimized entry into LTCHs and RHs
- Strategies to care for residents in place

### 3. PEOPLE IN THE WORKPLACE

#### BARRIERS

- Staff shortages
- Staff recruitment challenges
- Increased workload with COVID-19 IPAC protocols

#### FACILITATORS:

- Financial and psychological support
- Leveraging allied health professionals in LTC

#### IDENTIFIED NEEDS & RECOMMENDATIONS

- Help with staff recruitment and training
- Better staff job security and wellness
- Evaluation of on-the-ground leadership

### 4. PANDEMIC RESPONSE AND SURGE CAPACITY

#### BARRIERS

- Slow outbreak responses
- Case reporting issues

#### FACILITATORS:

- Strong leadership during outbreaks
- Outbreak management teams
- Capacity to separate positive and negative COVID-19 cases

#### IDENTIFIED NEEDS & RECOMMENDATIONS

- Sustainability of pandemic response measures
- Pandemic response plan for dementia wards

### 5. PLAN FOR COVID-19 AND NON-COVID-19 CARE:

#### BARRIERS

- Lack of leadership presence on the ground
- De-prioritization of non-COVID care and services

#### FACILITATORS

- Delivering virtual care when possible
- Investment in person-centred design of LTCH

#### IDENTIFIED NEEDS & RECOMMENDATIONS

- Greater leadership presence and accountability
- Alternative care models and resources
- Focus on holistic approach to resident well-being

### 6. PRESENCE OF FAMILY

#### BARRIERS

- Stringent visitor policies
- Harm of lack of family presence
- Challenges of technology

#### FACILITATORS:

- Substitutes to in-person visiting
- Strategies to allow family caregivers into LTCHs

#### IDENTIFIED NEEDS & RECOMMENDATIONS

- Processes to re-integrate family caregivers

## Introduction

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Long-term care homes (LTCH) have been the epicenter of the COVID-19 pandemic in Canada with residents accounting for more than 80% of the country's deaths.(1) There is concern that despite these predisposing risks, the long-term care (LTC) sector was both underprepared and underequipped to protect their residents and staff. The Canadian Foundation for Healthcare Improvement (CFHI) and Canadian Patient Safety Institute (CPSI) used a rapid qualitative analysis approach(2) to conduct key informant interviews with stakeholders working in or peripherally supporting LTCH during a 3-week period between late May and early June of 2020. CFHI and CPSI purposively sampled health system leaders and family partners in care from across Canada. Stakeholders were asked to describe the factors that contributed to COVID-19 outbreaks in long-term care (LTC) and other congregate settings, identify promising practices with the potential for short-term spread and scale, and provide suggestions on how to maintain essential non-COVID-19 care for older adults through 2020 and beyond. The resulting CFHI/CPSI report *Reimagining Care for Older Adults: Next Steps in COVID-19 Response in Long-Term Care and Retirement Homes* provides a description of what happened between March-May 2020 in LTCH and retirement homes (RH), and identified six promising practices and policy that may reduce the risk of another wave of outbreaks in LTC or mitigate its effects. These areas include 1) preparation, 2) prevention, 3) people in the workforce, 4) pandemic response and surge capacity, 5) plan for COVID-19 and non-COVID-19 care, and 6) presence of family.(3) These six priority areas were further broken down into a series of questions to ask when assessing preparedness and response capacity.

To build on this original report, CFHI engaged the Knowledge Translation Program (KTP) at St. Michael's Hospital to perform a secondary analysis on a subset of the interviews to identify and categorize barriers, facilitators and current practice gaps to COVID-19 preparedness.

Leveraging both the CFHI/CPSI report data, and the IPAC+ Resource Repository, the objectives of this analysis were to:

1. Identify barriers and facilitators to, as well as practice gaps in, COVID-19 preparedness in LTC.
2. Map relevant tools and resources from the IPAC+ Resource Repository to identified barriers, facilitators, and practice gaps. In partnership with the Regional Geriatric Program (RGP) of Toronto, the KTP developed the IPAC+ Resource Repository, an online library where key stakeholders can freely access up-to-date Ontario-based pandemic infection prevention and control (IPAC) resources for long-term care in one centralized location.(4)

## Methods

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The KTP was provided with non-verbatim detailed notes from 25 stakeholder interviews as well as the final CFHI/CPSI's *Reimagining Care for Older Adults: Next Steps in COVID-19 Response in Long-Term Care and Retirement Homes*.(3)

These notes were analyzed using a rapid qualitative analysis approach,(5) due to 1) the nature of the data provided (i.e., detailed notes rather than formal transcripts), and 2) the need to analyze this data quickly to identify appropriate strategies to support LTCHs throughout the second wave of COVID-19.

