

Re-imagining Long-term Residential Care in the Covid-19 Crisis

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We planned to celebrate on March 25, 2020 more than a decade of research by our international, interdisciplinary team studying nursing homes in Canada, the US, the UK, Germany, Norway and Sweden¹.

Our plan was to highlight some of what we learned during those years and to share our publications. When we cancelled our event, we decided instead to think through together the lessons for the pandemic from the research done by us and others, to suggest what we can do and should not do now, and what we should plan for in the future.

There is no question that the COVID-19 crisis calls for extraordinary and immediate measures. There is also no question that some of the most vulnerable live in what are commonly called the nursing homes where people require 24-hour care. Those providing paid and unpaid care are particularly vulnerable as well.

There is a real tension in balancing between the urgent need for compromise and alternative strategies and the need to ensure protection and care, now and in the future. Safety is clearly the priority now but we must make sure that in doing so we build on the existing research, while drawing lessons for the future that allow us to do more than provide a safe environment for all those who live, work and visit in

long-term residential care. We do so on the basis of our extensive research, which you will find listed at the end of this document.

The Right to Care

The importance of universal, publicly funded, accessible health services has never been clearer. Study after study, commission after commission, have demonstrated that a universal health care system is not only more equitable but also more efficient and less costly for society as a whole. Moreover, ensuring everyone has the care they need helps protect us all, as has become so evident in this crisis. But one major gap in our Canadian universal system is long-term residential care or what are more commonly called nursing homes, although they do receive varying forms of public funding and regulation. Yet nursing homes provide extensive health services, and this has become increasingly the case as our governments have made it harder and harder to get into a home by failing to provide enough beds to meet the need. That the largest proportion of deaths in Canada are in nursing homes attests not only to the vulnerability of residents but also to residents' high health care needs and our failure to implement the evidence. As the World Health Organization pointed out many years ago (2002:5)² "strategies for providing long-term care have been low on government agendas everywhere". Since then, government policies have made long-term residential care less accessible, without appropriately adjusting to the rising need for care within these nursing homes. There have, however, been increasing discussions of the need for reform in these times and lots of evidence on how to do it.

Our purpose in the project was to identify promising practices for treating both residents and care providers with dignity and respect and for allowing them not only to stay safe but also to flourish. We sought to find ideas worth sharing, ideas

that could help make nursing homes a positive option rather than the last and least attractive one. And we talked about promising rather than best practices because context matters, and what works well in one jurisdiction or even within it may not be effective in another area or for another group. Along with others, we have been successful at identifying many promising practices and some definite principles for all jurisdictions, although the ways to implement them may vary. We have been less successful in convincing government to put these ideas into practice. Indeed, some policies have gone against the evidence.

One of the most obvious policies that ignores the evidence is the move to further privatize care services. In spite of the evidence that market strategies do not work well in health services, the Ontario competitive bidding process for establishing nursing homes with public funding has favoured large corporations and has resulted in a significant expansion in for-profit ownership. Private, for-profit services are necessarily more fragmented, more prone to closure and focused on making a profit. The research demonstrates that homes run on a for-profit basis tend to have lower staffing levels, more verified complaints, and more transfers to hospitals, as well as higher rates for both ulcers and morbidity. Moreover, managerial practices taken from the business sector are designed for just enough labour and for making a profit, rather than for providing good care. These include paying the lowest wages possible, and hiring part-time, casual and those defined as self employed in order to avoid paying benefits or providing other protections. As the experience with SARS and COVID-19 shows, these workers cannot afford to stay home when they are ill and can carry infections from place to place. In addition to these for-profit employment practices, homes are contracting out whole services such as cleaning, laundry, dietary and security. This contracting out brings even more people into the home on a daily basis, people who can present a risk and

be at risk. And they can fragment teamwork. Moreover, the workers are not necessarily people trained in health services or screened for infections on entry.

As the 2002 Royal Commission on the Future of Health Care in Canada³ made clear, the extent and nature of our health care system is a matter of values.

Currently, the state of nursing homes and the number of beds available suggest we do not highly value older people or the growing number of younger people who are now in nursing homes or those who provide their care. At least we do not value them enough to ensure they have the conditions and care they need. Public health services must include nursing homes and be more effectively integrated in the health care system. To be accessible, these homes must not only be publicly funded but also be available in sufficient numbers for those who need care. And they must have enough resources and methods of supporting the work to provide appropriate care.

It is not easy to change ownership patterns during this crisis, although countries such as Spain have moved in that direction and British Columbia has in essence made staff in seniors' homes public employees. Planning for the future has to ensure infection control but it also has to be about much more than that. We have to move to include long-term residential care in our public services, not only in terms of funding but also in terms of delivery, to ensure the focus is on care rather than on profit. We also have to deal now with the problems facing the nursing home labour force.

