howegroup

BC Care Providers Association Review of the response to COVID-19 in seniors care and living

A dialogue with providers

Final report: November 16, 2020

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- Terry Lake – CEO, BCCPA
- Mike Klassen – Acting CEO/VP, Public Affairs, BCCPA
- Debra Hauptman – BCCPA Board member, Vice-Chair, Priorities & Policy Committee; CEO Langley Care Society
- Dave Hurford – BCCPA Board member; Chair, SafeCare BC; CEO Three Links Care Society
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Executive Summary

Purpose

The purpose of this engagement was to provide the BCCPA Board of Directors with a report of the impact of COVID-19 in the seniors care and living sector along with actionable recommendations for the Ministry of Health. For the purpose of this report the term *seniors care and living sector* is inclusive of long-term care, assisted living, independent living and home health. BCCPA members from the seniors care and living sector shared their expertise and insights on the factors that contributed to and helped to curb the transmission of COVID-19 in BC. The specific objectives were to: (1) identify facilitating factors and challenges in the response to COVID-19 in the seniors care and living sector in BC and (2) to convey the voice of BCCPA membership.

In parallel with this engagement, BCCPA developed an extensive literature review and gap analysis report on COVID-19 and seniors care in BC.[1] This report was intended to: highlight what other countries have done with respect to COVID-19 in seniors care; highlight what Canada and other provinces have done to deal with COVID-19 in seniors care; highlight what BC has done with respect to COVID-19 in seniors care; document BCCPA's response and sector leadership throughout the course of COVID-19 thus far; and outline any potential gaps or additional recommendations.

Methods

Howegroup conducted a brief survey and facilitated a participatory exercise with BCCPA Board members to define the engagement purpose and scope in March 2020. An active Advisory Committee comprised of BCCPA senior leadership and Board members provided ongoing oversight and direction into this engagement. A mixed methods engagement strategy was utilized, inclusive of a member survey (n=72 of a possible 134 long-term care and/or assisted living providers), interviews (n=25), roundtables (n=13 independent living and n=13 home health providers) and an online member submissions portal limited to input on draft recommendations submitted to the Ministry of Health (18 written submissions received).

It became apparent early in the process that long-term care and assisted living shared similar experiences which differed from independent living and home health. As such, the findings are organized into 1) long-term care and assisted living, (2) issues specific to home health, (3) issues specific to independent living, and 4) preparing for a second wave.

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[1] Kary, M. Literature review and gap analysis report on COVID-19 and seniors care in British Columbia. September 2020. BCCPA

Key findings: long-term care and assisted living

The following emerged as key themes to long-term care and assisted living providers:

- Actions that flattened the curve
- Factors contributing to transmission
- Health and human resources –systemic challenges, single site order, wage levelling and pandemic pay
- Personal protective equipment (PPE)
- Communication
- Visitation
- Moving COVID-19 positive seniors to specialized units
- The financial impact among providers
- The burden of audits and reporting
- Support from sector associations
- Senior and worker rights

Actions that flattened the curve

Providers report that timing played a large in role in BC experiencing lower COVID-19 rates when compared with other provinces, particularly with respect to limiting travel during Spring Break in early March. As COVID-19 impacted the eastern provinces, BC had the ability to learn, to a limited degree, about transmission and apply best practices. Infrastructure also played a role, with BC having fewer multi-bed rooms and, in general, spaces that allow for distancing of seniors. Providers agreed that the strong leadership of the Provincial Health Officer (PHO), for the public as well as the health system, played a significant role in limiting the transmission of COVID-19 in BC as did fewer COVID-19 cases in the community. Restricting non-essential visits also helped to limit transmission in seniors care and living. Providers acknowledged the collaboration across the sector and particularly the sharing of information and support *among providers* as integral in the response to COVID-19.

Factors that contributed to the transmission

Providers reported that staff working at multiple sites was the most significant factor contributing to the transmission of COVID-19 among seniors in BC, which is underpinned by the systemic lack of health human resources and reliance on part-time and casual workers. Providers also reported that lack of available PPE, particularly early in the pandemic, contributed to the transmission of COVID-19, as did breaches in PPE protocol (e.g. donning and doffing). The complex and increasing acuity (e.g. comorbidity, dementia) of seniors was identified as an underlying factor in the high rate of COVID-19 transmission as was the unique nature of the virus (e.g. ability of the virus to transmit prior to presenting symptoms). In general, while providers had serious concerns about a lack of consistent communication, providers did not attribute lack of policies, inconsistent messaging or lack of training around infection and control to the transmission of COVID-19 in BC.

Health human resources

Health Human Resources (HHR) was identified as having a significant impact on the transmission of COVID-19 in seniors living and care. More than half of survey respondents agreed or strongly agreed that sharing staff between sites (68%) and insufficient worker education and training (52%) contributed to the transmission of COVID-19. Almost two thirds of respondents disagreed or strongly disagreed that insufficient wages contributed to the transmission of COVID-19. Actions taken around HHR, including the single site order, wage levelling, and pandemic pay played a role to limit transmission but with significant impact to operations and possibly intensifying this pre-existing crisis.

Providers agreed that the *single site order* helped to limit the transmission of COVID-19 (58, 91% of survey respondents) and should continue until a vaccine is found (62, 86% of survey respondents) however significant drawbacks exist that should be addressed. Providers reported that the single site order disadvantaged casual employees (53, 80% of survey respondents) and that the order was not implemented

consistently by each health authority (38, 65% of survey respondents). The order put undue strain on operators at the time of implementation and continues as sites face challenges with the loss of casual staff, covering regular shifts and also to provide coverage for vacation and sick time. Interviewees reported a great deal of frustration and pointed to inequitable implementation, particularly with the health authority staff exemption.

Providers are concerned about the extra cost of *wage-levelling* which may prove to be unsustainable and eventually impact the cost of care for seniors. Providers expressed concern regarding the inequity in *pandemic pay* and the distress it caused (and is causing) among those ineligible for the additional pay. The majority of survey respondents (43, 69%) agreed or strongly agreed that *all* workers in seniors care and living should receive pandemic pay.

Personal protective equipment

Providers faced many challenges with respect to personal protective equipment, particularly around securing and maintaining supply (including lack of support to obtain PPE), escalating cost, and messaging from health officials. Providers reported a critical shortage early in the pandemic and expressed concern about maintaining this supply moving forward. Worry was compounded by the escalating costs of PPE. Providers noted the confusion caused around discrepancies in guidelines from the BCCDC and health authorities, particularly Fraser Health, as well as changing guidelines during the pandemic. Providers agreed that frontline workers should have mandatory ongoing training in PPE, including health authority workers, whom providers reported were inadequately trained in the use of PPE.

Inconsistent and unclear communication

Inconsistent and unclear communication from the Ministry of Health and health authorities to providers inhibited the response to COVID-19, created a great deal of extra work for providers, and led to frustration and confusion among seniors and families. Providers found direction and information from the Ministry of Health, Provincial Health Officer, and health authorities was at least somewhat effective (>82% of survey respondents), however a substantial proportion of respondents reported that information and support from the Office of the Seniors Advocate was not effective (>88% of survey respondents).

There were significant inconsistencies between communication and directives from the Ministry of Health and the health authorities. Providers overwhelmingly agreed there was a lack of clarity around which body had authority as directions were given or changed (50; 79.4% of survey respondents). Providers expressed concern that seniors and families were receiving communication on orders at the same time as providers (often via the Provincial Health Officer/ Minister of Health update at 3 pm). Providers would like to see one source of information for the sector, including families and residents, to ensure timely, consistent information is provided. Fraser Health was consistently an outlier with respect to providing unclear communication, changing directions, and imposing unreasonable requirements on providers that intensified workloads and caused undue stress for staff, residents, and families.

Rights of seniors and staff

Actions of the Province to limit the transmission of COVID-19 has had a detrimental impact on the rights of seniors and staff.

Providers reported that seniors' quality of life was negatively impacted in the following ways:

- Seniors were restricted to their suites without any social contact, very limited recreation, and no access to the outdoors for prolonged periods. This was particularly challenging for seniors with mobility issues and dementia.
- Seniors and their families were kept apart during a very stressful time creating distress and anxiety among seniors and family members. Families were kept apart when they needed each other most.
- Interests of staff were put ahead of seniors by allowing some health authority staff to work in multiple sites while seniors were restricted to their suites.
- Some providers believe that seniors were denied access to necessary medical professionals and equipment by keeping them on-site and not moving them to a COVID-19 specialized unit.

Providers reported that staff rights were impacted through the following ways:

- Staff rights were violated when the Province requested personal information of staff, including Social Insurance Numbers, to fulfill the single site order. This information was not necessary and some employers refused to provide it.
- Staff were not given the opportunity to choose the site that would become their 'single site'. Many staff had indicated a preference and subsequently directed to work full-time in another location.
- Seniors living and care workers were not treated equally across the province. Those working for privately-owned sites were not included in wage levelling and did not qualify for pandemic pay despite filling the same role, sometimes working in the same site. Managers and leaders were not included in pandemic pay. Some managers are making less than the nurses they are supervising.

Visitation

Providers overwhelmingly agree that limiting family visitation was critical to containing the transmission of COVID-19, particularly at the onset of the public health emergency declaration (59; 98.3% of survey respondents). As restrictions were lifted, 16 (27.6%) of survey respondents changed their opinion and were no longer in favour of restricting visits. Providers acknowledge the impact on residents, families and staff has been profound. Moving forward, providers need additional funding and resources to manage and support families and provide enhanced cleaning and PPE to support family visitation. As well, providers would like to see flexibility built into visitation such that community circumstances may dictate visits, rather than a provincial approach, particularly as restrictions need to resume.

Moving COVID+ seniors

Providers had mixed feelings about moving seniors diagnosed with COVID-19 from their residence to a specialized unit, influenced by the ability of the site to effectively isolate seniors, the needs of the senior, and the capacity of the residence they are living in to meet the seniors' needs. Survey respondents overwhelmingly agreed moving COVID-19 positive seniors to a specialized unit would have limited the transmission of COVID-19 (42; 70% of survey respondents agreed or strongly agreed) and may have provided better access to medical professionals and equipment. Many providers reported that when a site can effectively isolate seniors in their room and provide adequate care, it is not necessary to move them.

Financial impact
Long-term care and assisted living providers report spending an excessive amount on COVID-related expenditures and are unclear as to whether they will be reimbursed (as the Ministry of Health has not provided clear guidelines or timelines). Several providers reported lost revenue from an increased vacancy rate. Others commented on the unknown costs associated with staff burnout and mental health and wellness that are anticipated in the future. As well, there are concerns that significant increases in wages will ultimately be passed onto seniors, further impacting affordability of care.

Audits and reporting
In addition to regular daily duties and responsibilities, providers had a tremendous extra burden placed upon them to respond to COVID-19. Survey respondents reported spending hundreds of extra hours to respond to requests for reporting and additional inspections over the course of the pandemic. Many providers are finding the requests for information and additional inspections/audits overwhelming. Fraser Health stood out as placing unsustainable demands on-sites through reporting and inspections including ongoing changes to audit requirements.

Federal support
Federal government support did not emerge as an important factor in the interviews or the roundtables with providers. When asked specifically on the survey, there were mixed feelings as to the importance of federal government leadership in developing quality standards for the seniors care and living sector moving forward, with 43% indicating that this was very or extremely important and 40% indicating that this was slightly or not at all important. Nevertheless, the majority of survey respondents (42, 71%) reported that it was very or extremely important that the federal government invested in the seniors care and living sector moving forward.

Support from associations
A collaborative effort helped to limit the transmission of COVID-19, including support from WorkSafeBC, SafeCare BC, BCCPA, and EngAge BC. A large proportion of survey respondents reported that WorkSafeBC was effective in communicating best practices (35, 61%) and advocating for the safety of workers (36, 63%). A higher proportion of respondents reported that SafeCare BC was effective in advocating for the safety of workers (42, 75%), as well as providing information (43, 74%), and delivering Operation Protect (35, 71%).

Key findings: home health
Home health providers reported the most significant success factor for limiting the transmission of COVID-19 as being the ability to collaborate at a management level. Providers with sites in other provinces had the advantage of leveraging learnings and policies from their colleagues. Providers also reported the nature of the home health model meant that seniors (their clients) had fewer contacts and therefore less chance of transmission. The most significant challenge for home health providers was the *lack of communication* and information directly from the Ministry or health authorities. Initially, providers did not receive any information and then the information they did receive was fragmented and often contradictory from one source to another.

While access to PPE was clearly a struggle across the country and across the continuum, home health providers reported that home health was overlooked. Providers recognized that it may not be realistic for the government to fund PPE for privately retained home health providers, but there is a role for government to ensure adequate *supply and coordination* of allocation for public safety. Private home health providers emphasized the lack of government support, feeling that the Ministry of Health often overlooks private care. Employees of privately retained providers were not eligible for pandemic pay,

resulting in pay inequities across workers performing similar, if not the same, tasks. Overall, home health providers are asking to be given consideration by the Ministry of Health as playing an essential role in seniors care.

Key findings: independent living

A variety of factors helped to limit the transmission of COVID-19 in independent living sites (also referred to as seniors living or retirement living) including communication by the Provincial Health Officer to the general public around the severity of COVID-19, which created a climate where residents, families, and visitors were responsive to the changes necessary on-site such as limiting visitation. A great deal of information sharing occurred between seniors care and living providers, allowing for best practices to be implemented quickly. Independent living providers who also operated long-term and assisted living units implemented many directives intended for higher levels of care at their independent living sites.

Independent living providers identified many areas for improvement, with the most crucial being the recognition of the role independent living plays in the seniors care and living continuum. Independent living was omitted from much of the communication, support, and funding provided by the Provincial Health Officer, the Ministry of Health, and health authorities. Smaller, single sites were left completely on their own to source information and resources. The single site order that limited staff from working at more than one site was not applied to home health workers. As a result, independent living sites may have multiple home health workers coming and going, creating a higher risk than necessary and an imbalance in the freedoms among staff and between staff and residents.

Preparing for a second wave

Providers overwhelmingly agreed that **worker shortage is their number one concern** regarding a second wave of COVID-19 in BC, which is compounded by limits on casual workers as a result of the single site order. Following this, worker exhaustion, fatigue, and burnout (including senior management) is top of mind. Providers are also concerned about a lack of PPE and other supplies, and the strain of managing visitation, including 'message fatigue' among family members.

Aligning with the findings from the engagement the following recommendations regarding pandemic preparedness and coordination, reducing infection transmission, supporting staff and operators, and providing social supports are put forth to the Ministry of Health.

Recommendations

Ten priority recommendations

1. The Ministry of Health provide an **overarching pandemic plan** with clear lines of responsibility and for communication across the continuing care sector, inclusive of publicly subsidized and privately retained home health and independent living. This provincial plan for all health regions should clearly identify which guidelines and/or mandates takes precedence. When a public health emergency is declared, the authority for issuing pandemic-related orders should be restricted to the Provincial Health Officer. Communication to seniors, providers, and families should be limited to a single source, as much as possible.