Rapid analysis is a form of qualitative content analysis that offers a feasible and rigorous method through which to categorize qualitative data on a limited timeline. Healthcare researchers have leveraged rapid qualitative analysis to respond to other complex health emergencies much like the COVID-19 global pandemic. The rapid analysis process has been shown to save time compared to thematic analysis, and overlaps with >75% of the findings identified through thematic analysis.(2)

The rapid qualitative analysis approach provides a series of concrete steps to guide qualitative analysis. The process was operationalized using the following steps:

1. One staff member (AT) read through the interview notes in their entirety to get an overall view of the data.
2. The organizational coding framework was informed by the six LTCH priority areas (preparation, prevention, people in the workforce, pandemic response and surge capacity, plan for COVID-19 and non-COVID-19 care, and presence of family) and their corresponding questions, developed through the primary analysis of this data and described in the original CFHI/CPSI report.(3) This framework was used to discern barriers, facilitators and identified needs/recommendations to pandemic preparedness in LTCHs, as described by participants.
3. Two KTP staff members (AT, OS) independently coded a random sample of 20% (5/25) of the interview summary notes using the organizational coding framework. The two independently coded matrices were compared for discrepancies. Disagreements were resolved through discussion between the two staff members, or by a member of the research team otherwise uninvolved in the interview process in the case of persisting conflicts (TF or KQL).
4. One staff member (AT) then independently mapped text from remaining interview notes to each parent node and generated child nodes relating to barriers, facilitators, and identified needs/recommendations described by participants.
5. Once all interview notes were assigned to parent and child nodes, one staff member (AT) reviewed the CFHI/CSPI's Reimagining Care for Older Adult's report to supplement the codes with details clarified in the primary analysis.
6. Two KTP staff member (AT, KQL) identified relevant resources from the IPAC+ Resource Repository or other known resources that could be leveraged to support barriers, facilitators or identified needs/recommendations.
7. One KTP staff member (AT) then reviewed gaps in the resources to identify areas for further development.
8. Sub-questions within each priority area were then dissolved, and codes were collapsed and refined through iterative rounds of review by the research team (AT, KQL, OS, TF, SS).

## Results

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We analyzed notes from 25 interviews (n=26 total participants) with health system leaders discussing pan-Canadian perspectives on the COVID-19 pandemic in LTCH and RHs. Below, we present the results organized within each of the six priority areas identified in the original report.(3)

## 1. Preparation

Questions to ask when assessing pandemic preparedness in LTC:

- Have homes updated implementation of IPAC standards and training?
- Have homes met with regional partners to co-design response plans for different outbreak scenarios (e.g., using tabletop simulations)?
- Have homes and/or others secured personal protective equipment (PPE) supply and management arrangements?
- Are third-party assessment and guidance to ensure adherence to IPAC protocols being leveraged?

### BARRIERS

- **Health system focus on preparing acute care, not LTC:** COVID-19 preparation focused on acute care hospitals and this impacted PPE access and supply chains in LTCH.
- **IPAC implementation challenges in LTCHs:** IPAC practices were challenging to implement for a number of reasons, including longstanding infrastructure issues (e.g. shared rooms, air conditioning with poor filtration and ventilation, large public dining and visiting spaces, lack of sinks for staff members to wash their hands) and lack of IPAC knowledge and training among staff. Given the greater time commitments from overworked staff and additional expenses of IPAC equipment (e.g., PPE, hand sanitizer, cleaning supplies), IPAC practices have been difficult for LTCHs to implement.

### FACILITATORS

- **Pre-established partnerships and plans between hospitals and LTCHs:** LTCHs that were best prepared had pre-established, formalized partnerships with acute care hospitals that could be leveraged for support during times of crisis. For instance, in Ontario, the Kingston, Frontenac, Lennox and Addington (KFL&A) region developed strong outbreak management plans in collaboration with the municipal government, university, LTC, public health, and the local hospital. They modeled their IPAC readiness inspections and coaching on their annual flu preparations, and recruited restaurant inspectors and a public health nurse to their team.
- **Access to and management of PPE:** Early in the first wave, homes that were prepared with sufficient PPE supplies were those that had the financial resources or access to charitable donations, for example, through the Canadian Alliance to Protect and Equip Seniors Living (CAPES) initiative. Provincial/territorial and regional inventory with centralized supplies housed at hospital hub sites helped keep PPE levels stocked and costs down in some areas. In Prince Edward Island, Nova Scotia, Alberta, British Columbia and Manitoba, centrally managed supply chains were implemented early.

### IDENTIFIED NEEDS & RECOMMENDATIONS:

- **Ongoing focus on IPAC training and assessments:** Participants shared that future efforts should focus on ongoing IPAC training for staff and interim strategies to circumvent LTCH infrastructure challenges, such as adapting visitation schedules or implementing barriers between residents in shared rooms. Participants made suggestions to use decentralized training or train-the-trainer approaches for IPAC education. There was also a desire to see strengthened LTCH regulation with more frequent inspections and audits of IPAC readiness. LTCHs were also encouraged to perform regular self-assessments.
- **Develop PPE supply chain:** It was recommended that homes have a clear plan in place to report, acquire and replenish needed supplies. Some participants suggested housing PPE at a local hospital hub and allocating resources through a regional PPE site coordinator as needed.
- **Development of individualized outbreak response plans:** Participants felt that hospitals should work collaboratively with LTCHs (both urban and rural) in an effort to develop an individualized plan for each home, signed off by a public health unit or by provincial health authorities, and reviewed annually in preparation for pandemic emergencies. This plan should outline response team responsibilities, communication plans, available resources for homes (e.g., PPE, IPAC equipment) escalation pathways for troubled homes, chain of protection outlining who will stop doing their current jobs and step into different roles during the pandemic, and guidelines for working with the home and community care sector. This plan may include a standard hospital 'playbook' or the use of drills, simulations and/or exercises to organize and test professional leadership, PPE and IPAC training.