The Long-term Residential Care Labour Force

Our project was based from the start on several explicit assumptions that grew out of our previous work, assumptions that have been reinforced by our research and

by the current crisis. Five of those assumptions are particularly important to research on the labour force and relate to an additional overall assumption, that care is a relationship that needs fostering and support.

First, the conditions of work are the conditions of care. Although there has been a great deal of recent discussion about resident-focused care, staff cannot easily focus on residents if the conditions do not now allow them the resources, the structures, the support, the time, and the capacity to do so. Second, as the determinants of health teach us and as is becoming increasingly obvious once again with the pandemic, housekeeping, dietary, laundry, clerical and recreation services are critical components in care. Third, the labour in nursing homes includes a host of paid and unpaid work carried out not only by staff, families and volunteers but also by paid staff who take on unpaid work. Fourth, care work is skilled work, and those doing the work require ongoing education and training for the nursing home environment. Fifth, the bulk of the labour is carried out by women, many of whom are racialized and/or new to this country. As well, women account for the majority of residents, although the number of men is increasing. Moreover, the resident population has become increasingly diverse. In keeping with our search for promising practices, these are principles that establish the basis for research, policies and practices which themselves may vary with context.

Undoubtedly, the most obvious condition of work is the staffing levels and another example of where evidence has been ignored. Research more than a decade ago, when resident care needs were not as high as they are now, determined that homes should ensure a minimum of four hours of direct nursing care per resident per day. These figures are for staff actually providing care, and thus would not include those on training programs or on sick leave or maternity leave or on vacation. Nor

does this minimum include the vital non-nursing staff, such as dietary, laundry and housekeeping workers. Few Canadian jurisdictions require minimum staffing levels and none match the minimum standard set out in the research more than a decade ago. The overall pattern in Canada is of staffing levels below the four hour minimum. In ordinary times, we need higher staffing levels not only to ensure residents have the care they need but also to reduce the incidence of staff injury, burnout and exhaustion. As our research indicates, under pre-pandemic conditions, staff in Canada were almost seven times as likely as their Nordic counterparts to report that they face violence on a daily or almost daily basis. Although resident needs are very similar to those in Canada, staffing levels in Nordic countries are much higher. Especially in times of crises such as that created by COVID-19, we need even higher staffing levels to meet both the growing demand for care and for safety precautions but also to cover for staff who become ill.

Low staffing levels have contributed to the high demands on family and volunteers to not only provide social support but also some direct care such as helping residents eat, walk or dress. It is often assumed this is work any woman can do, and it is primarily done by women. However, this is skilled labour and if these unpaid workers are not properly prepared for the work, they risk injury to themselves and to the residents. And they can complicate the work of staff, even increase their workload. If we are to rely even more on these unpaid workers during this crisis, we need to ensure they have appropriate training and are coordinated with paid staff, recognizing the full range of work involved in health care. The same applies when governments are tempted to call on the unemployed to fill the care gaps. We must remember not only the skills involved in the labour but also the extra work required to integrate as well as supervise those unfamiliar with the work or workplace.

It is important to remember that residents get admitted to homes only when a crisis occurs that demonstrates the family can no longer provide care at home. This has become clear to us in our current project which focuses on the move into long-term care. We have been repeatedly told that the move into a nursing home happens only when there is a breaking point and the person or persons at home can no longer provide the care required. Although families often feel guilty about “putting my mother in a nursing home”, they know they do not have the skills, the physical and emotional capacity or the environment and equipment to provide the required care. Family members, for example, point to their lack of skill in ensuring the right medications are taken at the right time and actually swallowed, to the physical strength of those who need care putting the whole family at risk, to the stress of providing constant care, to the complicated machinery involved and to the difficulty in ensuring appropriate nutrition. The 24-hour demands are overwhelming even for those who have quit their paid work in order to provide this unpaid care. To suggest that families take the resident back home underestimates the complex, skilled care needs as well as the resources required while ignoring the needs that got them there in the first place and may put both the resident and the family at risk for even more than infections. Furthermore, given the long waiting lists for the move into nursing homes and the processes for admission, there is no guarantee that a resident can return to the care home they left although some jurisdictions have moved to make readmission easier.

An important indicator of the low staffing levels is the number of privately paid personal companions hired by families to make up for the gaps in care. Few of the homes we studied provide formal agreements on what these companions can and cannot do. While they may relieve some of the paid staff’s workload, they may

also create difficulties for the regular staff in terms of coordinating work, especially if the work hours of a companion are irregular and if they only report to their private employer. Moreover, the companions constitute another group of people coming into a home that may bring in disease, as is the case with families and volunteers. They may also be employed in more than one place, and are most often in a precarious position as a result of their employment and frequently their immigrant status. Some of those we encountered have formal healthcare training, and so could perhaps with caution be integrated into the staff. But they too require continual testing for the virus.