2. Health authorities adopt a **standardized pandemic response plan** for the continuing care sector, inclusive of publicly subsidized and privately retained home health and independent living, which clearly outlines what happens in the event of an outbreak. This plan, shared and implemented consistently across all health authorities, should include details of how health authority infection control teams will

be mobilized in the event of an outbreak, as well as incorporating all necessary safety guidelines. This plan must also outline the measures that will be taken to support any necessary unique considerations for rural and remote areas, the nature of health care personnel, and staffing limitations.

3. Continue the **single site order** policy for staff in long-term care and assisted living residences. Measures must be put in place which address the loss of casual employees needed for sick day and vacation relief. Consistent with the intent of the single site order policy, the Ministry of Health should expand the single site order to include acute care employees from working in long-term care or assisted living residences. Providers require additional financial resources for staffing to sustain the single site order. *Note government investment already committed to support this recommendation.

4. Create additional capacity and more suitable environments that ensure **reduced transmission of infectious diseases among residents with advanced dementia** and socially inappropriate behaviours.

5. The Provincial Health Officer to **establish rapid testing** alongside screening protocols for residents and staff in long-term care, assisted living, and independent living.

6. **Address critical staff shortages** by expanding training for new and established care staff. Fund roles such as 'Comfort and Support Workers' or 'Pandemic Workers' or 'Personal Support Workers' to perform non-care tasks and functions in the care setting to alleviate the burden on direct care tasks completed by care aides and nurses. Target unemployed workers such as in the hospitality sector and internationally-educated nurses (IENs) for recruitment and onboarding programs. Work with the federal government to extend the number of hours that international students can work and expand the post-graduation work permit program to include private post-secondary institutions.

7. **Maintain funding for wage levelling** and extend to staff across the continuum of care in order to provide equitable pay for frontline staff. Develop clear guidelines, consistent messaging, and ongoing funding for sustainability.

8. **Support psychological health and safety programs for workers, residents/seniors and families.** Coordinate these efforts with BC's Ministry of Mental Health and Addictions.

9. Ensure the **timely dispersal of allocated per-bed funding advances** to cover provider pandemic-related expenditures for PPE, staffing, and other requirements. Pandemic funding should be concomitant with any orders to implement add-on procedures that require additional staffing, equipment, and supplies. All advanced funding will be subject to reconciliation. Clear guidelines provided on allowable expenses.

10. Establish **robust protocols for safe and frequent social contact between residents and family members**, in collaboration with SafeCare BC. Strengthen connections between families and seniors through the use of tools and technology.[2] Establish **clear and consistent visitation guidelines** directly from the PHO to support visitation across the province. The PHO is asked to consider a flexible approach to restricting visitation, reflecting COVID-19 community case numbers.

[2] *Note that BCCPA has developed a 'Best Visit Possible' guide in response to this need and that SafeCare BC is a natural partner as they have already developed an online Safe Visitation training module for families.

Additional recommendations are as follows:

Pandemic preparedness and coordination

11. In-person inspections be conducted regularly, more frequently for pandemic preparedness and in-person. **Audits and inspections should be streamlined and consistently implemented across all health authorities**, with results shared directly with management and staff to support quality improvement. Recommendations that require additional resources for infection prevention and control measures and equipment must be supported with additional funds or by issuing recommended supplies and equipment.

12. Where appropriate, **communication will be disseminated to providers in advance** of public announcements in order to support enhanced planning and mitigate confusion among seniors and families.

13. Formalize the **partnership between the Ministry of Health and BCCPA to support communication**. BCCPA is positioned to act as a conduit to engage the sector through its membership and to hold a key role in developing and disseminating a Ministry of Health's formalized communication plan.

Reduce infection transmission

14. Designate health authority **specialized COVID-19 units**, with the opportunity for providers, in collaboration with families, to exercise discretion based on resident need, site capacity, family preference, and system capacity to protect vulnerable populations. Staff assigned to work in these settings should qualify for bonus compensation.

15. Provide **clear and consistent guidelines on the proper use of PPE and standards for PPE supplies** for application in pandemic situations for health and community care settings across the continuum, including publicly subsidized and privately retained home health. Communication and guidelines to stem from BCCDC and all messaging to be consistent across health authorities. Coordinate with infection prevention specialists, and provincial/federal government procurement agencies and ensure ongoing continuing education.

16. **Maintain the Province's PPE reserve** to cover the needs of the entire continuing care sector, inclusive of publicly subsidized and privately retained home health and independent living. Establish a mechanism for routine turnover of PPE stockpile, such that they do not expire and that the stockpile must have the capacity to meet surge demands. *Note the Province's Provincial Supply Chain Coordination Unit is making its stockpile of PPE available to a wide group of organizations, including private home care and community living.

17. **Establish a timeline for decommissioning the use of sites with multi-bed wards**, and work with these operators to replace them with newly created bed stock. The Province to establish a capital renewal program.

18. The Province to provide **equitable access to specialized infection control resources and equipment**, such as what is available now to health authority operated sites across the continuum of care, inclusive of independent living and home health.

Support staff and operators

19. **Support training programs** for long-term care, assisted living, home health, and independent living workers. The programs will be led by clinical nurse educators on the use of PPE, pandemic preparedness and maintaining relevant standards.

20. Create opportunities for discussion and action to **address the impact of the pandemic on seniors' and workers' rights**, leveraging BCCPA's Care to Chat forum.

21. **Formalize partnership between the Province and BCCPA**, given BCCPA's past work and commitment to HHR in seniors care. Designate BCCPA as the resource recruitment lead for the non-government sector.[3]

Provide social supports

22. **Support social worker and/or spiritual support professional positions and provide training** for residents, family members, and staff. Support those dealing with grief or the emotional toll of the pandemic.

23. Support a more formalized **sector collaboration with the BC Patient Safety and Quality Council/Patient Voices Network and SafeCare BC** to ensure continuous dialogue with seniors and families. Promote systemic and operational improvements that enhance the resident and family experience.

24. Incorporate learnings into the **BCCPA Quality Framework** in the context of a pandemic, including a discussion around seniors' rights.

[3] Since 2018, BCCPA has undertaken multiple measures to analyze and resolve the crisis, including hosting a sector-wide collaborative with care providers, government, labour unions and training colleges; issuing two reports outlining the scale of the crisis and providing 10 recommendations on how to resolve it; establishing a $25,000 HCA bursary program in partnership with Okanagan College; partnering with Health Match BC to design their new Choose2Care recruitment campaign; and delivering the provincial approved HCA curriculum to 80 students in communities on Vancouver Island and in the Interior in collaboration with our education partners Discovery Community College and SafeCare BC.

Introduction

About BC Care Providers Association

BC Care Providers Association (BCCPA) was established in 1977 and represents the interests of non-government providers delivering continuing care and seniors living across BC. Along with its operating arm, EngAge BC, BCCPA's membership includes over 380 organizations, delivering long-term care, home health, assisted living, and independent living. BCCPA represents the majority of non-government long-term care and assisted living providers in British Columbia and their growing membership is expanding to include a significant proportion of independent living and private home health operators as well (Table 1). The Board of Directors is comprised of senior leaders within the sector, representing all regions of the province.

Table 1. BCCPA sector membership

Ownership Status		BCCPA Members	Total Number of Providers/Operators in BC
Long-Term Care & Assisted Living	Private For Profit	165	217
	Non-Profit	83	185
	Government Owned & Operated	0	132
	Undefined	0	2
	Subtotal	248	536
Independent Living		71	154
Home health		50	142*
Total		369	832

*Based on 2016 WorkSafeBC home health classification unit data

Impact of COVID-19 on the sector

At the time of finalizing this report (November 6, 2020), there had been a total of 125 COVID-19 outbreaks in BC's health care sector. This includes 18 acute care sites and 107 long-term care, assisted living, and independent living residences. Of these, 27 remain active and 98 have been declared over[4]. Eighty-eight seniors' care residences have had one outbreak, thirteen have experienced two outbreaks, and six have experienced three outbreaks. Over the course of the pandemic, the number of sites under outbreak protocol reached the first peak between late March and early May 2020, and then decreased significantly over the summer months. Currently the province is experiencing a notable increase in the number of outbreaks, though with the support of rapid response teams approximately half of outbreaks have been

[4] http://www.bccdc.ca/Health-Info-Site/Documents/BC_Surveillance_Summary_Sept_17_2020.pdf

successfully limited to a single case (often a staff person). There were a total of 976 cases of COVID-19 in the health care sector, 555 in patients and residents, and an additional 420 in staff/other non-residents[5]. One hundred and fifty-three residents lost their lives with COVID-19 as a contributing factor; 25 of the 536 residences in BC (or 4.7%) lost seniors.

Thirty-nine COVID-19 outbreaks have occurred in privately-owned residences, 40 in non-profit residences, and 18 in publicly owned and operated care residences, as well as 10 independent living residences (Table 2). Care residences experiencing outbreaks include both union (69%) and non-union environments (11%); where unionized homes are represented by HEU, BCGEU and/or BCNU.[6] The majority of outbreaks (97%) have been experienced in the Fraser and Vancouver Coastal Health Authorities, with two outbreaks in the Interior Health Authority and one in the Northern Health Authority; no outbreaks have been experienced in Island Health region (Table 3)[2].

Table 2. COVID-19 outbreaks in seniors care and living residences, by ownership type

Ownership Status		COVID-19 Outbreaks	Total Number of Residences in BC	Percentage of Residences with Outbreak	Percentage of Residences with Multiple Outbreaks
Long-Term Care & Assisted Living	Private For Profit	39 outbreaks at 36 sites	217	17%	1%
	Non-Profit	40 outbreaks at 28 sites	185	16%	7%
	Government Owned & Operated	18 outbreaks at 14 sites	132	11%	3%
	Undefined	0	2	0	-
	Subtotal	97 outbreaks at 78 sites	536	15%	4%
Independent Living		10	154	7%	-
Total		107†	690	16%	13%

† Note that the 107 outbreaks have occurred at 88 care residences, including 36 private for profit, 28 non-profit, 14 government owned and operated, and 10 independent living residences.

[5] Croll, L. Quick facts, COVID-19 in seniors care by the numbers. November 2, 2020. BCCPA
[6] The union status of the remaining 20% of care residences is unknown.

Table 3. COVID-19 outbreaks in seniors care and living residences, by health authority region

Health Authority Region	Active	Resolved	Total
Fraser	16	54	70
Vancouver Coastal	8	26	34
Interior	0	2	2
Island	0	0	0
Northern	0	0	1
All BC	27	80	107†

† Note that the 107 outbreaks have occurred at 88 care residences, including 36 private for profit, 28 non-profit, 14 government owned and operated, and 10 independent living residences

In response to COVID-19, government, sector associations, unions, leaders, management, and employees worked tirelessly to limit the transmission of COVID-19. Dozens of initiatives were launched at all levels, however, seven emerged from this engagement as having the greatest impact on reducing transmission of COVID-19 in the seniors care and living sector:

1. **Restricting visits to long-term care**, **March 16, 2020:** The Province moved to restrict visitors in long-term care to essential visits only. Essential visits included compassionate visits for end-of-life care and visits that support care plans for residents based on resident and family needs.

2. **Operation Protect, March 23, 2020**: SafeCare BC launched "Operation Protect" asking the public to donate personal protective equipment and medical supplies, such as gloves, masks, and hand sanitizer, to health-care workers during the COVID-19 pandemic.

3. **COVID-19 Emergency Prioritization in a Pandemic PPE Allocation Framework, March 25, 2020**: The Ministry of Health committed to helping health care providers determine what type of PPE individuals working or visiting health care settings will receive when demand overwhelms supply.

4. **EquipCare BC, April 3, 2020**: The Province of BC announced the $10 million EquipCare BC program, managed by BCCPA. The funding targeted both funded and private long-term care and assisted living to help providers acquire infection prevention and control products as pandemic protection.

5. **Single site order, April 10, 2020**: The order mandated staff working in long-term care and assisted living to only work at one site to limit transmission of COVID-19 between sites (*see inset below*). All staff were reassigned by mid-June 2020.

6. **Wage levelling, May 8, 2020**: The Province of BC announced wage levelling across the province to bring all frontline workers in long-term care and assisted living up to the top wage rate. Wage levelling was made available to frontline workers in assisted living and long-term care sites in British Columbia, including nursing staff, care aides, select allied health professionals, and support services. Excluded staff included managers, physicians, some allied health professionals, and others. Staff working in home health and independent living, however, were not eligible for wage levelling.

7. **Pandemic pay, May 19, 2020:** The Province of BC announced a lump-sum payment of about $4/hour for a 16 week period starting Mach 15, 2020 for frontline workers in health and social services and corrections (cost sharing with the federal government). *Only those working in publicly funded sites were eligible for pandemic pay*.

Single site order

The Single Site Order (Health Care Labour Adjustment Order, April 10, 2020) mandated staff working in long-term care only work at one site to limit transmission of COVID-19 between sites. To fulfill this order, the Province issued *Information Collection to Allocate Staff Working in Facilities (the "Data Collection Order")*. Personal information of workers, including Social Insurance Numbers were collected for all workers as "the PHO deemed it necessary to obtain personal and employment related information about staff to support decisions about the allocation of staff among facilities[7]". On April 16, 2020 Health Employers Association of BC (HEABC) released the Single Site Transition Framework (SSTF) to all long-term care and assisted living providers in the province. Progress made with single site staffing orders varied by health authority, with some regions implementing more quickly than others. By June 18, 2020 more than 8,700 multi-site workers at 501 residences were reassigned to single sites. Single site orders do not include frontline workers in either the acute care or home health sectors.

Purpose of the engagement

The *purpose* of this engagement was to provide the BCCPA Board of Directors with a report of the impact of COVID-19 in the seniors care and living sector along with actionable recommendations for the Ministry of Health. BCCPA members from long-term care, assisted living, independent living, and home health shared their expertise and insights on the factors that contributed to and helped to curb the transmission of COVID-19 in BC. The specific *objectives* were to:

1. Identify facilitating factors and challenges in the response to COVID-19 in the seniors care and living sector in BC.
2. Convey the voice of BCCPA membership.

While the perspectives of frontline workers, seniors and families are clearly invaluable in documenting the impact of COVID-19 on the sector the scope of this report is on the provider perspective.

BCCPA has adopted a "Team BC" approach for working with government stakeholders and has been engaged in ongoing dialogue with the senior leadership within the Ministry of Health. The Ministry of Health has been consulted and has indicated support for this engagement and for a subsequent industry dialogue in the fall (Care to Chat).

In parallel with this engagement BCCPA has developed an extensive literature review[8] to:

- Highlight what other countries have done with respect to COVID-19 in seniors care
- Highlight what Canada and other provinces have done to deal with COVID-19 in seniors care
- Highlight what BC has done with respect to COVID-19 in seniors care
- Document BCCPA's response and sector leadership throughout the course of COVID-19 thus far
- Outline any potential gaps or other recommendations not outlined initially

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[7] Province of British Columbia Order of the Minister of Public Safety and Solicitor General. Emergency Program Act, Ministerial Order No. M105.

[8] Kary, M. Literature review and gap analysis report on COVID-19 and seniors care in British Columbia. *September 2020.* BCCPA

The discussion section of this report reviews the draft recommendations put forth to the Ministry of Health on July 27, 2020 and further explores gaps to uncover new areas for consideration followed by a summary of provider input with revisions and additions indicated.