### RECOMMENDED RESOURCES:

[COVID-19 IPAC Fundamentals Training](#)

[Library of Donning and Doffing videos for PPE Relevant to LTC Settings](#)

[IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19](#)

[Recommended Steps: Putting on Personal Protective Equipment \(PPE\)](#)

[Public Health Ontario YouTube Channel: Video Tutorials on PPE and Environmental Cleaning](#)

[Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings \(3rd Edition\)](#)

[Best Practices for Hand Hygiene in All Health Care Settings, 4th edition](#)

[Coronavirus Disease 2019 \(COVID-19\) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings](#)

[Public Health Ontario Webinar Series - COVID-19: Considerations for Long Term Care and Retirement Homes \(LTC/RH\)](#)

[Personal Protective Equipment \(PPE\): Guidance for the LTC & RH Sectors](#)

[Personal Protective Equipment \(PPE\) Burn Rate Calculator](#)

[Interactive Excel Template for Tracking COVID-19 Cases and IPAC Practices](#)

[IPAC Canada Audit Toolkit](#)

[IPAC Self-Assessment Tool](#)

## 2. Prevention

Questions to ask when assessing preventative measures in LTC:

- Are homes regularly and systematically testing, even those without symptoms? Do homes have rigorous contact tracing protocols in place?
- Have homes implemented universal masking and other IPAC precautions?
- Have homes worked with partners to optimize care models, to reduce the number of outside care providers coming into the home and to manage how often residents need to leave for care (e.g. using virtual care, strong primary care, and on-site services where appropriate)?
- Are approaches in place (e.g. via intensive home and community care supports) to reduce the number of people who are waiting in hospital for other types of care and/or who need LTC?

### BARRIERS

- **LTCH admissions from acute care:** The surge of admissions from acute care hospitals to LTCH early in the pandemic generated an influx of residents to LTCH that made it more difficult to practice proper infection prevention strategies.
- **Inconsistent public health guidance:** Recommended IPAC best practices were sometimes perceived as unclear, inconsistent, and delayed. One participant described public health guidelines as being 'two weeks behind'.
- **Poor adherence to IPAC best practices:** Participants described that screening protocols initially did not include a comprehensive list of symptoms (e.g., excluded loss of taste and smell). There was also a lack of access to testing, delays in receiving test results, and poor reporting of outbreak data to public health.

### FACILITATORS:

- **Early implementation of IPAC measures:** Quick and early decisions by LTC leadership on LTCH lockdowns, early surveillance testing, aggressive implementation of universal masking, and proper use of PPE were viewed as essential to successful infection prevention. To support contact tracing, participants described using existing applications, such as BookJane, to facilitate reporting and tracing.
- **Use of mobile assessment centres:** Delivering testing to staff and residents on site at LTCHs or RHs through mobile assessment centres was seen as an important preventative measure which minimized the need for residents and staff to leave LTCHs and RHs.
- **Geographic advantages:** Some areas were able to implement an 'iron ring strategy', whereby controlling access points, monitoring, and quarantining travelers, and assessing commercial traffic, provinces and territories prevented COVID-19 from entering their communities. This translated to reduced cases in LTCHs. In Atlantic Provinces, there were border checks on highways. In the Yukon, government controls were placed at the Whitehorse airport and major highways; travelers entering underwent mandatory 14-day isolation in hotel rooms paid for by the government.

### IDENTIFIED NEEDS & RECOMMENDATIONS:

- **Routine testing, surveillance and contact tracing in LTCHs:** Participants expressed a need for sufficient access to testing equipment (e.g. nasopharyngeal swabs), broad testing availability for those who have been exposed, and ongoing surveillance. This includes surveillance of all residents, staff, family caregivers and visitors for early detection of carriers (symptomatic and asymptomatic) to ensure those infected are isolated before they transmit the virus to residents. Best practice was described as weekly or bi-weekly testing with rapid (e.g., 24-48h) turn-around time for LTCHs. Participants also felt that homes needed plans in place for contact tracing, for example, registering anyone who enters the home.
- **Minimize entry into LTCHs and RHs:** There was an identified need to have plans developed by each home's leadership to minimize the total number of people/care providers entering the home while ensuring that residents' needs are met. RHs faced challenges from local health integration networks (LHIN) in trying to reduce entry into their buildings. Some LTCHs experienced success with reducing and restricting mobility between sites, but outlined that there needed to be dedicated transportation options available if residents needed to leave.
- **Strategies to care for residents in place:** Participants described a need to reduce admissions to LTCH from acute care. Home care was frequently discussed as a temporary solution to reduce LTCH admission. To do this, however, it was acknowledged that there would need to be an expansion of home care capacity through supports such as enhanced PPE competency, testing for home care staff, home care options for patients with dementia and expanded services to include dialysis, chemotherapy, or mechanical ventilation.

