LONG TERM CARE: COVID-19 SERIES

Session 7:

Disclaimer: All information is provided by healthcare providers working in long-term care facilities across Ontario including those at Baycrest. All identifying information including names of individuals, organizations, or locations have been removed for privacy. **The answers below are amalgamated responses from our Hub team members and Learning Partners.**

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Question 1: I am wondering if anybody has a positive experience to share with redeployed staff in long-term care and to share what you think made it successful?

Answers: Our long-term care home is a large facility so it may look different from the average LTC home. Within our facility, we have a clinic from our local health services center where we redeployed the staff from there. These included the administrative staff, occupational therapists and speech pathologists and the like. To prepare them for their redeployment in LTC, we were at an advantage as all of them had already attended our facility's orientation session and they had an idea of our policies and protocols. The main roles were to help with feeding our residents and to have them be engaged in our "comfort care hourly rounding" process to help the staff on the unit. To prepare them for these roles, we had a team of internal staff, including myself, who would train groups of three for an hour around "comfort care rounding" process and then another hour training on the unit on how to feed residents. I think this designated training time was important to orient redeployed staff before sending them onto the unit. Another important component to our success was to keep an open line of communication with our internal staff about the redeployment. For example, our PSW team are very used to doing their hourly rounding and they were surprised that on some of the units there were other staff to help with that protocol. So the two key components for our successes in integrating redeployed staff centered on **providing dedicated training time** in small groups to allow them to ask clarifying questions and to **keep open lines of communication** and support staff about these changes that were happening.

I'm a family doctor who spent most of my career working in community health centers with little experience in long-term care. I am currently helping a colleague of mine at the long-term care facility he works at as he hasn't been able to go into the LTC home himself. So what has worked very well for me was having regular access to my colleague by phone so that I can ask about certain residents or the facility's resources, protocols and policies. Having access to this one-on-one connection with someone who is very experienced in working at the facility and collaborating on care with him has been very helpful for my transition. In addition, I have also received great support from the staff and got a great orientation from the medical director. I find it's still a great learning curve, despite my experiences working with elderly patients, it's a different context in a LTC setting as in addition to learning about the relevant COVID materials, I am needing to learn more around wound care, how to examine patients that can't move easily or unable to converse with easily. That can be very challenging.

Question 2A: In contrast, has anyone had a negative or less than stellar experience with redeployed staff so that we can discuss what we can try to do to make it better and to prevent negative experiences happening elsewhere?

Answer: I'm a behavior support consultant working outside of Ontario, and I have been redeployed to a facility where I normally provide support so I had some previous knowledge on how this facility operated. One of my roles was to link the acute care time to the long-term care team. As our LTC home is quite large, you may have heard about it in the news that we had an

outbreak that got a bit out of control for a short while, so we had redeployed staff from acute care (hospital setting) come assist in our LTC facility. One of the things I found difficult was that there was a lot of defensiveness from the LTC team that was difficult to overcome. The staff felt there was a lot of negative media going on so when the acute care teams came in to help, they saw themselves as knights in shining armor coming in to save them, when in actuality they didn't necessarily need saving. I think both the internal staff and redeployed staff worked very hard. The acute care team brought their own educators and they worked very hard as well. Another issue we had with the acute care teams being redeployed to the LTC facility was they weren't accustomed to using PointClickCare. They weren't given enough orientation and when they were set up, they had lost their acute care linkage and could no longer receive emails from their managers in acute care that were still connecting with them. This was a huge issue for a few days until they were able to access their acute care network so that they could feel supported from the acute care side in addition to the support within LTC.

Question 2B: What was your personal experience having to deal with these issues that came up with acute care teams entering the LTC facility to help?

Answer: When I was redeployed, it was mainly to look after a resident who had a hyperactive delirium and was COVID-positive. It was very difficult to keep him isolated in his room and unfortunately, I think that his delirium was likely missed because by the time I got there, he was hypoactive and very sick so then my role became more palliative and end of life care. Another time I was redeployed, I was to be a one-on-one attendant with a COVID-negative resident with dementia, who wanted to visit everyone on the unit and this became difficult, as there were COVID-positive residents on the unit she would want to visit. Overall, I had some knowledge about these residents already, and despite the challenges, I have been enjoying my redeployment experiences.

Question 2C: If you could turn the clock back to do it again, is there anything that you think that would have helped to make the situation better?

Answer: I think the best thing is to move forwards rather than turning the clock back. This has given an appreciation on behalf of both teams and more understanding on the difficulties that not only acute care faces but also LTC. So as I mentioned my role was to help transition residents from acute care into long-term care and the teams were kept separated and never really talked or met in anyway. I think this experience with redeployment has provided a **peace bridge** so that we can move forwards and gain better understanding, which is a very positive thing. The only thing I would say would have been better in hindsight would have been to give all external practitioners and support teams access to all internal chartings so that they can have remote access to PointClickCare because that would have made external support much more effective.

Question 3: Mario/Heli (guest speakers), do you have any thoughts on these experiences mentioned in terms of your presentation and what you have heard what may have gone well and not have gone well?