Methodology

Governance and oversight

Howegroup conducted a brief survey and facilitated a participatory exercise with BCCPA Board members to define the engagement purpose and scope in March 2020. From inception, the sector voice has driven this engagement.

An active Advisory Committee comprised of BCCPA senior leadership and Board members provided ongoing oversight and direction into this engagement – including reviewing engagement tools, contributing to stakeholder selection, and drafting recommendations for submission to the Ministry of Health.

Engagement

A mixed-methods engagement strategy was utilized, inclusive of a member survey, interviews, roundtables, and an online member submissions portal (limited to input on draft recommendations submitted to the Ministry of Health). A summary of data collection methods is presented in Table 5.

Industry association leadership interviews and correspondence review

Semi-structured interviews and a review of correspondence and documentation were conducted by Howegroup with leaders from BCCPA, EngAge BC and SafeCare BC. These interviews provided additional background information on the context and key initiatives with the Ministry and within the sector and helped to shape the scope and direction of the engagement.

Member survey

An online survey (utilizing Qualtrics as the platform) was emailed directly to 134 long-term care and assisted living member providers and promoted on the BCCPA website and member bulletin.[9] The survey was open from August 5th to 30th, 2020 and consisted of open and closed-ended questions.

In total, there were 72 of 134 long-term care and/or assisted living providers who responded to the survey.[10] The majority (44%) were leaders (CEO/ED) and one third were managers. Over half of the respondents were from the Fraser Health region (53%). There was a fairly even distribution from Interior Health (14%), Vancouver Island Health (14%), and Vancouver Coastal Health (10%). Five providers reported operating in multiple health regions. The majority were private for-profit organizations (62%) and almost half operated long-term care (48%). Among those who provided long-term care, the average number of beds was 162 and among those who provided assisted living, the average number of units was 111. A total of 11 sites reported a COVID-19 outbreak and six reported losing seniors with COVID-19 as a contributing factor.

[9,10] Note there are 248 distinct long-term care and assisted living providers. Emails were sent to 134 providers representing multiple sites and providers offering more than one type of care (i.e. long-term care *and* assisted living).

Quantitative analysis was conducted by Lianping Ti, PhD, Assistant Professor, University of British Columbia in collaboration with Howegroup. Overall descriptive statistics were conducted on each of the variables of interest, using frequencies and proportions for categorical variables, and means and central tendency measures for numeric variables. In addition, each of the response variables were also stratified by region, ownership type, presence of an outbreak, care type, and provider size. Thematic analyses were conducted for all open ended comments. The analyses of open ended questions were conducted by Howegroup by examining key themes (in MS Excel and MS Word). Data were reviewed for alignment and deviations between themes. Independent thematic analysis was conducted by both Howegroup partners, and collectively reviewed to reduce bias. Relevant and reflective quotes were highlighted for inclusion in this report and where possible, the discussion and conclusions were verified with interview, survey, round-table and web submission data.

Member interviews

Semi-structured telephone interviews were conducted with a purposive sampling of long-term care, assisted living, independent living, and home health providers (N=25) from July to September 2020. The sampling was within the following dimensions: operating within various health authority regions (noting several provides operate in multiple regions), with varying business models and size of operation, and with or without outbreaks (Table 4). Efforts were made to ensure the experience of interviewees represented the breadth of providers from BC. Interviews were also conducted with two home health providers, with services in four regions, one of which being private and one not-for-profit. Thematic analyses were conducted on all interview input. Unless otherwise noted, quotes throughout this report are drawn from interviews.

Table 4. Description of the twenty-five providers interviewed

Provider type	Region				Business model		Outbreak declared*
	Fraser Health	Vancouver Coastal	Vancouver Island Health	Interior Health	Private	Non-profit	
Long-term care	14	6	4	5	6	13	6
Assisted living	13	5	3	3	6	11	
Independent living	10	3	3	6	7	9	
Home health	2	2	1	1	1	1	

*Outbreak is defined as 1 or more staff / residents testing positive for COVID-19

Roundtables

Roundtables were held in collaboration with EngAge BC, with an open sampling of independent living and home health providers, also representing a cross section of BCCPA and EngAge BC membership. Two one-hour roundtables were conducted via Zoom – one with 13 individuals representing 8 independent living providers and one with 13 home health providers. Participants were owners, CEO's and senior management. The roundtables were facilitated as a semi-structured focus group; notes where taken by both Howegroup representatives and later verified with the Zoom recording. Providers were asked for their input on success factors within the subsector such as what helped to limited the transmission of COVID-19, areas for improvement with respect to communication and access to information, the impact of the single site order to their operations, operational impacts such as financial and staffing, implications of pandemic pay, access and use of PPE, and on the relevance of specific draft recommendations submitted to the Ministry of Health. Thematic analyses were conducted on all input by Howegroup.

Written online submissions targeting feedback on draft recommendations

Draft recommendations were collaboratively developed during the engagement process with input from the BCCPA Board, the Advisory Committee, BCCPA senior leadership, and reflection on the Royal Society of Canada's *Restoring Trust* report[11]. Draft recommendations submitted to the Ministry of Health were shared with all BCCPA members via a member bulletin. Members were invited to submit their written responses via an online submission platform (hosted internally within BCCPA's website). A total of 18 submissions were received in August and September 2020 from a mix of private and non-profit provider from across the seniors care and living sector.

Table 5. Summary of data collection methods

Method	BCCPA Members (N)	Sample (n)	Percentage sampled	Description of participants	Data collection conducted by	Analysis conducted by
Member survey	134*	72	54%	CEO/ ED, Senior Managers	W. Giannasi, MPA; J. Hystad, MSc.	Statistical analysis: Lianping Ti, PhD Open-ended questions: W. Giannasi, MPA; J. Hystad, MSc.
Member interviews of long-term care and assisted living	248	25	10%	CEO/ ED	W. Giannasi, MPA; J. Hystad, MSc.	W. Giannasi, MPA; J. Hystad, MSc.
Roundtable 1 (Independent Living)	71	13 individuals	18%	CEO/ ED, Senior Managers	W. Giannasi, MPA; J. Hystad, MSc.	W. Giannasi, MPA; J. Hystad, MSc.
Roundtable 2 (Home Health)	50	13 individuals	26%	CEO/ ED, Senior Managers	W. Giannasi, MPA; J. Hystad, MSc.	W. Giannasi, MPA; J. Hystad, MSc.
Web submissions	319	18	6%	CEO/ ED, Senior Managers	W. Giannasi, MPA; J. Hystad, MSc.	W. Giannasi, MPA; J. Hystad, MSc.

* Note there are 248 distinct long-term care and assisted living providers. Emails were sent to 134 providers representing multiple sites and providers offering more than one type of care (i.e. long-term care *and* assisted living).

Review process

A panel of senior researchers were asked to review this engagement report at arm's length. In collaboration with the Review Committee Chair, Dr. Carole Estabrooks, Howegroup asked the reviewers to consider:

1. Whether the ***purpose*** of the engagement and the report was clear, and whether the objectives were met.
2. Whether the ***scope, breadth and depth*** of the finding and recommendations align with the objectives.
3. Whether the findings were presented with a ***balanced perspective***, keeping in mind the scope of the engagement (BCCPA membership).
4. Whether ***biases*** were clearly articulated and whether additional biases should be identified.

[11] Estabrooks CA, Straus S, Flood, CM, Keefe J, Armstrong P, Donner G, Boscart V, Ducharme F, Silvius J, Wolfson M. *Restoring trust: COVID-19 and the future of long-term care.* Royal Society of Canada. 2020

5. Whether critical ***resources*** had been addressed, and whether anything was missing that should have been included in the engagement report or the literature review (written by BCCPA).
6. Whether additional ***recommendations*** should have been considered and whether stated recommendations were adequately supported through the literature review or sector engagement.

Members of the panel included: Dr Carole Estabrooks (Chair) and Drs Joan Bottorff, Denise Cloutier, Gail Donner, Janice Keefe, and Sharon Strauss.

Reviewers each provided their written comments to the Chair, who summarized key themes for Howegroup to work into the final report. This final report incorporates comments from the reviewers.

Limitations

There are several limitations to the engagement. Providers were (and still are) time-constrained and request-fatigued. Providers were dealing with a multitude of requests for information, potentially precluding them from responding to requests for and participating in interviews and completing the survey. It is possible that those completing the survey and completing in interviews may have been more motivated to do so, potentially introducing bias into the results.

With respect to the survey: (1) there were missing data which could have impacted findings, (2) there may be response biases related to the individual who completed the survey, as this ranged from chief executive officers to managers to executive assistants, (3) some sites operated within umbrella organizations, therefore the operations and logistics may be similar across these sites and multi-site providers may be over-represented, and (4) given the small sample size, the study sample may not be representative of long-term care or assisted living sites in other settings which may limit the generalizability of the findings.

More specifically, there was a relatively low response rate, based on BCCPA membership: 54% for the survey; 10% for member interviews; 18% for the independent living roundtable; 26% for the home health roundtable, and 6% for web submissions. In addition, one large private provider contributed 7 of the 18 web submissions (e.g. leaders at seven individual sites from one umbrella organization completed an online form). These leaders may have a shared experience and therefore biased the findings. Sixty-two percent of *survey* respondents and 68% of *interview participants* were private for profit providers which is greater than the 51% of BCCPA members who are private for profit providers suggesting they are over represented in this engagement.

The report includes sections on the rights of seniors and staff and family visitation from the perspective of the provider and have not been verified by seniors, staff or family members who may have additional perspectives.

Findings

Engagement findings from long-term care and assisted living providers are presented first, followed by a summary of relevant findings for home health and independent living. While several of the issues and systemic challenges experienced by all levels along the continuum are common, there are some specific nuances among home health and independent living providers. Findings are presented as follows:

- Factors that contributed to flattening the curve in BC
- Factors that contributed to the transmission of COVID-19
- Health and human resources – including systemic challenges, the impact of the single site order, wage levelling, and pandemic pay
- Personal protective equipment (PPE)
- Communication
- Senior and staff rights
- Visitation
- Moving COVID-19 positive seniors to specialized units
- The financial impact among providers
- The burden of audits and reporting
- Support from sector associations
- Issues specific to home health
- Issues specific to independent living
- Preparing for a second wave

Factors that contributed to flattening the curve in BC

Providers report that timing played a large in role in BC experiencing lower COVID-19 rates when compared with other provinces, particularly with respect to limiting travel during Spring Break in early March. As COVID-19 impacted the eastern provinces, BC had the ability to learn, to a limited degree, about transmission and apply best practices. Infrastructure also played a role, with BC having fewer multi-bed rooms and, in general, spaces that allow for distancing of seniors. Providers agreed that the strong leadership of the Provincial Health Officer (PHO), for the public as well as the health system, played a significant role in limiting the transmission of COVID-19 in BC. Additionally, the PHO's messaging and leadership led to fewer cases in the community and therefore fewer cases in seniors care and living. Restricting non-essential visits also helped to limit transmission in seniors care and living. Providers acknowledged the collaboration across the sector and particularly the sharing of information and support among providers as integral in the response to COVID-19.

Factors that contributed to the transmission

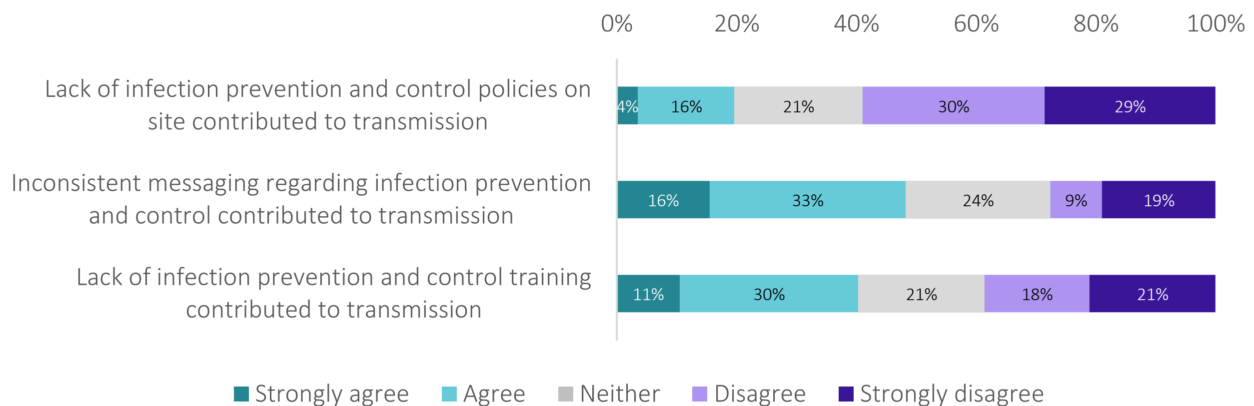
Providers report staff working at multiple sites was the most significant factor contributing to the transmission of COVID-19 in BC, which is underpinned by the systemic lack of health human resources and reliance on part-time and casual workers. Providers also report that lack of available PPE, particularly early in the pandemic contributed to the transmission of COVID-19, as did breaches in PPE protocol (e.g. donning and doffing). The complex and increasing acuity (e.g. comorbidity, dementia) of seniors was identified as an underlying factor in the high rate of COVID-19 transmission as was the unique nature of the virus (e.g. ability of the virus to transmit prior to presenting symptoms).

Factors contributing to the transmission of COVID-19:

- Staff working at multiple worksites
- Staffing shortages
- Lack of available PPE early in the pandemic
- Shared rooms; inability to isolate COVID-19 positive seniors
- Acuity of seniors (e.g. dementia)
- Complexity/unknown characteristics of COVID-19

Providers were quick to pivot existing infection prevention and control strategies (i.e. for seasonal influenza) and apply them to COVID-19. These were further adapted and revised as the pandemic unfolded. In general, while providers had serious concerns about a lack of consistent communication, providers did not attribute lack of policies, inconsistent messaging, or lack of training around infection and control to the transmission of COVID-19 in BC (Figure 1).