Higher staffing levels are a necessary but not sufficient condition to keep those who live, work and visit in care homes safe. New managerial strategies taken from the for-profit sector have contributed to an increasing reliance on part-time and casual labour as a strategy to reduce the costs of benefits and to keep staffing levels as low as possible. Yet, especially given the low wages and benefits, most of these part-time and casual workers want and need full-time work. As a result, they take another part-time job at another care home, travelling there by public transit because few can afford a car. The risk of sharing any virus is obvious. Moreover, so many part-time and casual workers undermine continuity in care for residents, a continuity that is particularly important for those with dementia. And they may undermine the teamwork that is important in care.

British Columbia has recognized this issue by effectively making all workers in seniors' homes public employees, raising their wages to the union rates and ensuring that they are offered full-time work in a single home. All jurisdictions should do the same, not just for now but also into the future. It is not good enough

to prohibit workers from working in two places. We must make sure that they get the same hours of paid work. Moreover, for the same reasons, governments should move to eliminate the outsourcing of services such as dietary and housekeeping; services that also bring outsiders into the home on a regular basis, outsiders who may or may not have education for health care. And during the pandemic, they should offer to house staff in hotels so they will not have to commute or put their household members at risk.

Union contracts provide workers with employment protections such as benefits, sick leave, paid vacations and the right to say no to unsafe or unfair conditions. Many of those who are part-time, casual, on contract or work for an outsourced firm do not have these protections. Unions and professional associations have also helped define who can do what as a way to protect both the worker and the resident, in part by ensuring skills and supports. The proposal to suspend contracts in order to create more flexibility for employers risks that protection. While we have certainly seen much more flexible divisions of labour in other countries, this flexibility has to be understood in the context of their training and education systems, their regulations for safety, their supports for workers and their staffing levels. Moreover, there tends to be a strong emphasis on, and time for, collaborative teamwork as a way of ensuring quality care in those workplaces with a more flexible division of labour.

Working conditions also include access to equipment that keeps both staff and residents safe and comfortable. Injury rates have long been very high in nursing homes, especially for injuries related to dealing with bodies that have to be assisted. While many homes we visited have installed shower and bath systems as well as lifts that help keep residents and workers safe, they too often do not have

enough staff or enough time to operate this equipment safely. Long before this crisis, supplies such as adult briefs were often rationed in ways that made it difficult to follow safety practices. As has become increasingly obvious in this crisis, much less attention has been paid to equipment to protect against vicious infections, even though there were clear recommendations following SARS to provide equipment for now and stockpiles for the future. In part this reflects the notion that these are homes, rather than places of congregate living where people have complex care needs. Yet when people need to be bathed and taken to the toilet, dressed and changed in bed, helped to eat and drink, given the correct medications and assisted to walk, there is no possibility for the staff, family or volunteers to social distance. There is now a recognized need for protective equipment but it is still lower priority than other health care settings. This should not be a competition for safe equipment but rather a recognition of the very high risks in nursing homes for both staff and residents. We not only need such safety equipment now, and in the future, we need to ensure that those providing care have the time and the training to use the equipment.

We also need to develop surge capacity to ensure a prepared labour force in times of crisis. A recent report from the Organization of Economic Cooperation and Development and the International Labour Organization (2019:21)⁴ provided further support for what we have found in our research. The report, prepared before the pandemic, was warning that preparation for the future means:

improving the status and working conditions of care workers, promoting long-term care workers representation, social dialogue and collective agreements, as well as providing stable and formal jobs with adequate labour and social protections, including adequate wages with suitable hours, as well

as a reduction in mental and physical risks. They are key to reducing high turnover rates.

If we follow these guidelines to do what we can now, then those with experience who have left the field may be willing to return.

Regulations

For the most part, regulations are designed to promote good care, prevent problems before they may occur and protect residents and, less often, staff. They are frequently a response to identified problems. As our article *It's a Scandal*⁵ demonstrated, regulations are often the consequence of scandals exposed in the media. The scandals and the regulations are most detailed and numerous in the countries with the most for-profit firms. However, the regulations most often focus on workers and on physical structures rather than on ownership or on working conditions and employer practices such as hiring part-time.

During this pandemic, there are calls from employers to suspend regulations. While there may indeed be some regulations that prevent necessary flexibility in these times such as the requirement to get everyone who is able to breakfast in the dining room, we should be very careful about which regulations we suspend and not allow any wholesale suspension. We must ensure that there are evidence-informed assessments for suspending any regulations, the reasons for the suspension and clear rules about how long any suspension will last. We must also ensure that the important regulations are enforced quickly and effectively. This is especially the case when it comes to health and safety regulations. We need to look carefully at the homes where outbreaks have occurred and resulted in deaths,

examining not only their current but also their past practices. This includes the requirements for training and the form the training takes as well as its frequency.