### RECOMMENDED RESOURCES:

[COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes](#)

[COVID-19 Patient Screening Guidance Document \(Page 2: Regular Screening Questions\)](#)

[COVID-19 Guidance: Long-Term Care Homes \(Page 4: Summary of Required Precautions; Appendix: Summary for Active Screening for Long-Term Care Homes\)](#)

[COVID-19 Reference Document for Symptoms](#)

[COVID-19: How to Self-Monitor](#)

[How to Self-Isolate](#)

[COVID-19 Surveillance Testing- Long-Term Care Homes \(LTCH\) Fillable Checklist](#)

[COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#)

[Library of Donning and Doffing Videos for PPE Relevant to LTC Settings](#)

[Recommended Guidelines Pandemic Universal Masking in LTC/CC](#)

[Universal Mask Use in Health Care Settings and Retirement Homes](#)

[Video Tutorial: Putting on Mask and Eye Protection](#)

[Library of Donning and Doffing Videos for PPE Relevant to LTC Settings](#)

[Just Clean Your Hands' Long-Term Care Program](#)

[IPAC Extender Training Module](#)

### 3. People in the Workforce

Questions to ask when assessing preparation of the workforce in LTC:

- Have homes stabilized and reinforced staffing, as well as working conditions and psychological health and safety?
- Are staff limited to working in only 1 higher risk environment and are supports in place to make this possible?
- Are there plans to increase capacity through training and recruitment as required?
- Are the community-transmission risks that staff and their families may face understood and mitigated where possible?

#### BARRIERS

- **Staff shortages:** LTCHs and RHs have been chronically understaffed. Workforces typically include mostly part-time or casual workers with low wages and high turnover. Staff shortages during the pandemic have been exacerbated by illness, fear, the one-site limit per staff, and the loss of family/essential care visitors with visitor restrictions.
- **Staff recruitment challenges:** There have been challenges recruiting staff to LTCHs during the pandemic. Redeployment of staff from agencies, health regions, or even acute care centres to support LTCHs have sometimes been met with union issues. Redeployment of individual staff members to LTCHs were strongly discouraged, described as placing staff in 'impossible situations' which left these individuals deeply troubled and traumatized.
- **Increased workload with COVID-19 IPAC protocols:** The additional workload associated with implementing pandemic IPAC protocols has placed additional burdens on staff. This includes additional time required for augmented cleaning protocols and donning and doffing PPE, and fewer available staff caring for the same number of residents.

#### FACILITATORS

- **Financial and psychological support:** Programs to support staff financially (e.g., hazard pay) have been helpful. Quebec announced a plan to train 10,000 new healthcare aides and has offered them tuition and expense reimbursement (\$22,000 per student) for their year of studies. The presence of on-the-ground leadership was viewed as crucial for staff morale and psychological support. In one example, the Chief Executive Officer of a LTCH worked on the frontline as an aide in a difficult unit for more than two months. This was reported to have boosted staff morale.
- **Leveraging other allied health professionals in LTC:** The integration of emergency medical services (EMS) professionals (e.g., paramedics and EMS techs in New Brunswick), recreational therapists, nurses, and nurse practitioners trained to work in LTC has been helpful to support capacity in some homes.

#### IDENTIFIED NEEDS & RECOMMENDATIONS

- **Help with staff recruitment and empowerment:** There was an identified need for robust human resource support to increase recruitment as well as empower LTC staff with proper IPAC training and boost morale. Participants described a growing need for continuing education resources for redeployed staff who are new to the care of older adults in the LTC setting.
- **Long-term job security for staff:** For LTCH workers, such as personal support workers (PSW) or healthcare aides, there was an identified need to consider alternative payment models which support limited movement of staff between sites, but also provide adequate pay and security for workers. Participants considered whether temporary measures, such as hazard pay, would continue and/or become permanent, and considered long-term goals for the workforce, such as pay parity, registration and professionalization of the workforce, continuing education, and full-time employment.
- **Evaluation of on-the-ground leadership:** Participants called for on-site presence of management and the need for more educators and practice leaders with local responsibility and accountability on the frontline.