Figure 1. Infection prevention and control as contributing factors to transmission of COVID-19 (long-term care and assisted living)

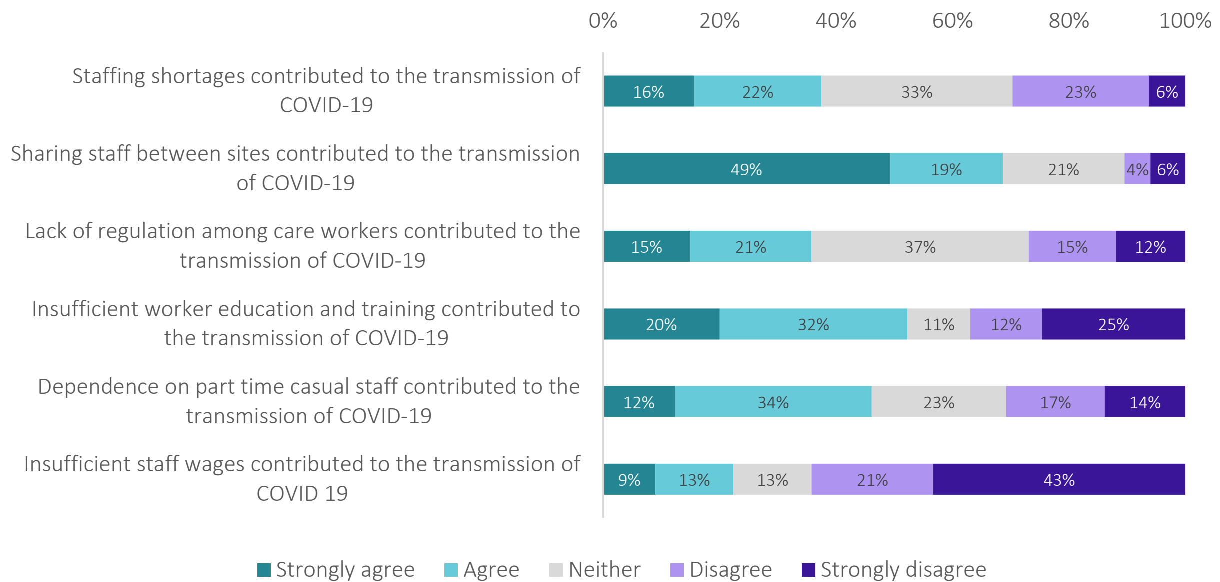


Health human resources

This section explores the impact of health human resources on the transmission of COVID-19, including staff working at multiple sites as well as training and education. The single site order, wage levelling, and pandemic pay are also discussed in this section.

More than half of survey respondents agreed or strongly agreed that insufficient worker education and training (29, 53%) and sharing staff between sites (39, 68%) contributed to the transmission of COVID-19 (Figure 2). Almost two-thirds of respondents disagreed or strongly disagreed that insufficient wages contributed to the transmission of COVID-19 (12, 22%). Interestingly, among the respondents operating assisted living sites with a larger number of funded and private units, a higher proportion reported that staffing shortages contributed to the transmission of COVID-19.

Figure 2. Opinions on health human resources impact on COVID-19 transmission (long-term care and assisted living)



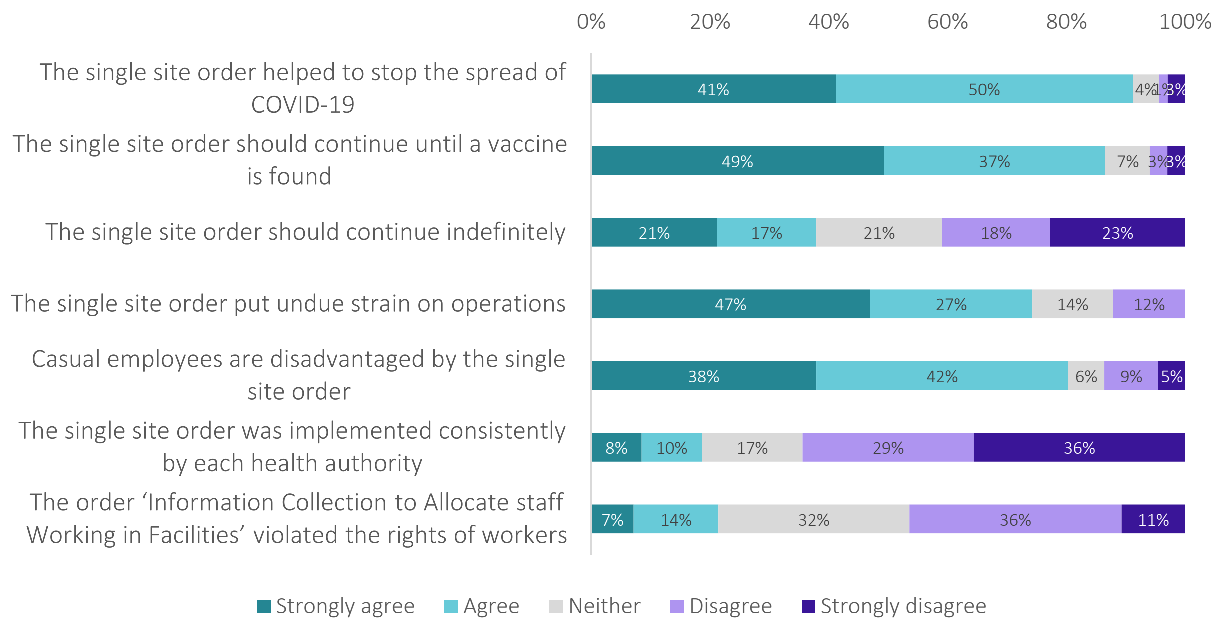
Single site order

The single site transition order applies to long-term care, private hospitals, assisted living, and mental health sites but does not apply to acute care, home health or independent living. Home health workers are allowed to work in community as well as long-term care and assisted living. Leaders spoke of the benefits, the implementation challenges, and the inconsistencies in communication and practice across the province.

Implementation of single site order

Illustrated in Figure 3, the majority of respondents agreed or strongly agreed that the single site order put undue strain on operations (49, 74%); however, respondents reported that it helped to stop the transmission of COVID-19 (58, 91%) and should continue until a vaccine is found (62, 86%). While there were mixed feelings as to whether the single site order should continue indefinitely, the majority (53, 80%) of respondents reported that casual employees were disadvantaged by the single site order. Of note, respondents reported that the single site order was not implemented consistently by each health authority (38, 65%).

Figure 3. Single site order impact on COVID-19 transmission (long-term care and assisted living)



Interviewees reported a great deal of frustration and pointed to the inequitable implementation, particularly the inconsistencies in health authority staff exemption.

> *"While the single site order helped to limit the transmission of COVID-19 the order was not implemented consistently. The biggest problem was [home health] health authority staff being exempt."*
> – Assisted living and independent living provider

> *"The single site order should include home health staff. Home health workers should be clustered. This would be difficult to execute but this is currently a significant gap."*
> – Assisted living and independent living provider

> *"I think the single site order implementation was a complete mess. It really affected staff and providers. There were significant coordination issues between the Provincial Health Officer and Medical Health Officers."*
> – Long-term care provider

> *"The single site order was the right thing to do but it's made the labour shortage even worse. Implementing the single site order without a labour recruitment strategy was problematic. As well, I can hire a care aide who is working at Tim Horton's or the meat processing plant in the morning and then comes into my site in the afternoon, but I can't hire the care aide across the street at another long-term care site. There were flaws in the policy."*
> – Long-term care provider

Providers emphasized the additional pressures the single site order is placing on an already strained system, particularly with respect to staffing. Sites are facing challenges with the loss of casual staff, covering regular shifts, and also to provide coverage for vacation and sick time. While the feeling has often been that staff

do not want to work on a casual basis and that employers are using casuals as a financial savings strategy, it may also be that staff want to work for more than one employer for other reasons, including variety and for scheduling flexibility.

> *"If we can't staff properly everything falls apart. We are having a very hard time staffing. We had challenges before and it's like we've been hit with a hammer. We are filling our lines with overtime every single day. Staffing is at a crisis level."*
> – Long-term care provider

> *"We lost 75% of our casual workforce. In spite of overtime, we are frequently running short of staff when no one is available to fill vacant shifts. Recruitment is a challenge as we are hardly receiving any job applications right now."*
> – Survey respondent

> *"The single site order showed a lack of understanding of the casual pool. This decision was influenced by the Office of the Seniors Advocate and unions. Most of the casual pool is dictated by people wanting flexibility and union contracts don't allow for this. Paying more would be beneficial of course but it's not the full picture that was provided."*
> – Long-term care and assisted living provider

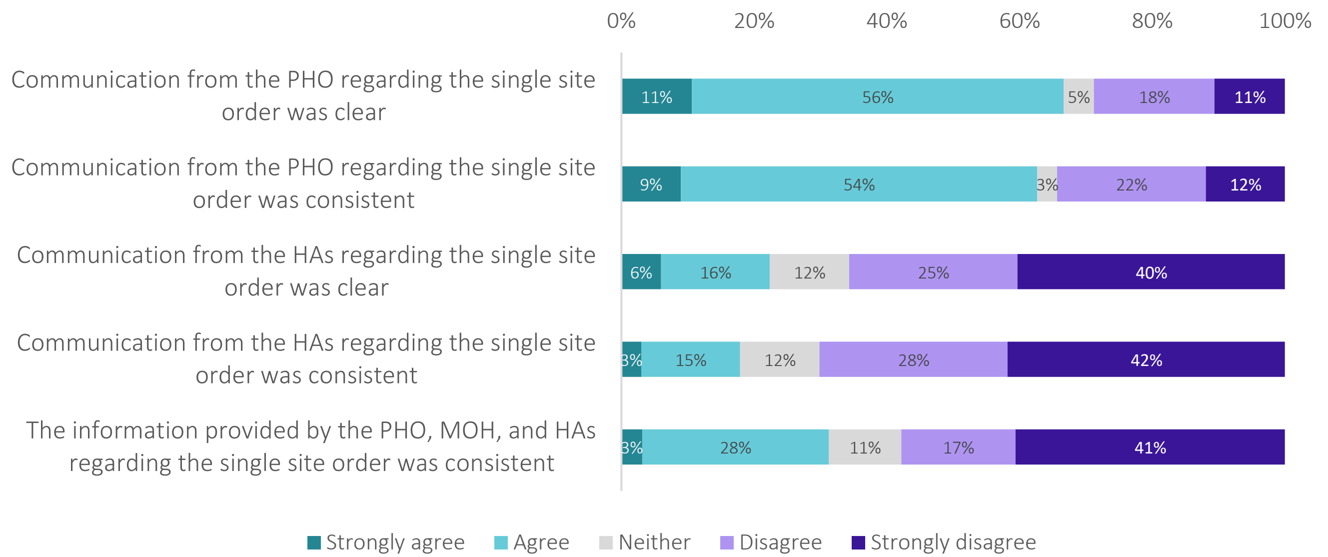
A couple of providers spoke of the benefits in terms of moving casual staff into full time positions and the stability it has created for their operations.

> *"The single site order has actually filled some of our lines. Many staff worked casual because they could. We could never rely on people showing up for shifts but the single site order forced people to make a choice."*
> – Long-term care provider

Communication around the single site order

While the majority of respondents report that the communication from the PHO around the single site order was clear and consistent (>62%), the opposite was true for communications from the health authorities (Figure 4). Interestingly, respondents with sites that had a COVID-19 outbreak reported that the communication from the health authorities was not clear nor was it consistent (100% disagreed or strongly disagreed) compared to those that did not have a COVID-19 outbreak (>62% disagreed or strongly disagreed).

Figure 4. Single site order communication (long-term care and assisted living)



The majority of survey respondents in Fraser Health, Interior Health, and Vancouver Coastal Health reported communications from their health authorities regarding the single site order was unclear and inconsistent. In contrast, the majority of respondents from Island Health reported clear and consistent communication.

Providers shared their struggles in working with the health authorities to reassign staff, with the errors that occurred, and the pressures this placed on them from a human resources perspective. There were significant issues with inaccuracy of staff lists.

> *"There was a lot of manual data manipulation/ re-entry on spreadsheets that had to be redone multiple times. This strained our human resources. There was confusion over whether Physiotherapists and Occupational Therapists fell under the order or not. There was no clarity on what to do when there were changes in assignment (e.g. employee resigned from other place of work and wanted to be assigned to preferred site). We received inconsistent direction and this created a lot of re-work."*
>
> – Survey respondent

Providers also reported examples where providers poached staff and offered higher wages to entice them. This caused undue stress on providers and staff and detracted from a usually collaborative sector approach.

Wage levelling

Wage levelling was applied to long-term care and assisted living for employees limited to working at a single site. Through this initiative, employees were entitled to receive hourly wages equivalent to the relevant Health Employers Association BC (HEABC) collective agreement and must receive the hourly wage equivalent of the highest increment they receive at any their worksites. Wage levelling was instituted to offset the potential loss of pay due to the Single Site Order (SSO). The requirement of having workers employed at a single site only has resulted in a significant increase of overtime and workload for frontline staff, as well as management.

"Because of wage levelling some staff are making more than their supervisors."
– Long-term care provider

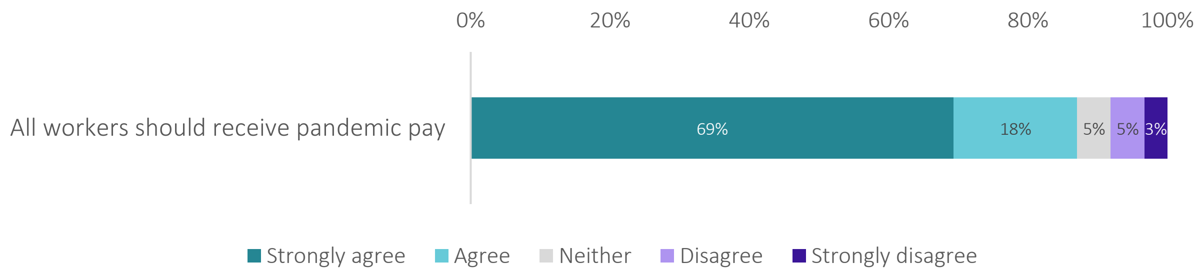
"Who are the winners here? The employers paying the lowest wages are now able to compete with better paying employers [to attract workers]. BCCPA really needs to look at this."
– Long-term care provider

"Wage levelling was a very bad decision. It was political and caused a lot of work and it's confusing. It should have been funded on a per unit or per bed formula. The wage levelling and single site order was like an accelerant to the [health human resources] issue."
– Long-term care and assisted living provider

Pandemic pay

Pandemic pay only applied to publicly subsidized employees; employees of privately retained providers were not eligible, resulting in pay inequities across staff (who were often performing similar tasks). Providers expressed concern regarding the inequity in pandemic pay and the distress it caused (and is causing) among those ineligible for the additional pay. The majority of survey respondents (43, 69%) agreed or strongly agreed that *all* workers in seniors care and living should receive pandemic pay (Figure 5).

