COVID-19 and long-term care

Deaths from COVID-19 have disproportionately affected seniors living in long-term care. Only 1% of Canadians reside in long-term care, but these deaths represent 80% of all COVID deaths in Canada.[1] This statistic is a result of issues that have been worsening for years; it is unfortunate that it took a pandemic to unmask the shortcomings of our long-term care facilities.

Three factors have made care facilities particularly vulnerable: the staffing model, aging facilities, and a frail, dependent client population. The problems with staffing are structural. Inadequate pay and part-time hours require care aides to work in more than one facility, allowing infections to spread between care homes. Lack of sick pay and a shortage of staff may have also encouraged some individuals to continue working even after becoming ill. Additionally, low pay has led to high staff turnover and reliance on temp agencies, which reduces staff familiarity with infection control measures.

As for the facilities themselves, many have shared bedrooms and bathrooms as well as crowded public areas, which make physical distancing difficult and negatively affect the organization's ability to meet cleaning standards. Work conditions were made even more challenging by limited access to personal protective equipment (PPE), as well as staffing shortages resulting from sick or quarantined staff. To be clear, individual health care staff are not at fault. Many continue to work despite fears for their own safety and while grieving the loss of residents for whom they have cared.

Prior to the pandemic, the BC Ministry of Health had increased the number of hours at care facilities to 3.36 from 3.14 hours per day, per client. While welcome, this increase is likely still inadequate. In less than 3.5 hours per day, staff are expected to provide each client with medications, personal hygiene, feeding, mobility assistance, and other services. This client population is becoming increasingly dependent and complex. Many live with multiple comorbidities, with an average of 65% of the clients being significantly cognitively impaired and 30% completely dependent on staff for all activities of daily living.[2,3] Those with dementia may wander throughout the facility, unable to practise proper hygiene.

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During the pandemic, steps have been taken to alleviate these problems. Staff are banned from working in multiple facilities and have been receiving full-time pay. Residents and workers are screened for illness, and PPE supply has increased. A rapid response SWAT team of infection control specialists was created to quickly respond to outbreaks. Care facilities have banned all visitors (excluding compassionate visits), leaving families struggling with their inability to see their loved ones, worrying about their health and well-being, and being unable to supplement care.

What can physicians do to help their clients in care? First, we can advocate for adequate funding to provide safer, more effective care. Consider supporting the national call to bring long-term care under the Canada Health Act, which would include targeted federal funding, national standards of care (including an increase to 4.1 hours of care per day), and place limits on private, for-profit care.[1,2,4]

Second, we can discuss goals of care with clients and/or their families. For clients who may not benefit from acute care transfer and hospital admission, it is important to communicate this well in advance. Inform them about the availability of care in facilities, including palliative care options.[5] Many frail, elderly patients at the end of life would prefer to receive care in their facility, which is their home, rather than be transferred to hospital for uncomfortable and ultimately futile care.

Finally, physicians can suggest ways for families and friends to stay in touch with their relatives in care. Options include phone or video calls, or old-fashioned letters and postcards. Families may also drop off familiar objects from home (with permission from the facility to ensure proper hygiene protocols are followed) or arrange visits that respect physical distancing, with the client inside and the family member outside a plate-glass window. ■

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This article is the opinion of the Geriatrics and Palliative Care committee, a subcommittee of Doctors of BC's Council on Health Promotion, and is not necessarily the opinion of Doctors of BC. This article has not been peer reviewed by the BCMJ *Editorial Board.*

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