#### RECOMMENDED RESOURCES:

[COVID-19 Workforce Matching Portal](#)

[Link2LTC- Hiring in LTC](#)

[Training for people going to work in LTC](#)

[Continuing Education for Staff Redeployed to LTCHs](#)

[LTC Orientation for Incoming Support](#)

[Resource for Rapid Redeployment of Health Professionals to Critical and Long-Term Care Environments](#)

[COVID-19 Communication Tip Sheet for Redeployed Staff Working in Long-Term Care with Residents with Cognitive Impairment](#)

[Infection Prevention and Control During COVID-19: Volunteer Staff Training](#)

[Infectious Questions Podcast Series: What health professionals need to know about 2019-nCoV and COVID-19](#)

[COVID-19: How to Self-Isolate While Working - Recommendations for Health Care Workers](#)

[Homeweb: Mental Health Supports for LTC](#)

[Wellness Together Canada: Mental Health and Substance Use Support](#)

[Supports for LTC Home Staffing](#)

[Public Services Health & Safety Association Mental Health Supports for Frontline Workers](#)

## 4. Pandemic Response & Surge Capacity

Questions to ask when assessing pandemic response and surge capacity in LTC:

- Do homes have formal, clear, and well-communicated plans of where they will turn for assistance if there is an outbreak?
- Is there a pre-agreed plan for surge support for every home if needed that will ensure a robust response?
- Are surveillance methods in place (e.g. data/dashboards) to proactively identify where surge capacity may be needed?
- How will homes reduce the risk of cross-infection in the case of an outbreak involving residents (e.g. testing before cohorting residents who are or are not infected)?

### BARRIERS

- **Slow outbreak responses:** There was high variability in outbreak support responses. While some acute care hospitals were able to respond and support LTCHs within 12 hours of the request for support, other hospitals took several days to respond. Public health or provincial responses were also described by stakeholders as being too slow. The importance of responding early and quickly was emphasized in order to proactively manage staff illness and fear.
- **Case reporting issues:** Participants described that early on, privacy policies interfered with data transparency, there was inconsistency in reporting of cases, and outbreak data were 'buried in bureaucratic systems'.

### FACILITATORS

- **Strong leadership during outbreaks:** Single health authorities regulating the pandemic response (e.g., in Saskatchewan, British Columbia, Alberta, Nova Scotia, and certain regions in Ontario) were able to move resources efficiently and were therefore more successful in responding to outbreaks than regions with multiple health authorities. Strong clinical leadership was also seen as a key factor in successful response to outbreaks. Participants reported that rapid access to expert advice was particularly helpful in situations for LTCHs in outbreak who reportedly needed guidance, coaching and reassurance from skilled outsiders. In some jurisdictions, helpful resources were put together to support this, including Infopoint, a help line where First Nations health managers can access reliable, credible resources and information on COVID-19.
- **Outbreak management teams:** Multidisciplinary outbreak management teams (e.g. in BC, Ontario) that entered homes with full PPE, IPAC training, conducted swabbing and assessment, performed deep cleaning, led daily huddles with staff, and provided independent, primary care support in outbreaks were able to rapidly stabilize situations. In some provinces (e.g., Quebec, Ontario), the Canadian Armed Forces were brought in to support with food delivery, housekeeping, bathing and changing of residents which allowed LTC staff to focus on patient care. In some jurisdictions, these 'local eco-system responses' were facilitated through strong hospital-home connections.
- **Capacity to separate positive and negative COVID-19 cases:** LTCHs with the resources to separate residents were advantaged in managing outbreaks. These LTCHs were often in urban locations and with single rooms. Some LTCHs even had the resources to transfer positive residents to separate locations such as hotels (e.g., Yukon, Nova Scotia) or vacant LTC homes (e.g., Prince Edward Island).

### IDENTIFIED NEEDS & RECOMMENDATIONS

- **Sustainability of pandemic response measures:** There was an identified need for outbreak management teams to be a formalized part of the public health response with appropriate funding and permanent organization for future outbreaks. Participants also mentioned the desire for sustainability of several data transparency efforts to track LTCH data across Canada, led by academic and volunteer groups working in collaboration with reporters and family members of residents. For example, the National Institute on Aging (NIA) Dashboard provides a platform to monitor and report COVID-19 cases in LTC.
- **Pandemic response plan for dementia wards:** Staff deployed to support LTCHs often did not have experience working with older adults or people with dementia (sometimes coming from pediatric, or surgical settings). Plans and resources in place to manage the outbreaks on dementia wards was identified as an important need.

### RECOMMENDED RESOURCES:

[COVID-19 Outbreak Guidance for LTCH \(Page 3: New Admissions and Re-Admissions; Page 4: Ways to Increase Physical Distancing in the LTCFH; Page 16: Declaring the Outbreak Over; Appendix 1: PPE Recommendations for Staff on Work Self Isolation\)](#)

[COVID-19 Outbreak Guidance for LTCH- Action Summary](#)

[Interactive Excel Template for Tracking COVID-19 Cases and IPAC Practices](#)

[Long-Term Care \(LTC\) Respiratory Surveillance Line List](#)

[COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#)

[LTC & RH Consult Line Information Sheet](#)

[COVID-19 Considerations for LTCH](#)

[How to Cohort During an Outbreak of COVID-19 in a Congregate Living Setting](#)

[Cohorting in Outbreaks in Congregate Living Settings](#)

[Healthcare Worker PPE Use and Cohorting in LTC and RHs](#)

[Tip sheet for careproviders conducting nasal and throat swabs with clients with cognitive impairment](#)

[Dementia Isolation Tool Kit](#)

[Guidelines for Supporting Clients Who Wander and Require Physical Isolation \(EN\)](#)

[De-escalation of COVID-19 Outbreak Control Measures in Long-term Care and Retirement Homes](#)

## 5. Plan for COVID-19 & Non-COVID-19 Care

Questions to ask when assessing plans for COVID-19 and non-COVID-19 care in LTC:

- Have homes stabilized clinical leadership (e.g. medical director) and ensured back-up?
- Do all residents have access to high quality primary health care that does not require them to leave the home during an outbreak?
- Have arrangements for access to needed specialty care been put in place?
- Do all residents have up-to-date, person-centred, integrated care plans in place?
- Have palliative approaches to care been embedded in the home's processes and culture?