Figure 5. Support for pandemic pay for all workers (long-term care and assisted living)



Personal protective equipment (PPE)

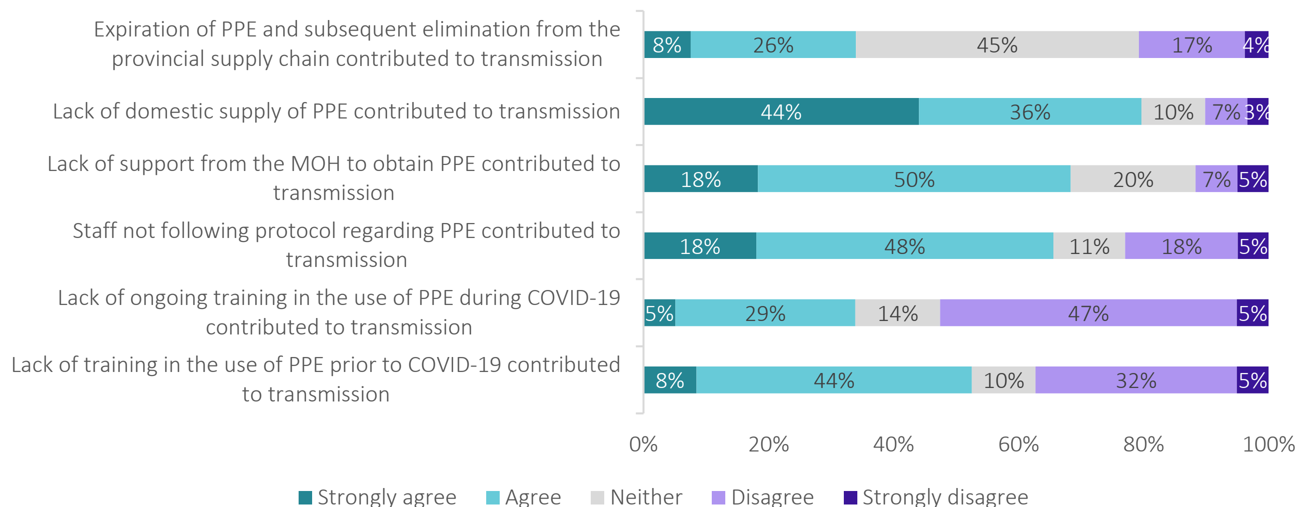
Providers faced many challenges with respect to PPE, particularly around securing and maintaining supply, escalating costs, and messaging from health officials. Providers reported a critical shortage early in the pandemic and expressed concern about maintaining this supply. Worry was compounded by the escalating costs of PPE. Providers commented on the confusion caused around discrepancies in guidelines from the BCCDC and health authorities, particularly Fraser Health, as well as changing guidelines during the pandemic.

"Fraser Health gravely concerns me that they did not follow BCCDC guidelines, particularly around not changing masks between residents."
– Long-term care provider

"The Provincial Health Officer did not have control of the health authorities' practices [with respect to PPE]. There was no enforcement or interest in monitoring the health authorities."
– Long-term care provider

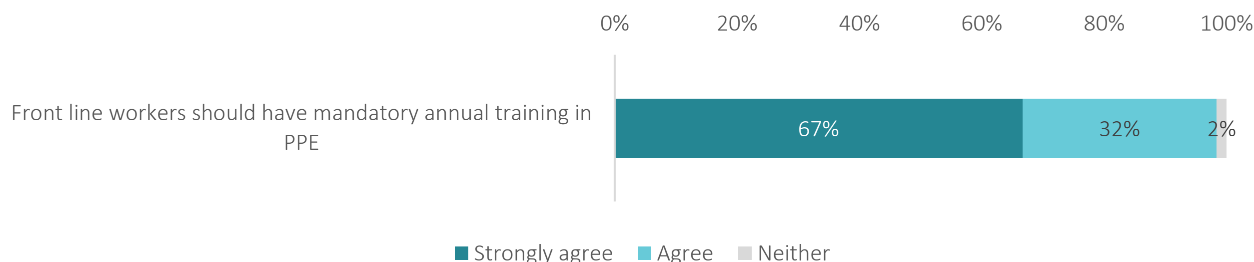
Many survey respondents reported that a number of PPE-related factors contributed to COVID-19 transmission (Figure 6), with the top three reasons being: lack of domestic supply of PPE (47, 80%), lack of support from the Ministry of Health to obtain PPE (41, 68%), and staff not following protocol regarding PPE (40, 66%).

Figure 6. PPE-related factors contributing to COVID-19 transmission (long-term care and assisted living)



Providers agreed that frontline workers should have mandatory annual training in PPE (see Figure 7). Further, among the 32 survey respondents who hosted health authority workers (e.g. health authority workers were brought onsite during the pandemic) and responded to the survey, only 14 (43%) reported their frontline workers were adequately trained in PPE.

Figure 7. Mandatory annual training in PPE (long-term care and assisted living)



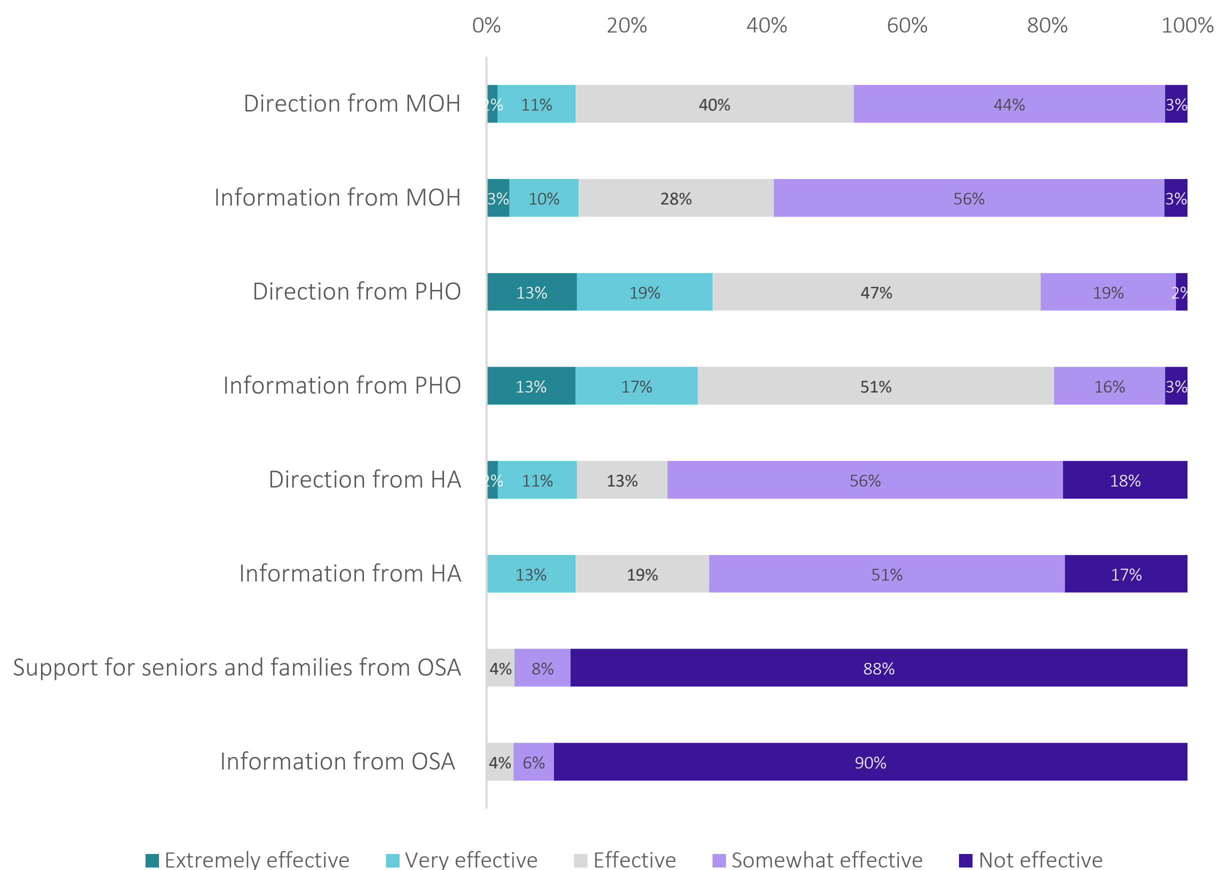
Providers reported the cost of PPE as one of the most significant financial impacts to their operation. The "burn rate" (i.e., the rate at which PPE was used) was significant in long-term care sites with outbreaks. One site reportedly went through 1000 gowns a week. BCCPA worked directly with several large long-term care and assisted living providers to examine additional costs and found that long-term care providers were spending upwards of $4-$5 a day, per bed on additional PPE and that assisted living providers were spending just under $2 a day per unit – equating to upwards of $15,000 per month for a 100 bed long-term care provider and $6,000 per month for a 100 unit assisted living operator.

Communication

Direction and information from the Ministry of Health, Provincial Health Officer, and health authorities was at least somewhat effective (>82%). In addition, a substantial proportion of survey respondents (>88%) reported that information and support from the Office of the Seniors Advocate was not effective.

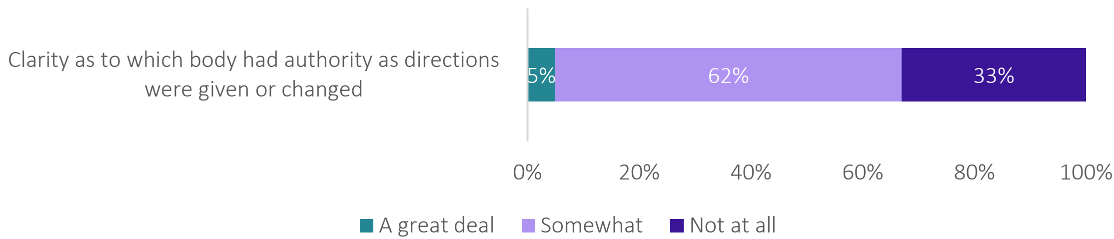
> *"We would get directives at 4pm on Friday so we'd all have to work the weekend. It seems the government does not know how it works in a smaller organization, when we don't have human resource officers or infection control resources. Their understanding of what our world is not adequate."*
>
> – Long-term care provider

Figure 8. Direction and information from government and the Office of the Seniors Advocate (long-term care and assisted living)



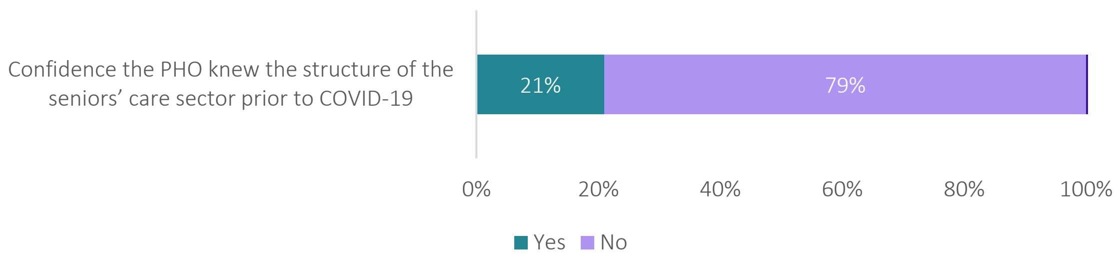
It was also not clear by survey respondents as to which body had authority as directions were given or changed (50; 79.4%), Figure 9.

Figure 9. Clarity regarding authority (long-term care and assisted living)



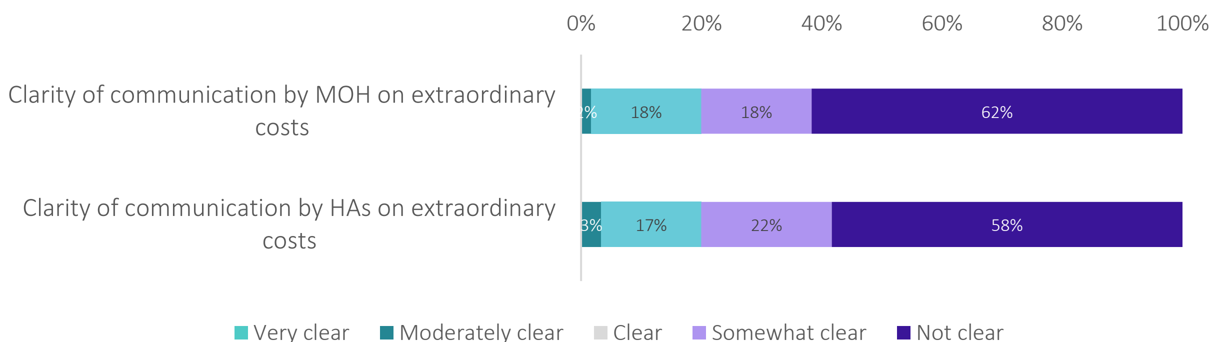
Over three-quarters (20; 33.3%) of respondents reported that the Provincial Health Officer did not know the structure of the seniors care sector prior to COVID-19 (Figure 10).

Figure 10. PHO sector knowledge prior to COVID-19 (long-term care and assisted living)



Over half of respondents reported there was a lack of clear communication by both the Ministry of Health (37, 62%) and the health authorities (35, 58%) regarding extraordinary costs – Figure 11.

Figure 11. Clarity of information regarding extraordinary costs (long-term care and assisted living)



While providers from all health authority regions report receiving unclear communication, respondents within the Fraser Health region reported the least clear and effective communication. This was confirmed during interviews with providers.

Consistency of information

Providers cite many issues with respect to communication, particularly around inconsistencies and the ensuing implications on safety, workload, and resources. Health authorities have provided inconsistent orders and direction within their own region and conflicting direction from one region to another. Many

providers have sites located in multiple health authorities making it a tremendous effort to monitor and implement the orders and directions.

Providers report receiving *clear* and *consistent* communication from the Provincial Health Officer (PHO) and appreciated the Minister of Health and PHO being on the same page with a consistently calm approach. Often though, providers received information at the same time the public received information. This did not give providers any lead time to prepare for inquiries from residents, families, and staff.

> *"I had my staff watching TV to see Dr. Bonnie Henry every day. We shouldn't be watching TV to get our updates. As well, this ended up being the same time that Fraser Health would hold their town halls."*
>
> – Long-term care provider

There were significant inconsistencies between communication and directives from the Ministry of Health and the health authorities. Providers reported health authority Medical Health Officers making decisions that were then rescinded on the same day by the PHO. Sites report feeling overwhelmed and 'paralyzed' by the volume of and contradictory information.

> *"The Ministry of Health and Interior Health was not communicating the same information at the same time, and it left providers with some big questions. I appreciate that we didn't know everything, particularly at the beginning, but one central information source would have helped. I would receive information at 8pm on a Saturday that was changed at noon on Sunday. It was paralyzing because we didn't know where to turn."*
>
> – Assisted and independent living provider

Providers indicated that one central source of information would have alleviated a great deal of burden on the sector, particularly when health authorities were interpreting information from the Ministry of Health differently. Representatives within health authorities also had different understandings of specific practices, furthering the inconsistencies of information.

> *"Differing health authority interpretations and practices was a challenge. We needed one voice and one direction provincially, especially when it's affecting the general public and not just long-term care."*
>
> – Long-term care provider

Providers would have appreciated minutes or written actions from health authority calls. This would have helped to alleviate information recall and, in the height of uncertainty, would have provided some level of clarity.

Long-term care providers were quick to cite support from their health authority leaders where credit was due:

> *"Interior Heath did a really good job of connecting with the providers and keeping them informed and problem solving with daily calls at the start and then scaling back to weekly. They were responsive and provided good information."*
>
> – Long-term care provider

"The level of engagement from Vancouver Coastal was incredible. From day one public health was here. I don't know where we would have been without support from Vancouver Coastal."
– Long-term care provider

Senior and staff rights

Actions of the Province to limit the transmission of COVID-19 has had a detrimental impact on the rights of seniors and staff. While the Emergency Health Order superseded both staff and seniors' rights (including the Residents' Bill of Rights[12]), providers reported seniors' quality of life was severely diminished. Residents were not provided options, family input was limited, and decision-making was top down. Providers hope to see a way forward that better balances the social and emotional needs of seniors with protecting their physical health and the safety of staff.