And we need to think about new regulations. One obvious area is the requirement to stockpile for emergencies and to keep these stockpiles current. We also need to look at the pressure to fill any bed as soon as possible, and at the consequences for that policy on the health and safety of all those involved in long-term residential care. In other words, we need better and better enforced regulations.

Physical Environments

A great deal of attention has been paid during this crisis to the fact that many homes in Canada have rooms for four residents, with only curtains separating them. In some cases, all four residents must use the toilets down the hall, further complicating the efforts to control infections. It should be noted that in Ontario private and semi-private rooms, when they are available, cost more and thus are limited to those who can pay more. These, like many other aspects of the physical environments in nursing homes, are not easy to change during the crisis, although we could certainly lift the surcharge on private rooms. During the crisis, we could also severely limit further admissions, especially the suggestion that more patients be sent to nursing homes from hospitals, in order to create more hospital space. And we could temporarily refit some of the public spaces to accommodate social distancing.

There is no shortage of evidence on the need for new physical structures. Indeed, the designs for new homes take important aspects of this research into account. It is important though that these new designs not only allow for private rooms and outdoor spaces, non-slip floors and smaller units, good sight lines and

communication systems as many do, but also that they have appropriate space for in-house food, laundry and cleaning services that ensure the safety of staff. They need staff rooms that not only allow a private space for respite but also for changing out of travel clothes that bring in viruses. And they need to continue to provide spaces that allow the community to be active in the home, doing so in ways that provide the resources to ensure the community can do so without undermining their safety or that of staff and residents. Finally, they need surge capacity, extra space and convertible space for times of crisis.

Where to From Here?

The research is clear. In the **short term**, we must

1. Follow the BC example and make all staff either full-time or permanently part-time and limit their work to one nursing home.
2. Raise the wages and ensure the staff has benefits, especially for sick leave.
3. Offer alternative housing for staff.
4. Provide testing for all those living in, working in, or visiting nursing homes.
5. Provide hands-on training for all those entering nursing homes.
6. Keep essential regulations and contract protections.
7. Ensure protective equipment now.
8. Assess the skills of anyone paid to provide care and limit what those who are not trained staff are allowed to do.
9. Severely limit transfers from hospitals.

In the **long term**,

1. Continue all these strategies in the future, while ensuring regulations are effective and enforced and contracts supported.

2. Use the model of the *Canada Health Act* to develop a universal public long-term residential care plan that is adequately accessible and funded.
3. Develop a long-term labour force strategy following the guidelines from the OECD-ILO report.
4. Stop privatization and ensure non-profit ownership.
5. Stop contracting out food, housekeeping and most laundry services.
6. Ensure that any vaccines and/or drugs that result from the public funding for research are made widely available and publicly funded.
7. Ensure protective equipment, and stockpile for the future. In doing so, recognize that protection goes well beyond protection against a virus.
8. Move to integrate and coordinate health care services through public mechanisms.
9. Build surge capacity into the physical structure of the homes, and into labour force planning.
10. Establish and enforce minimum staffing levels and regulations.
11. Attend to context and diversity
12. Ensure new homes are designed to protect residents and staff while also allowing the community to enter safely and all those in the home to flourish.
13. Listen carefully to staff, residents, families and volunteers, taking their ideas into account.

This crisis offers us the opportunity to learn about how to create a new normal, to think through how we design, structure, access and organize long-term residential care. Indeed, it allows us to reimagine nursing homes that are rewarding places to work, where life is worth living for residents and where visitors feel comforted about the care. There is no going back but there are ways forward that allow us to

continue caring and sharing, collectively providing for care. We hope our many ways of sharing what we have learned assist in this reimagining process.

¹ For details on our research methods, see Armstrong, Pat and Ruth Lowndes, eds. (2018) *Creative Teamwork: Developing Rapid, Site-switching Ethnography* New York: Oxford University Press.

² World Health Organization (2002)

³ Royal Commission on the Future of Health Care in Canada. The Romanow Commission (2002) Ottawa: Royal Commission in the Future of Health Care

⁴ Organization of Economic Cooperation and Development and the International Labour Organization (2019) *New Job Opportunities for an Aging Society*. <https://www.oecd.org/g20/summits/osaka/ILO-OECD-G20-Paper-1-3-New-job-opportunities-in-an-ageing-society.pdf>

⁵ Lloyd, L., A. Banerjee, C. Harrington, F.F. Jacobsen, & M. Szebehely. (2014). It is a scandal: Comparing the causes and consequences of nursing home media scandals in five countries. *International Journal of Sociology and Social Policy*, 34(1/2):2-8.

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