### BARRIERS

- **Lack of leadership presence on the ground:** Some clinical directors were not physically present on site while their LTCH was in outbreak. It was suggested that many directors were scared of the virus for personal health reasons. There were reports of medical directors insisting on rounding virtually and not providing on-site support to staff.
- **De-prioritization of non-COVID care and services:** Maintenance of non-COVID care and services important to resident health and quality of life have been de-prioritized during the pandemic. There has also been insufficient consultation with residents on changes to care plans and limitations to person-centred care in general due to IPAC protocols.

### FACILITATORS

- **Delivering virtual care when possible:** Many participants used platforms and products such as the Ontario Telehealth Network, Microsoft Teams, or Thinkresearch to deliver virtual primary health care delivery care with coordinated on-site delivery by PSWs and registered practical nurses. However, some also cautioned against providers using virtual care as an excuse to not be physically present on-site. In some provinces, all family physicians are paid for providing virtual care over the phone.
- **Investment in person-centred design of LTCH:** Newer LTCH designs may facilitate person-centred care. For example, in Quebec, the [Maisons des Aînés](#) model describes a plan for the renovation or re-build of LTCHs including 'pods' of 12 residents who share similar characteristics and interests, larger individual rooms with private bathrooms and accessible showers to facilitate personal care support if required, activity rooms, spaces dedicated for visiting loved ones (day or night), and creating a more residential design.

### IDENTIFIED NEEDS & RECOMMENDATIONS

- **Greater leadership presence and accountability:** There was an identified need to implement a 7-day/week management strategy to ensure continued support and decision capability on site. Ideally, there should be a medical director and a Chief of Medical staff (or other alternative) responsible for providing back up to the home to reinforce clinical leadership if the home needs additional support in a pandemic. Regulatory changes are needed to improve medical director accountability. In some cases, medical directors were completely absent on site.
- **Alternative care models and resources:** In addition to virtual care, participants desired more onsite services or mobile care clinics for primary care and high volume specialty services to keep residents from having to leave the LTCH to access care. There was an expressed need to provide resources to support these alternative care models. For example, one participant identified the need for Indigenous resources to support virtual care.
- **Focus on holistic approach to resident well-being:** There was a need for greater focus on resident well-being, including shared decision-making approaches and updates to advanced care plans.

### RECOMMENDED RESOURCES

[RGP of Toronto Senior Friendly Virtual Care Webinar Series Part 1](#)  
[Ontario eConsult Program Web-Based Tool](#)

[Quick Reference Flyer: VirtualCare™ Service](#)

[Virtual care supports resource](#)

[Summary of Services to Enhance Medical Capacity During COVID-19](#)

[Ethical Guidance for People who Work in Long-Term Care: What is the Right Thing to do in a Pandemic? \(Page 3-7: Why do we isolate people who have a contagious illness?\)](#)

[Decision Aid: Staying or Leaving a Long-Term Care Facility During COVID-19](#)

[Decision Aid: Staying or Leaving a Retirement Home During COVID-19](#)

[Thinking About Removing Your Older Loved One from Long Term Care During COVID19? Checklist](#)

[Engaging in Advance Care Planning for COVID-19](#)

[Advanced Care Planning, Goals of Care, and Treatment Decisions & Informed Consent](#)

[COVID-19 Goals of Care Communication Guide for Clinicians](#)

## 6. Presence of Family

Questions to ask when assessing presence of family in LTC:

- Do homes recognize and support family caregivers as essential partners in care?
- Have policies regarding family presence been revisited with resident/family representatives at the table?
- Have harm reduction approaches been considered to support family presence (in-person and/or virtually) and are appropriate infrastructure, supplies, and policies in place?
- If family caregivers are not permitted in the home, what are the alternate plans for ensuring that the care and services (e.g. assistance with eating, translation) that they normally provide are not compromised?

### BARRIERS

- **Stringent visitor policies:** Participants described visitor policies as overly stringent, leading to the loss of essential family partners in care and formal and informal translators. Family caregivers were thought of as the 'hidden helpers' that supplement the PSWs significantly; this resource was removed with the introduction of visitor restrictions.
- **Harm of lack of family presence:** The psychological impact of having no visitors was described as significant for both residents and their family; denying this contact with love ones created 'despair and despondency'. Family presence is often a very helpful support, particularly for individuals with later-stage dementia or those who do not speak the same language as their paid care providers.
- **Challenges of technology:** Technology has been challenging to coordinate throughout the pandemic. Barriers have included limited access or residents having low familiarity or comfort with technology.