Examples of how ***seniors' rights*** were impacted:

- Seniors were restricted to their suites without any social contact, very limited recreation, and no access to the outdoors for prolonged periods. This was particularly challenging for seniors with mobility issues and dementia.
- Seniors and their families were kept apart during a very stressful time creating significant distress and anxiety among seniors and family members. Families were kept apart when they needed each other most.
- Interests of staff were put ahead of seniors by allowing some health authority staff to work in multiple sites while seniors were restricted to their suites.
- Some providers believe that seniors were denied access to necessary medical professionals and equipment by keeping them on-site and not moving them to a COVID-19 specialized unit.

"Seniors lost their right to freedom and to associate, to self-determination. We told our residents to stay in their suite, they couldn't even see their neighbour. They ate alone."
– Campus of care provider

"Seniors are impacted by receiving their daily meals alone in their suite. The food is not as hot as it should be. Some residents are losing weight because they are socially isolated."
– Long-term care provider

"The focus was on the virus and not the people. It was about doing audits and screening staff and cleaning but seniors never came into it. Residents ate alone for 60 days."
– Long-term care provider

Examples of how ***staff rights*** were impacted:

- Staff rights were violated when the Province requested personal information of staff, including Social Insurance Numbers, to fulfill the single site order. This information was not necessary and some employers refused to provide it.
- Staff were not given the opportunity to choose the site that would become their 'single site'. Many staff had indicated a preference and were subsequently directed to work full-time in another location.

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[12] https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/accountability/policy-and-standards

- Seniors living and care staff were not treated equally across the province. Those working for privately-owned sites were not included in wage levelling and did not qualify for pandemic pay despite filling the same role, sometimes working in the same site. Managers and leaders were not included in pandemic pay. Some managers are making less than the nurses they are supervising.

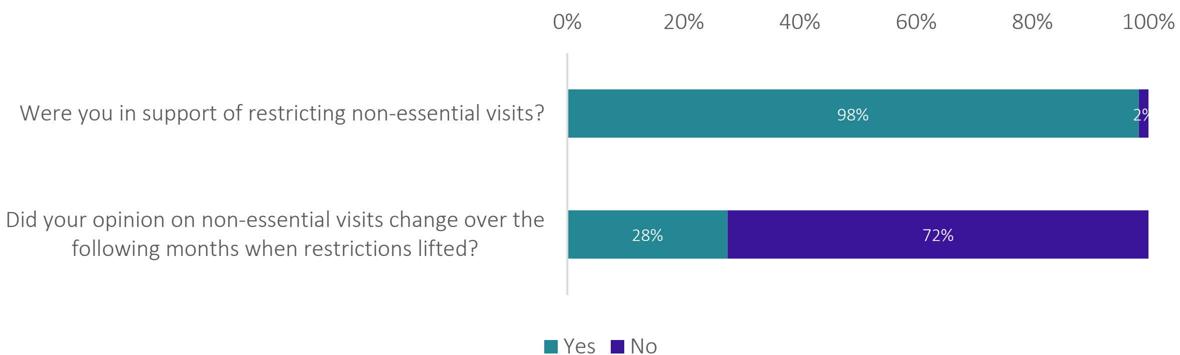
"Staff lost their rights too. They can't bring coffee in, can't change at home, can only use one door, lost the right to work where they want to. You have to give up your other jobs, your right to congregate. We closed down the cafeteria. They had to wear goggles and masks."
– Long-term care provider

"Managers and leaders have been unappreciated by the whole system."
– Long-term care provider

Visitation

The vast majority of participants (59; 98.3%) were in support of restricting non-essential visits near the onset of the public health emergency declaration. However, over the following months until restrictions were lifted on June 30, 2020, over a quarter (16; 27.6%) changed their opinion (Figure 12).

Figure 12. Support for visitation (long-term care and assisted living)



Regardless of provider support for restricting visitors, the impact on residents, families, and staff has been profound and caused distress among all stakeholders. Providers questioned the negative impact on residents and their families:

"The impact of not seeing loved ones took a huge toll on the elderly, especially those with dementia."
– Survey respondent

"Restricting visitors was needed at first so we could see the impact and figure out a plan. The residents and families have suffered greatly though, and it has put undue stress on our staff."
– Survey respondent

Nearly all respondents (92%) reported that additional resources are needed to schedule and manage visitations in order to allow for visitations to continue through a second wave of COVID-19. Similarly, 90% of respondents required additional resources to conduct enhanced cleaning as well as access to PPE for

family use that is separate from staff requirements in order to allow for visitations to continue through a second wave of COVID-19.

"The visitation policy has overtaken our work schedules. Managing upset families or families with concerns, or who want to bring things in, takes an enormous amount of time."
– Survey respondent

"I would have appreciated communication from the health authority to residents and families directly so I wasn't seen as the bad guy implementing directives we received. This would have helped with our resident and family relationships and our workload."
– Assisted living provider

Support needed for visitation

Providers commented on additional measures put in place to support visits, including self-assessment and screening practices. Long-term care and assisted living providers are divided on whether they support robust measures to allow families and non-essential visits to continue in the event of a second wave. For those who support visits, they require:

- Clarity regarding expectations and restrictions for visitors, including clear rules for families and providers
- Education on infection control for families
- Screening and rapid testing; including priority testing for seniors care staff
- The ability to provide PPE to visitors if needed
- Presence of staff to support safe visits
- Funding to support safe visits (including staff, technology, and other infection control measures)
- Emphasis on outdoor visits, where possible, including window visits.

As well, providers would like to see flexibility built into visitation such that community circumstances may dictate visits, rather than a provincial approach, particularly as restrictions need to resume.

"To have the manpower and the resources to implement and maintain the robust measures will be challenging."
– Survey respondent

"*Staff had to use their sick time to get tested and wait for results."*
– Long-term care provider

"The isolation from family and loved ones has had a dramatic impact on the resident's well-being. If we are able to 'safely' re-open with additional precautions in place, I feel it would benefit the residents in our care."
– Survey respondent

For those that do not support visits the reasons are solely due to concerns that the risk is too high:

"The risk from contact with numerous people from the community is too high. Not only residents are exposed to the risk but also staff."
– Survey respondent

"It's far too big of a risk. Half of the families are still not in support of relaxed visits/outings due to risk to their loved ones. I get calls regularly from assisted living families that they feel other residents are endangering their loved ones by having non-essential visits and outings."
– Survey respondent

One provider aligned positioning around visits with moving COVID-19 positive residents:

"Families should not be allowed to visit during the pandemic. All the more reason that COVID-19 positive residents should be moved to a designated health authority site so that families can still visit residents that are not infected."
– Survey respondent

Moving COVID-19 positive seniors to specialized units

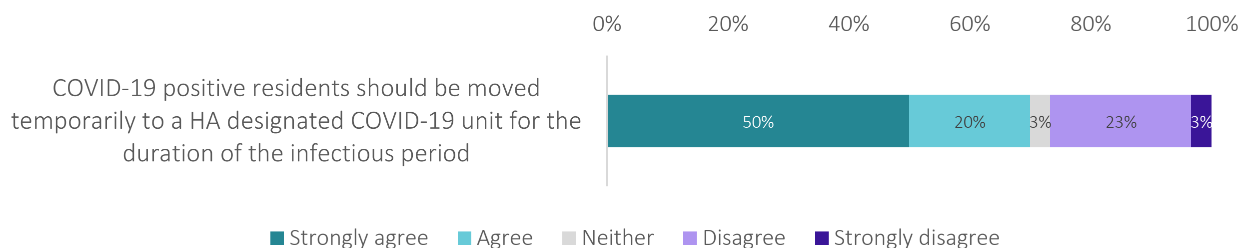
Providers had mixed feelings about moving seniors diagnosed with COVID-19 from their residence to a specialized unit, influenced by the ability of the site to effectively isolate, the needs of the senior, and the capacity of the residence they are living in to meet the seniors' needs. Survey respondents overwhelming agreed moving COVID-19 positive seniors to a specialized unit would have limited the transmission of COVID-19 (42, 70%), Figure 13. Interviews confirmed that, for the most part, sites were not built with appropriate areas for isolating seniors – which is of particular concern when caring for residents living with dementia. Further, some providers reported seniors may have received better medical care in an acute setting, specifically with respect to access to physicians, specialists, and respiratory therapists. Providers indicated that physicians moved to virtual conferencing; reducing, and in some cases stopping, coming on-site to provide medical care to residents. Providers also felt seniors may have had access to more advanced medical equipment in a specialized unit.

While a specialized unit was established using a Vancouver Coastal site (George Pearson Centre), it is understood that only a handful of seniors were moved to this location. While there was capacity for multi-health authority utilization the lack of communication and collaboration between health authorities precluded this specialized site from being utilized to its potential.

"Long-term care was used as a place where COVID-19 was going to happen. We could have stopped the spread if [seniors] went to another site. Seniors were not given a chance to see how this would work, access to specialists, better equipment."
– Long-term care provider

"There were a lack of options for residents and families. Residents were not allowed to go to the hospital. The focus was on the virus and not the people."
– Long-term care provider

Figure 13. Moving COVID-19 positive seniors to a designated unit (long-term care and assisted living)



Providers acknowledged the ethical challenge of allowing seniors to remain where they are comfortable or moving them to a space that is unfamiliar. Providers felt that when a site can isolate seniors in their room and provide adequate care, it is not necessary to move them.

"We need an ethical decision on this. If one resident has COVID-19 then they should be moved. If hospitals are at capacity then they should stay."
– Long-term care provider

"Our site is all single rooms so we can isolate residents. I feel that overall, we know our residents better and we know what their needs are. Sending them away is not in their best interest. We just have to be vigilant in our infection control measures."
– Long-term care and assisted living provider

"If a person is near end of life then, if possible, have the person supported or cared for in a separate area (isolated). If they are not at the end and reasonably strong, then it is a good idea to move them."
– Long-term care provider

"We were no longer a long-term care setting, we became an ICU setting (end of life protocol). Rights quite honestly didn't apply. It was hard to go by residential living rules when we were in such a critical time. Residents' ability to choose was simply not doable."
– Long-term care provider

Financial impact

Long-term care and assisted living providers report excessive expenditures related to COVID-19 and are unclear as to whether they will be reimbursed.[13] Providers report being told by the Ministry of Health and health authorities that they would be reimbursed but without clear guidelines or timelines, thereby placing the risk on the sites.

While expenses varied greatly, providers reported spending up to $2,500 additional costs per long-term care bed. The most significant expenditures include:

- Wage levelling and pandemic pay costs
- Costs associated with the single site order, primarily overtime
- PPE
- Additional administrative costs (i.e. reporting and inspections)
- Screening costs for visitors
- Cleaning
- Supplies for in-room dining
- Distancing measure costs (i.e. plexiglass, etc.)

Several providers also reported lost revenue from an increased vacancy rate. Others commented on the unknown costs associated with staff burnout and mental health and wellness that are anticipated in the future. As well, there are concerns that significant increases in wages will ultimately be passed onto seniors, further impacting affordability of care.

[13] Providers were asked to quantify their expenditures, but the ranges and classification of expenditures varied too greatly to draw meaningful conclusions.

“Wage and supplies have risen three to four-fold.’
– Long-term care provider

“We have submitted over $200K in pandemic expenses and only $70K was reimbursed.”
– Survey respondent

“This significant increase in wages will lead to cost increases that then lead to affordability issues for seniors.”
– Long-term care and assisted living provider

Audits and reporting

In addition to regular daily duties and responsibilities, providers had a tremendous extra burden placed upon them to respond to COVID-19. Survey respondents reported spending hundreds of extra hours to respond to *requests for reporting* and *additional inspections* over the course of the pandemic. Many providers are finding the requests for information and additional inspections/audits overwhelming, particularly as audits and reporting requirements went from a monthly frequency to weekly and then daily during an outbreak without additional resources to support this work.

Examples of additional demands in response to COVID-19 include:

- Receiving, communicating, and revising orders and information from a variety of sources
- Organizing and management of supplies
- Extra education and training for staff
- Adding extra staffing, booking, and scheduling around sick time
- Infection control management
- Responding to audits and surveys
- Extra communication with families, physicians, and coworkers
- Implementing the single site order
- Assisting new residents who are isolating in their room for 14 days
- Daily inspections

“I would say half my day is spent on responding to calls and emails from families about visits and video calls.”
– Long-term care provider

“COVID-19 occupied all my time at work, in the evenings and the weekends, mainly responding to emails, reading correspondence, implementing orders, rescinding orders, implementing new orders, posting information for staff and education, and figuring out the status quo in a constantly changing landscape.”
– Long-term care provider

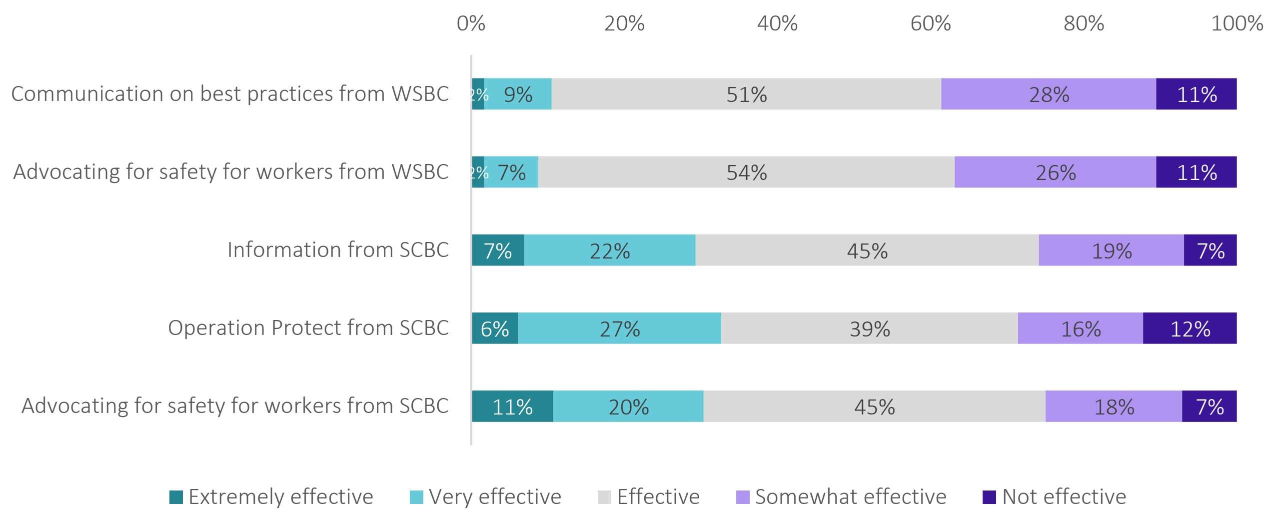
“We receive onerous requests and inspections from Fraser Health that are becoming more prescriptive all the time. We are coming to the point where we are going to have to hire someone just to respond to Fraser Health requests. They don’t realize our teams are really small.”
– Long-term care provider

Support from associations

A collaborative effort helped to limit the transmission of COVID-19, including support from WorkSafeBC, SafeCare BC, BCCPA, and EngAge BC. Among the highest rated in terms of effectiveness was EquipCare BC, supporting SafeCare BC to advocate for PPE and enhanced communication from the BCCPA, and advocating for worker safety, and Operation Protect from SafeCare BC.