Answer: It's actually interesting and thank you for sharing your experience with all of us and it's quite interesting the fact that you've been consulting at this facility and then it's like it was a different experience for you when you were redeployed. It really speaks to the point I made earlier about the impact that this pandemic has had. It was interesting to hear about the media attention and quite often, we don't really hear about the human side of LTC in the media and how this has impacted staff and those that work in LTC. The loss of residents and how has that impacted staff because we all know that working in LTC, it's like being in someone's home and staff are treating residents as they do family. So going through that loss has a huge impact and I don't think it goes recognized very well in the mainstream media. Also how LTC is portrayed in the media will also affect people's responses to help coming in because it's seen negatively and it's understandable for those to be on the defensive. The LTC system has had its flaws for many years now and this pandemic is opening the government's eyes in terms of the changes that need to be made.

I want to echo the sentiments of the peace bridge and the idea that we've had discussions amongst our group that we are hoping this situation help bridge those lines of communication between acute care and LTC because as PRCs we sometimes are involved in supporting those transitions from acute care to LTC and vice versa. We have certainly seen breakdowns in communication that can happen so we are hoping that this will lead to a better understanding and appreciation of the challenges that both sides face.

Another point is thinking about who is being redeployed, what their skillset is, and how their skillset can be best matched to what role. Another question to ask is what tools we would need to succeed in that role and that includes access to technology and things like PointClickCare. How can PCC be more accessible? It all boils down to communication.

Question 4: I am curious if you can elaborate on physician competencies when it comes to working in LTC?

Answer: I think this pandemic is really raising the issue of what is different in LTC and there has been a lot of work around competencies for medical directors. For example in the US with the American Medical Directors Association, there is work being done around competencies for attending physicians in LTC and what do we need to do well in order to be effective in our role as an attending physician in LTC, how can we work with our teams, and what are the required competencies around communication skills, end of life care, palliative care, goals of care and advance care planning, in addition to managing infection control. Many LTC physicians have dealt with outbreaks in their homes, which may be different than if you have been a primary care physician in the community. Then the whole issue around dementia, behavior management, being able to recognize delirium and these are things that LTC physicians handle every day. So

how can we support physicians and other staff who are coming into the LTC sector? I think it's important to recognize what is different about LTC and it's really a defined skillset to work in this setting. So it's interesting that in some jurisdictions, for example in the Netherlands, where being a LTC physician is its own specialty with designated residencies to train physicians to gather the skills and experience to work in LTC. I think this pandemic is bringing this to light and it is a very interesting discussion that I'm sure we will have more conversations about in future.

Question 5: Does anyone have any other experiences with redeployment that they might like to share?

Answers: I'm a nurse practitioner and currently my LTC facility is not on outbreak, but we had some staff be brought in help. They have been wonderful and have been very good with completing orientation. However, stories that I've heard from other locations where there are COVID outbreaks is that the redeployed staff have great potential to work in a greater capacity, but because of barriers, such as access and orientation to PCC, these redeployed staff are working more as PSWs or RPNs as opposed to RNs or whatever capacity they can potentially provide that would actually help take the load off the internal staff. This is unfortunate as the staff are exhausted from working like this and another thing that's been really brought to light is how different each LTC facility is. There is varying resources and availability of resources between each LTC facility so you don't really know until you get there and realize what is and isn't available. Even with PPE, there was one facility that was using garbage bags because they no longer had gowns to wear. So these differences between LTC facilities, I think has been a huge eye opener for many redeployed staff coming from acute care to realize. LTC staff have been very appreciative of their help and now the concern has shifted to what happens when these redeployed teams leave? I think a plan needs to be well developed and communicated before it's launched to help assist that eventual transition. This ECHO series has been great to create discussions around this.

By training, I am a speech pathologist who now works in education so I haven't worked in LTC in many years. So when I was told I would be redeployed as a manager in a 400-bed LTC facility and that I would be working on weekends when there would be no other managers around, my anxiety went through the roof. I was happy to be redeployed and help, but it was important for myself and others like myself to get the support we needed. Even knowing the different codes to enter and exit the various units was important as they differ between each unit. A colleague of mine who was also redeployed made a very helpful sheet I could keep on me with all the codes so it made moving between units easier. What I found the most challenging were the constant changes in infection control policies and keeping updated with them. For example, there were changes in the types of PPE that were appropriate and for what rooms, and transitioning from disposable gowns to reusable ones and the process around how to properly reuse gowns. By my third week of redeployment, I was more comfortable and I think that since the staff didn't know me, their attitude was of "nice to have you here and we'll call you when we need you", but many staff had other resources to turn to so I personally didn't get a lot of calls.

I had a similar experience. I am a Nurse by training so I have that experience, but since obtaining my PhD, my role has changed outside of patient care. My experience with being redeployed into LTC was really interesting and I think the staff were really appreciative. It was quite anxiety invoking at first when I was reassigned as a manager for a unit, and there was a lot of uncertainty of what we were doing. I think I was grateful for the leadership team for providing us with moderate amounts of information and required us to participate in daily huddles while we were actively working.

Question 6: What are some experiences around redeployed staff to assist with providing virtual care?

Answer: So we are trying to ramp up virtual care and we realized that many on our team are very busy with their usual work so it's difficult to ask them to facilitate e-visits with the families or doctors as it would take away from their important clinical work on the unit. At the same time we have staff who aren't able to work their usual outpatient clinics so some of our redeployed staff are being brought into management positions and others as telemedicine facilitators or "clinical liaisons. So these Clinical Liaisons are helping us to set up and facilitate the e-visits with family members and to set up the virtual care with physicians. We are a larger facility so we have one clinical liaison on each unit during the daytime shifts on weekdays. So overall, it's been a phenomenal experience and the skillsets we have available, such as neuropsychologists and social workers, are great additional skillsets that are being deployed and providing support to staff and residents.