### FACILITATORS

- **Substitutes to in-person visiting:** There were descriptions of LTCHs purchasing iPads to facilitate virtual visits. Outdoor and physically distanced visits (e.g., window or garden visits) have allowed residents and families to be together while staying physically distanced. In Nova Scotia, all LTCHs were equipped with iPads in late May.
- **Strategies to allow family caregivers into LTCHs:** Some homes or provinces implemented a flexible visitor policy which allowed for visitation under certain conditions, for example compassionate visitor policies with one visitor per resident if in end-of-life situations or "1-person allowed in rules" with PPE training for family members. In one unique example of a workaround to visiting restrictions, a home employed six family caregivers in residential aide positions in order to provide them with IPAC training, appropriate PPE and permit their entry to provide essential care for their loved ones.

### IDENTIFIED NEEDS & RECOMMENDATIONS

- **Processes to re-integrate family caregivers:** Participants felt that there was a need to distinguish between family caregivers and visitors and emphasized the need to re-integrate family caregivers into LTCH to support residents and reduce burden on healthcare workers who rely on help from family caregivers. Before doing so, there was an expressed need for guidance on how to ensure that family caregivers could receive adequate IPAC training and access to PPE.

### RECOMMENDED RESOURCES

[CFHI Webinar: Spotlight Series: Policy Guidance for Reintegrating Essential Care Partners During COVID-19 and Beyond](#)

[Resuming Visits in Long-Term Care Homes](#)

[Finding the Right Balance: An Evidence-Informed Guidance Document to Support the Re-Opening of Canadian Long-term Care Homes to Family Caregivers and Visitors during the COVID-19 Pandemic](#)

[IPAC Extender Training Module](#)

[COVID-19 IPAC Fundamentals Training](#)

[Virtual Visits ToolKit](#)

[Keeping Families in the Loop: Bridging Conversations through Mindful Communication with Families](#)

[Coronavirus Disease 2019 \(Covid-19\): Supporting Your Loved One in a Long-Term Care Facility](#)

[Help Keep our Residents Safe from Covid-19: LTCH Plan for Visitor Restrictions Fillable Letter](#)

[Visitors Tool: Key Considerations for Long-Term Care Homes](#)

[COVID-19: Visiting Long-Term Care Homes](#)

[Guide for Visits in Long-Term Care - No Outbreak](#)

[Guide for Visits in Long-Term Care - Outbreak](#)

## Discussion

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In this rapid qualitative analysis, we identified barriers, facilitators and identified needs/recommendations to COVID-19 preparedness described by key stakeholders in LTC. We also provided linkages to useful Ontario-based resources and tools from the IPAC+ Resource Repository(4) to support each of the priority areas. This analysis reflects Canadian experiences of the first pandemic wave between March and May 2020 in LTCHs and RHs. Some of the organizational challenges described during this period have since been addressed. Through concerted regional and provincial efforts, several LTCHs and RHs across Canada have now secured adequate PPE supplies and delivered IPAC training to their staff members. Although these steps forward in LTC's COVID-19 preparedness have been encouraging, participants still identified needs for an ongoing focus on IPAC education, regulation, and assessment as well as access to routine COVID-19 testing and surveillance measures in homes. Several longstanding issues in the LTCH and RH sector have continued to pose barriers to proper infection control practices into the second COVID-19 wave. For instance, many of the older LTCH buildings have structural designs, which are not conducive to physical distancing; these will likely require significant investment of resources to adapt and these changes are unlikely to be made before the end of the pandemic. Furthermore, the severe staff shortages have made effective IPAC training and adherence to proper COVID-19 protocols difficult; similarly, the inconsistent access to sick pay and adequate salary remain challenges in many places.

In spite of many of these persisting issues, some LTCHs managed to prepare and respond better than others. Facilitators of strong pandemic preparedness and response were often common to more than one priority area. These included strong and proactive leadership, and collaborative partnerships. Strong partnerships with acute care hospitals provided the foundation for robust preparation, prevention practices, and workforce support. Established trusting relationships prior to the pandemic were an asset; however, many acute care hospitals entering into new partnerships with LTCHs were able to adapt quickly and create “roadmaps” for navigating their supportive role.(6) These partnerships were perceived to be key in providing homes with several resources to manage outbreaks including clinical expertise, staff reinforcement, on-site COVID-19 testing for residents, and IPAC training.(6)

In addition to fostering much-needed collaborations between LTC and local community partners, the pandemic also catalyzed the development of other long-needed supports for LTCHs (i.e., the prioritization of mental health supports for staff). The high levels of fear and low morale discussed in the assessed interviews can be corroborated by many other reports on the experiences of frontline staff during this pandemic.(7) The majority of COVID-19 outbreaks in LTCHs and RHs have started with staff transmission, and infections among staff are a risk factor associated with higher mortality rates in residents.(9) In the current analysis, participants identified a need to empower and educate LTC frontline workers, many of whom are of low socioeconomic status, living in multigenerational households, and have difficulty self-isolating.(8) We predict that there may be a need to facilitate support for rent, groceries, or hotel accommodations for staff required to quarantine. Other considerations for supporting staff during the pandemic may include providing clear direction and guidance from on-site leadership, prioritizing staff health (e.g., offering free mental health support, providing meals, ensuring staff have adequate time off), implementing human resources policies (e.g. hazard and sick leave pay, full-time employment, staffing flexibility, redeploying staff from other health care facilities), and providing staff with adequate COVID-19 related resources (e.g. decision-making guidelines for IPAC, strategies to minimize resident isolation, policies regarding transfers of COVID-19 residents to and from hospital).(10) It will be important to focus on the sustainability of staff support efforts following the pandemic to avoid ‘the next healthcare crisis’ in LTC.(10,11)