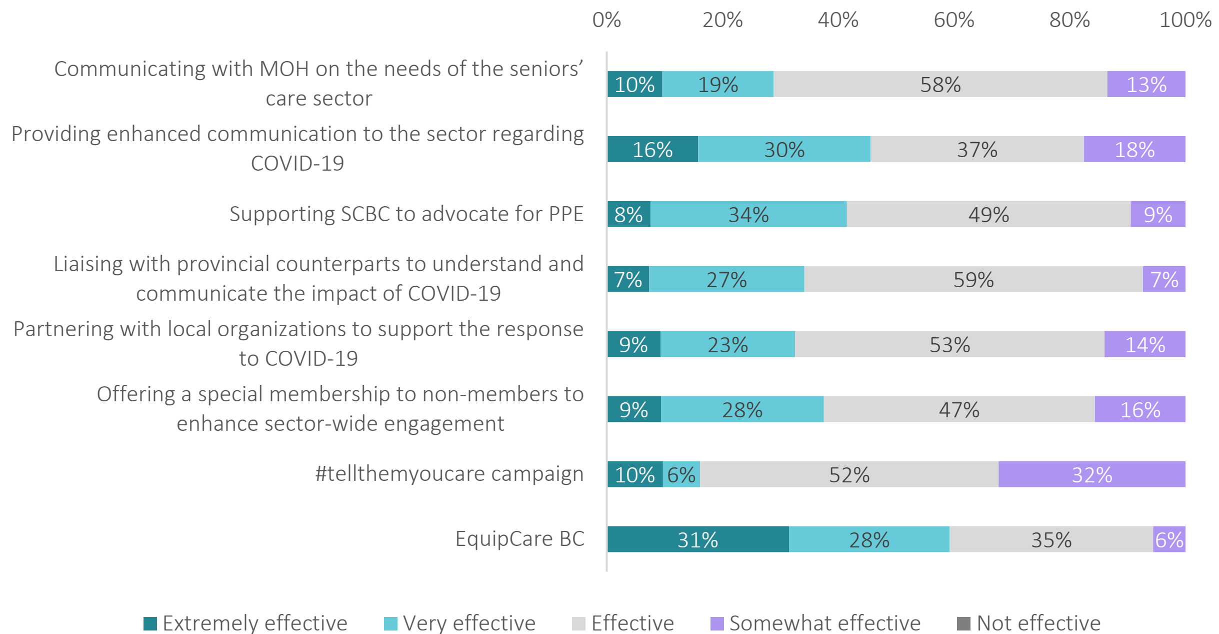
As illustrated in Figure 14 a large proportion of survey respondents reported that WorkSafeBC (WSBC) was effective in communicating best practices (35, 61%) and advocating for the safety of workers (36, 63%). A higher proportion of respondents reported that SafeCare BC (SCBC) was effective in advocating for the safety of workers (42, 75%), as well as providing information (43, 74%), and delivering Operation Protect (35, 71%).

Figure 14. Effectiveness of support from WorkSafeBC and SafeCare BC (long-term care and assisted living)



All survey respondents reported that BCCPA and EngAge BC were effective in their support in response to COVID-19, with at least one-third indicating that they were very or extremely effective at communicating and liaising with Ministry of Health, SafeCare BC, local organizations, and provincial counterparts (Figure 15). Over half of the respondents (32, 59%) reported that EquipCare BC was very or extremely effective.

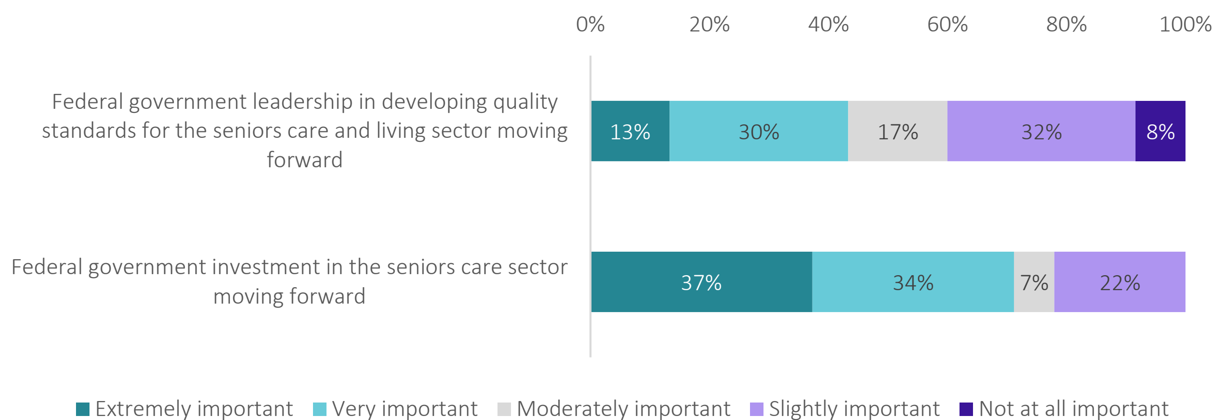
Figure 15. Effectiveness of support from BC Care Providers Association and EngAge BC (long-term care and assisted living)



Federal support

Federal government support did not emerge as an important factor in the interviews or the roundtables with providers. When asked specifically on the survey, there were mixed feelings as to the importance of federal government leadership in developing quality standards for the seniors care and living sector moving forward, with 26 (43%) indicating that this was very or extremely important and 24 (40%) indicating that this was slightly or not at all important. Nevertheless, the majority of respondents (42, 71%) reported that it was very or extremely important that the federal government invested in the seniors care and living sector moving forward (Figure 16).

Figure 16. Federal government leadership and investment (long-term care and assisted living)



Home health

Although the single site order was not intended for home health, providers commented on how the policy was applied and impacted their operations. Home health leaders spoke of the issues with respect to inadequate staffing and the inconsistent implementation of policies between health authority and contracted (private and non-profit) providers.

Success factors

Home health providers reported the most significant success factor for limiting the transmission of COVID-19 as being the ability to collaborate at a management level. Providers with sites in other provinces had the advantage of leveraging learnings and policies from their colleagues. Providers also reported the nature of the home health model meant that seniors (their clients) had fewer contacts and therefore less chance of transmission.

Challenges

The most significant challenge for home health providers was the *lack of communication* and information directly from the Ministry or health authorities. At first providers did not receive any information and then what information they did receive was fragmented and often contradictory from one source to another.

"Communication and information around the use of PPE varied greatly between health authorities. What could have helped would have been clear messaging from the government."
– Home health provider

"We had to curate information from five health authorities, often contradicting each other. Health authority representatives would be contradicting each other on the same call. There just needs to be central coordination – not health authorities having different interpretations and opinions."
– Home health provider

While access to PPE was clearly a struggle across the country and across the continuum home health providers reported that home health was overlooked.

"Home health was just a bit forgotten. It didn't occur that workers and seniors needed PPE to protect staff and seniors."
– Home health provider

Providers recognized that it may not be realistic for the government to fund PPE for privately retained home health providers, but at the very least there is a role for government to ensure adequate supply and coordination of allocation for public safety.

When asked whether home health providers have noticed a shift in more engagement, interest or support since the start of the pandemic the response was negative. Instead providers have turned to industry associations and their colleagues for resources.

"We haven't seen any support from government but now we know where to turn for resources. We look to WorkSafeBC, our own corporate resources, BCCPA and SafeCare BC. BCCPA and SafeCare BC have reached out to provide support."
– Home health provider

Private home health providers emphasized the lack of government support, feeling that the Ministry of Health often overlooks private care.

"The Ministry has a blind spot for private care in general, whether in residential or home care."
– Home health provider

"We didn't get any direct communication at all. We received communication second-hand through the sites we worked for and they were getting information that was different from different health authorities from their own organizations. We ended up educating a lot of the sites we were doing work for. We had to break it down to what we could do legally and safely."
– Home health provider

Impact to operations

When asked what the most significant impacts were to operations home health leaders pointed to the additional costs for staffing, PPE, and educating staff, as well as the indirect impact of the Canadian Emergency Response Benefit.

"We saw some staff that were trying to work as little as possible and get paid as much as possible. In some cases, the clientele came back faster than the staff came back to work."
– Home health provider

Employees of privately retained providers were not eligible for pandemic pay, resulting in pay inequities across workers performing similar, if not the same tasks. This resulted in some providers increasing wages, which they have indicated is not sustainable. Further, these inequities devalued some workers. Providers find that home health is often overlooked as being part of the continuum of care and that for *private* home health providers, it is as if they are invisible.

"Private providers were this unseen group that weren't considered. To tell staff that the government wasn't giving them an increase was hard. It's like we didn't exist."
– Home health provider

Recommendations

When asked about the specific recommendations put forward to the Ministry of Health in July 2020, the key take-away is to ensure continuing care is defined to include explicit reference to home health, including that which is privately retained.

Independent living

Success Factors

A variety of factors helped to limit the transmission of COVID-19 in independent living sites (also referred to as seniors living or retirement living). Communication by the Provincial Health Officer to the general public around the severity of COVID-19 created a climate where residents, families, and visitors were responsive to the changes necessary on-site such as limiting visitation. A great deal of information sharing occurred between seniors care and living providers, allowing for best practices to be implemented quickly. Independent living providers who also operated long-term and assisted living units implemented many directives intended for higher levels of care at their independent living sites.

Other factors identified by independent living providers as limiting the transmission of COVID-19 included:

- Overall acceptance of directives by staff, residents, and families
- Early implementation of PPE protocols
- Direct communication with families to help reinforce messages to seniors
- Grocery and meal delivery to suites limited reasons for seniors to leave the building
- Early implementation of screening programs
- Focus on mental health for residents such as balcony visits, hallway programs

"The reason BC did so well, is that we were quick to implement protocols we learned from other provinces."
– Independent living provider

Challenges

Independent living providers identified many areas for improvement, with the most crucial being the recognition of the role independent living plays in the seniors care and living continuum. Independent living was omitted from much of the communication, support, and funding provided by the Provincial Health Officer, the Ministry of Health and health authorities. Smaller, single sites were left completely on their own to source information and resources.

Seniors who live in independent living are functionally independent and able to direct their own care. Residents often receive hospitality services (such as meals, housekeeping, recreation services etc.) and access to amenities. In addition, it is also not uncommon that residents receive external care or support services from privately retained home health providers and/or family members and friends. As a result of this independence providers and staff were not made aware of COVID-19 test results. There was confusion whether or not providers would not be involved if there was potential exposure in the building. Further, in some cases seniors living with dementia symptoms did not understand the call received regarding their results. It is possible that they would have benefited from assistance from the staff.

Impact to operations

The financial impact of the pandemic to independent living providers is significant. Providers experienced increases in PPE, labour and food supplies, disposables, tray delivery, extra staffing for screening, overtime, and sick leave. Many sites have also allowed seniors to break their lease to move home with family but are not filling units quickly as there is some reluctance to move into congregate living.

The single site order that limited staff from working at more than one site was not applied to home health workers. As a result, independent living sites may have multiple home health workers coming and going,

creating a higher risk than necessary and an imbalance in the freedoms among staff and between staff and residents.

"Staff rights were put above seniors. Seniors had to stay in one space but staff did not."
– Independent living provider

"I cannot believe pandemic pay was not offered to private pay assisted living or independent living. There is no difference in our staff. A food server has the same role, same risk, no matter if they are in a private- or publicly-funded site."
– Independent living provider

Other challenges included:

- Incredible workload on leadership and management, in addition to front line workers
- Synthesizing and implementing massive, ongoing changes
- Excessively high costs of PPE
- The introduction of the Canadian Emergency Response Benefit dampened efforts to hire multi-skilled support staff

Preparing for a second wave

Greatest concerns regarding a second wave

Providers overwhelmingly agreed that worker shortage is their number one concern regarding a second wave of COVID-19 in BC, which is compounded by limits on casual workers as a result of the single site order. Following this, worker exhaustion, fatigue, and burnout (including senior management) is top of mind. Providers are also concerned about a lack of PPE and other supplies, and the strain of managing visitation, including 'message fatigue' among family members.

"We are very short of Care Aides and Registered Nurses. There are very few resumes out there - staff are very tired from no vacations and overtime, which greatly increased as we lost capacity due to the single site order. This is concerning because when people are tired they make mistakes."
– Long-term care provider

"We have some staff that are working so much and burning out. We have staff with health problems from the stress and/or working so much. I am really worried about the health of my staff the most and the additional workload, stress, and anxiety."
– Long-term care provider

"Staff are having PTSD symptoms… we are anxious about another outbreak. We have overwhelming exhaustion. There has to be more help for smaller organizations."
– Long-term care provider

"As I talk to my peers, I hear how many people are thinking of retirement. It is frightening to me how many people I hear this from. There will be gaps in leadership."
– Long-term care provider

Preventing a second wave

Investment in health human resources was identified as the most important long-term action to improve seniors care and living in BC. More immediately, providers identified the following top priorities in preventing a second wave in seniors care and living in BC:

- Screening for COVID-19; rapid testing for everyone entering the building
- Stable, available PPE through a provincial stockpile
- Infection control procedures and adherence
- Strict visitation policies that limit visitors and ensure social distancing
- Adherence to social distancing, mandatory masks
- Training and education on PPE and infection control measures
- Investment in infrastructure
- Clear, consistent communication led by the Provincial Health Officer
- Communication to providers before the public to allow for planning and to reduce frustration among residents and families

"We desperately need additional staff, especially if current staff get sick."
– Long-term care provider

"We need additional support staff, housekeeping, food services and administration staff."
– Long-term care provider

Discussion

The purpose of this engagement was to provide the BCCPA Board of Directors with a report of the impact of COVID-19 in the seniors care and living sector in BC along with actionable recommendations for the Ministry of Health. The discussion explores gaps in the draft recommendations submitted to the Ministry to uncover new areas for consideration followed by a summary of provider input with revisions and additions indicated.

Gap analysis

The literature review[14] identified a number of gaps in the draft recommendations that may warrant further consideration. Below is a discussion of the gaps with a comparative analysis based on the sector engagement which identifies where additional recommendations may be necessary. Overall, engagement findings aligned well with the literature.

Gap identified from a review of the literature (Kary)	Alignment with engagement findings (Howegroup)
Testing: A testing strategy is required for BC's seniors care workers, particularly as many workers and residents may be asymptomatic.	Findings from the engagement support the need for access to rapid testing alongside a testing strategy for workers and seniors.
Focus on quality: There is a need for a quality framework, particularly with regard to COVID-19.	The engagement highlights the many ways seniors' rights and freedoms were impacted by the response to COVID-19, including being socially isolated with limited access to services. The engagement highlights the need for a quality framework particularly to address times when seniors must stay in their suite for extended periods.
Surge capacity: Having the necessary health human resources for facilities in outbreak status or that are facing significant shortage. Some European countries have developed regional networks and clinical support teams.	Providers are concerned about human resources ongoing as well as the need for support during an outbreak. Providers stressed the importance of adequate training in PPE and infection control among these supports. Providers also indicated these external supports, who have experience in acute care, do not necessarily have the skills and understanding to work in seniors care. Beyond human resources, there is a need for a PPE stockpile, and corresponding plan, to respond to surges in demand in the event of localized or regional outbreaks.