One novel aspect of this report was the linkage of relevant resources, which could help to overcome barriers, leverage facilitators, and fill in identified needs and recommendations. Importantly, there were certain topics discussed by participants for which we could find no relevant resources to offer support. For instance, proactive outbreak response planning was viewed as a key facilitator to outbreak preparation; however, we could not find guidance on how drills or simulations might be coordinated with a large number of community partners. LTCH leadership would likely benefit from such a resource given the few jurisdictions that implemented these exercises in the first wave. Additionally, we found limited resources

to support LTCHs in reducing movement of residents in and out of homes. Homecare was mentioned as a possible alternative for reducing resident admissions to LTC and as a way to decant residents in the event of outbreaks; however, there were few resources to help staff and caregivers navigate homecare options. Currently in Canada, residents receiving homecare are eligible for a maximum of 8 hours per day, unless paying privately. Many LTCH residents are typically living with moderate to severe frailty, requiring a high level of care. Families may not have the capacity to care for residents at home (e.g. appropriate access to bathroom with assistive devices etc.), even with homecare support. Virtual care was another commonly discussed solution to deliver primary and specialty care while minimizing resident movement. While we identified some general resources to navigate virtual care for LTCHs, we did not find any tailored to Indigenous communities, which was a gap specifically identified by one interview participant.

Although reduced entry into homes was generally supported, some participants felt that family/essential care visitors should be allowed re-entry. Recently, there have been calls to draw necessary distinctions between visitors and family caregivers, the latter of which should be granted access into LTCHs during the pandemic to provide essential services to residents. A review of LTC pandemic visitor policies in Canada recommended that family caregivers should be self-designated, given identification badges, abide by all IPAC and PPE requirements, be subjected to staff screening and testing protocols, and be provided entry into homes.(13) Since then, policy guidance for healthcare decision makers have echoed these recommendations, drawing attention to the harms of stringent visitor policies and the need to re-integrate these essential care partners.(14) We propose that additional user-friendly resources can be developed to support homes with the re-integration of family caregivers and also to prepare family caregivers for re-entry with training and access to PPE.

### **Limitations**

This report has several limitations. Rapid analysis of qualitative data is a useful method for projects under tight time restraints, particularly in the context of a swiftly unfolding global health crisis.(2) Although these methods have been shown to overlap with findings from traditional qualitative analysis by up to 70%,(5) it is possible our report may have yielded richer descriptions had we undertaken a full thematic analysis. Additionally, we were only able to analyze interview notes rather than verbatim transcripts. To minimize the gap between participants' perspectives and our analysis, we enhanced our understanding of the brief interview notes by referring to the primary data analysis presented in the original CFHI/CSPI report.(3) We acknowledge that this analysis reflects participant perspectives on the first wave of the pandemic; participants' perspectives on successful pandemic practices may have evolved over the course of the pandemic. British Columbia, for example, was seen to have a successful pandemic response in the first wave with a peak provincial daily case count of 91 on March 25, 2020; however, are now facing daily case counts in the 900s (as of November 2020).(15) Based on public reports and our team's ongoing discussions with LTC stakeholders, we postulate that many of the barriers, facilitators, and identified needs discussed during the first wave continue to be relevant in the second wave. Many of the resources linked to identified facilitators, barriers, and needs in this analysis are Ontario-based resources, however, we anticipate that much of the content will be relevant to stakeholders across Canada. Finally, this report precludes the perspectives of residents, family members/caregivers and frontline staff. Future reports should consider engaging all LTC stakeholders to elicit representative perspectives on COVID-19 preparedness in LTC.

### **Strengths**

The six priority areas used to structure our framework were inductively developed from the data in the initial report authored by CFHI and CSPI.(3) We built on this data-grounded framework to perform the secondary analysis of interviews and capture the barriers, facilitators and identified needs to pandemic preparedness. The results of this rapid qualitative analysis will inform immediate research efforts to promote the uptake of IPAC best practices in LTC during the second wave of the pandemic.

## Conclusion

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There are many resources available to support barriers, facilitators and identified needs/ recommendations to COVID-19 preparedness in LTCHs and RHs. Future resources might consider providing guidance on coordinating outbreak response drills or simulations, offering guidance on alternative care models for LTCHs, and supporting homes with the re-entry of family caregivers. As the pandemic endures, these findings can be leveraged to inform the development of new resources and strategies to support LTCHs and RHs through these difficult times.

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