[14] Kary, Michael. Draft literature review and gap analysis report on COVID-19 and seniors care in British Columbia. September 20, 2020. BC Care Providers Association.

Provincial Guidelines: Although the draft recommendations outlined the importance of a standardized pandemic plan, it may be possible to be more specific and include alert levels with corresponding protocols.	Providers feel strongly that a single source of communication to support provincial guidelines is necessary to support the health and safety of residents and workers.
Supports for community care: Beyond long-term care and assisted living, it will be important to include home care and independent living.	Providers strongly agreed that independent living and home health were largely excluded from the support and communication of the Province, including health authorities. Providers would like home health and independent living acknowledged as important players in the continuum of care. Providers would like to see these areas explicitly addressed in the recommendations moving forward and would like to see a greater integration and coordination across the continuum of care.
Community transmission: As a main factor contributing to COVID-19 outbreaks, limiting staff infection (and unknowingly bringing it on-site) reduces the risk for seniors. Providing accommodation for staff or staff confining themselves with residents provides a protective factor from outbreak.	Community transmission was identified by providers as a key contributing factor to outbreaks. Providers did not discuss providing staff accommodation or confining staff with seniors as a possible strategy to limit transmission. This warrants more discussion.
Physical environment: In addition to decommissioning multi-bed wards, the literature suggests advantages of self-contained small homes with clustered activity rooms. This allows for seniors to be compartmentalized based on risk as well as more easily isolated.	Providers agreed infrastructure played a role in the transmission of COVID-19, however was less of an issue in BC (with fewer multi-bed rooms). Providers would like to see investment in infrastructure however this was not seen as the most immediate need.
Supporting innovations: In addition to physical redesign, funding for innovations is recommended such as a COVID-19 Innovation Fund to assist non-government independent living, assisted living, and long-term care homes ensure safety, quality of life, and reduce social isolation.	Providers would welcome innovation support for non-government independent living, assisted living, and long-term care homes. Smart technologies to reduce workload pressures to enhance healthcare delivery and support social connections/reduce isolation, in collaboration with family, as partners in care, and would be of benefit.
Determining or prioritizing the effectiveness of approaches: A review of the literature emphasizes the importance of prioritizing the effectiveness of approaches toward reducing the transmission of COVID-19 in BC.	Through this engagement, providers identified approaches they deemed as most effective in the reducing transmission in BC. Next steps may be to explore which are sustainable over the long term, which would be effective in a new/different outbreak and which are generalizable to other jurisdictions beyond BC. Beyond the ten gaps identified in the Kary literature review, Howegroup recommends: 1. more dialogue around the rights of seniors 2. more dialogue around the rights of workers

Recommendations

Aligning with the findings from the engagement and the comparative analysis, the following recommendations regarding pandemic preparedness and coordination, reducing infection transmission, supporting staff and operators, and providing social supports are put forth to the Ministry of Health.

Ten priority recommendations

1. The Ministry of Health provide an **overarching pandemic plan** with clear lines of responsibility and for communication across the continuing care sector, inclusive of publicly subsidized and privately retained home health and independent living. This provincial plan for all health regions should clearly identify which guidelines and/or mandates takes precedence. When a public health emergency is declared, the authority for issuing pandemic-related orders should be restricted to the Provincial Health Officer. Communication to seniors, providers, and families should be limited to a single source, as much as possible.

2. Health authorities adopt a **standardized pandemic response plan** for the continuing care sector, inclusive of publicly subsidized and privately retained home health and independent living, which clearly outlines what happens in the event of an outbreak. This plan, shared and implemented consistently across all health authorities, should include details of how health authority infection control teams will be mobilized in the event of an outbreak, as well as incorporating all necessary safety guidelines. This plan must also outline the measures that will be taken to support any necessary unique considerations for rural and remote areas, the nature of health care personnel, and staffing limitations.

3. Continue the **single site order** policy for staff in long-term care and assisted living residences. Measures must be put in place which address the loss of casual employees needed for sick day and vacation relief. Consistent with the intent of the single site order policy, the Ministry of Health should expand the single site order to include acute care employees from working in long-term care or assisted living residences. Providers require additional financial resources for staffing to sustain the single site order. *Note government investment already committed to support this recommendation.

4. Create additional capacity and more suitable environments that ensure **reduced transmission of infectious diseases among residents with advanced dementia** and socially inappropriate behaviours.

5. The Provincial Health Officer to **establish rapid testing** alongside screening protocols for residents and staff in long-term care, assisted living, and independent living.

6. **Address critical staff shortages** by expanding training for new and established care staff. Fund roles such as ‘Comfort and Support Workers’ or ‘Pandemic Workers’ or ‘Personal Support Workers’ to perform non-care tasks and functions in the care setting to alleviate the burden on direct care tasks completed by care aides and nurses. Target unemployed workers such as in the hospitality sector and internationally-educated nurses (IENs) for recruitment and onboarding programs. Work with the federal government to extend the number of hours that international students can work and expand the post-graduation work permit program to include private post-secondary institutions.

7. **Maintain funding for wage levelling** and extend to staff across the continuum of care in order to provide equitable pay for frontline staff. Develop clear guidelines, consistent messaging, and ongoing funding for sustainability.

8. **Support psychological health and safety programs for workers, residents/seniors and families**. Coordinate these efforts with BC's Ministry of Mental Health and Addictions.

9. Ensure the **timely dispersal of allocated per-bed funding advances** to cover provider pandemic-related expenditures for PPE, staffing, and other requirements. Pandemic funding should be concomitant with any orders to implement add-on procedures that require additional staffing, equipment, and supplies. All advanced funding will be subject to reconciliation. Clear guidelines provided on allowable expenses.

10. Establish **robust protocols for safe and frequent social contact between residents and family members**, in collaboration with SafeCare BC. Strengthen connections between families and seniors through the use of tools and technology.[15] Establish **clear and consistent visitation guidelines** directly from the PHO to support visitation across the province. The PHO is asked to consider a flexible approach to restricting visitation, reflecting COVID-19 community case numbers.

Additional recommendations are as follows:

Pandemic preparedness and coordination

11. In-person inspections be conducted regularly, more frequently for pandemic preparedness and in-person. **Audits and inspections should be streamlined and consistently implemented across all health authorities**, with results shared directly with management and staff to support quality improvement. Recommendations that require additional resources for infection prevention and control measures and equipment must be supported with additional funds or by issuing recommended supplies and equipment.

12. Where appropriate, **communication will be disseminated to providers in advance** of public announcements in order to support enhanced planning and mitigate confusion among seniors and families.

13. Formalize the **partnership between the Ministry of Health and BCCPA to support communication**. BCCPA is positioned to act as a conduit to engage the sector through its membership and to hold a key role in developing and disseminating a Ministry of Health's formalized communication plan.

Reduce infection transmission

14. Designate health authority **specialized COVID-19 units**, with the opportunity for providers, in collaboration with families, to exercise discretion based on resident need, site capacity, family preference, and system capacity to protect vulnerable populations. Staff assigned to work in these settings should qualify for bonus compensation.

15. Provide **clear and consistent guidelines on the proper use of PPE and standards for PPE supplies** for application in pandemic situations for health and community care settings across the continuum, including publicly subsidized and privately retained home health. Communication and guidelines to stem from BCCDC and all messaging to be consistent across health authorities. Coordinate with infection prevention specialists, and provincial/federal government procurement agencies and ensure ongoing continuing education.

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[15] *Note that BCCPA has developed a 'Best Visit Possible' guide in response to this need and that SafeCare BC is a natural partner as they have already developed an online Safe Visitation training module for families.

16. **Maintain the Province's PPE reserve** to cover the needs of the entire continuing care sector, inclusive of publicly subsidized and privately retained home health and independent living. Establish a mechanism for routine turnover of PPE stockpile, such that they do not expire and that the stockpile must have the capacity to meet surge demands. *Note the Province's Provincial Supply Chain Coordination Unit is making its stockpile of PPE available to a wide group of organizations, including private home care and community living.

17. **Establish a timeline for decommissioning the use of sites with multi-bed wards**, and work with these operators to replace them with newly created bed stock. The Province to establish a capital renewal program.

18. The Province to provide **equitable access to specialized infection control resources and equipment**, such as what is available now to health authority operated sites across the continuum of care, inclusive of independent living and home health.

Support staff and operators

19. **Support training programs** for long-term care, assisted living, home health, and independent living workers. The programs will be led by clinical nurse educators on the use of PPE, pandemic preparedness and maintaining relevant standards.

20. Create opportunities for discussion and action to **address the impact of the pandemic on seniors' and workers' rights**, leveraging BCCPA's Care to Chat forum.

21. **Formalize partnership between the Province and BCCPA**, given BCCPA's past work and commitment to HHR in seniors care. Designate BCCPA as the resource recruitment lead for the non-government sector.[16]

Provide social supports

22. **Support social worker and/or spiritual support professional positions and provide training** for residents, family members, and staff. Support those dealing with grief or the emotional toll of the pandemic.

23. Support a more formalized **sector collaboration with the BC Patient Safety and Quality Council/Patient Voices Network and SafeCare BC** to ensure continuous dialogue with seniors and families. Promote systemic and operational improvements that enhance the resident and family experience.

24. Incorporate learnings into the **BCCPA Quality Framework** in the context of a pandemic, including a discussion around seniors' rights.

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[16] Since 2018, BCCPA has undertaken multiple measures to analyze and resolve the crisis, including hosting a sector-wide collaborative with care providers, government, labour unions and training colleges; issuing two reports outlining the scale of the crisis and providing 10 recommendations on how to resolve it; establishing a $25,000 HCA bursary program in partnership with Okanagan College; partnering with Health Match BC to design their new Choose2Care recruitment campaign; and delivering the provincial approved HCA curriculum to 80 students in communities on Vancouver Island and in the Interior in collaboration with our education partners Discovery Community College and SafeCare BC.

Overview of continuing care investments made by the Province of BC

During this engagement the Province has committed to the following continuing care investments, which will support several of the recommendations.

- **Infection prevention and control:** $1.7 million to provide training and supplies for 450 community care and long-term care homes throughout the province.
- **Incremental costs:** $26.6 million as one-time block funding to address costs incurred by long-term care and assisted living service providers such as deep cleaning, meal delivery, personal protective equipment (PPE), and security.
- **Single site wage top-up:** $165.4 million to cover health-care staff and service-provider costs related to the single-site directive, which restricts staff to work in one facility to prevent the spread of COVID-19.
- **Screening staff and visitors:** $122.4 million for up to four new staff per site for long-term care and assisted living facilities throughout the province to support infection prevention and control for a total of 1,752 FTEs.
- **Additional staff**: $97.5 million for an average of five new staff to address operational capacity in the long-term care and assisted living sector at 584 sites throughout the province, for a total of 2,920 full time equivalents.
- **PPE:** $146.7 million for additional PPE across the health-care system.
- **Recruitment and training:** $44.1 million for health authority and Health Employers Association of BC recruitment of 4,000 staff and for training of 3,000 new entry level community/long-term care staff at an average $12,000/FTE.
- **EquipCare BC:** $10 million program, managed by BCCPA. The funding targeted both funded and private long-term care and assisted living to help providers acquire infection prevention and control products as pandemic protection. Announced April 3, 2020.
- **10-year capital plan**: $1.4-billion to build new long-term-care facilities and eliminate multi-resident rooms, as well as providing greater oversight of private operators of seniors' homes and a continued wage bump to have staff work at just one site.

Further, SafeCare BC announced on September 3, 2020 that the Province of BC's Provincial Supply Chain Coordination Unit is making its stockpile of PPE available to a wider group of organizations, including community services such as private home care and community living providers.

Conclusion

The purpose of this engagement was to provide the BCCPA Board of Directors with a report of the impact of COVID-19 in the seniors care and living sector in BC along with actionable recommendations for the Ministry of Health. This engagement has:

- Revealed factors that contributed to flattening the curve and to the transmission of COVID-19
- Emphasized systemic HHR challenges, compounded by the single site order, wage levelling, and pandemic pay
- Uncovered challenges with PPE, communication, visitation, and moving COVID-19 positive seniors
- Highlighted the financial impact among providers and the burden of audits and reporting
- Reported on support from sector associations
- Uncovered how senior and worker rights have been impacted
- Documented issues specific to home health and independent living
- Provided considerations for a second wave

Throughout the engagement, providers acknowledged the tremendous effort put forth by all – government, health authorities, unions, associations, providers, leaders, and workers – in very uncertain times. The pandemic underscored the pre-existing health human resource crisis in BC, including reliance on casual workers and employees working at multiple sites.

"I've raised babies, cared for parents with cancer 24/7, this is much worse. There has to be more help for smaller organizations. I am burned out."
– Long-term care provider

The shortage of PPE, particularly early in the pandemic (and limited capacity to support surge demand) further contributed to the transmission of COVID-19. The engagement highlights significant challenges associated with communication – there is a lack of clarity and consistency from the Province which must be addressed moving forward including a single source of information for providers, seniors, and families and clear hierarchy with the health system. Providers believe restricting non-essential visits was key early in the pandemic, however, they also feel that the social and emotional toll on seniors is unacceptable and this must be addressed through funding to support seniors and families. The use of smart technologies will enhance social connections/reduce isolation, in collaboration with family, as partners in care. With a greater understanding of COVID-19 and the relative effectiveness of actions taken to limit the transmission, seniors' and worker rights must now be moved to the forefront of the discussion.

Several providers also reported lost revenue from an increased vacancy rate. Others commented on the unknown costs associated with staff burnout and mental health and wellness that are anticipated in the future. As well, there are concerns that significant increases in wages will ultimately be passed onto seniors, further impacting affordability of care.

Providers are deeply concerned about the workforce moving forward including the limit on casual workers, and mental health challenges and burnout at all levels including workers, managers, and senior leaders. **The sustainability of the sector is at risk without further attention to health human resources.**

The seniors care and living sector is comprised of long-term care, assisted living, independent living, and home health, delivered through various operational models. Each of these provide essential care, housing, and hospitality services to seniors throughout the province. The Province must recognize the contribution across the spectrum, and provide resources and supports to ensure seniors have the highest quality of life possible, and create safe conditions for all workers. Greater integration and coordination across the continuum of care will improve a response to a second wave.

Collaboration within the sector facilitated the response to COVID-19, with BCCPA playing a significant role in communication with members, advocating on behalf of providers and delivering key initiatives. BCCPA is well-positioned to act as a conduit to engage its members within the sector and to hold a key role in supporting the development and disseminating a formalized Ministry of Health communication plan. As well, with demonstrated commitment to advocating for a sustainable seniors care and living workforce, BCCPA is also well-positioned to partner with the Ministry of Health as the resource recruitment lead for the Province's non-government care and living sector.

"There is now a spotlight on long-term care and seniors. This is our opportunity to embrace some of the systemic issues that we have been struggling with for years. This may be the silver lining that it's emphasized the need for health human resources."
– Long-term care provider