Long-term Care: Behind the Curtain

By Crystal McCallum, RN MCISc

The horrific infection and death rates in long-term care (LTC) due to COVID-19 have illustrated the chronic under-resourcing faced by the facilities charged with caring for our most vulnerable Canadians. To help alleviate staff shortages, furloughed physicians and military personnel were brought in to assist as care aides. Several factors contributed to the staff shortages during the pandemic:

- Facilities were already running lean before the COVID-19 outbreak.
- Staff were restricted from working at more than one facility to reduce transmission from one location to another.
- The number of staff ill from the virus—and thus restricted from work—was relatively high in LTC.

Crystal McCallum, Director of the Wounds Canada Institute, has had extensive experience working in LTC as a PSW (personal support worker), RPN and RN. Below, she outlines her experience of a typical day and evening shift in LTC pre-pandemic, pulling back the curtain on the demands placed on personal support workers inside such facilities. When asked what her advice would be to the health-care workers and military personnel being deployed into LTC to assist with the personal care of residents she said: "If I had never worked in long-term care, I would need to know more about the culture of care—what a day looks like in long-term care."

She provides here an outline of what most "outsiders" don't realize happens every day. Even without the added challenge of a pandemic, is the scenario she reveals an appropriate or humane way to treat our most vulnerable residents and the people who care for them? (See companion article, "Wounds Canada's Response to the Canadian Armed Forces' Report on Their Experience in LTC During the Pandemic," on page 18.)

Day Shift

On day shift, residents in LTC, in general, must be awake, have received or been assisted with personal care and be in the dining room by 8:30 a.m. Personal care may include varying degrees of assistance with activities of daily living such as:

- Personal hygiene (modified bed-bath, hair care, shaving of facial hair, oral care, application of any treatment creams, deodorant and/or make-up)
- Toileting and/or incontinence care (including the emptying of any collection devices like catheter and ostomy bags)
- Dressing (including the application of compression garments when in use)
- Application of glasses and hearing aids (if in use)
- Application of treatment creams (if in use)
- Transfer to a wheelchair (if the resident uses one)
- Bed making (stripping and remaking the bed if it is soiled)
- Assistance with walking or locomotion to the dining room

With very few exceptions, ALL residents must eat/be fed in the dining room.

Transfers may require the use of mechanical lifts or other transfer aids such as canes, walkers or transfer boards/discs/poles/belts. Roughly 90% of residents require extensive assistance with activities of daily living.[1]

PSWs are also responsible for ensuring fall prevention strategies are in place throughout their shift. This may include the application of personal alarms, bed alarms or fall mats. They must also ensure that oxygen tanks have been filled and are appropriately set for residents requiring oxygen therapy. They fill tanks that are empty or partially empty and replace tubing and masks on a routine schedule. PSWs may also be asked to capture urine samples or obtain nasal and/or rectal swabs for monitoring purposes during this time.

PSWs are also to ensure that if in use, any pressure redistribution devices, such as therapeutic mattresses and seat cushions, hip/elbow/heel protectors, and bed positioning devices are in place and functioning properly. This task is ongoing throughout the day.

On average, two personal support workers provide this care for about 20 residents over a two-hour period. That's roughly six minutes for each pair of PSWs to provide each resident with personal care each morning.

In the dining room, PSWs are responsible for providing residents with varying degrees of assistance with eating and drinking (including the

consumption of nutritional supplements). This assistance varies from supervision to extensive assistance, meaning the PSWs feed the residents. Due to high rates of dysphagia, diets vary from regular to thin or thickened fluids, and from regular to soft, minced or pureed food. Roughly 75% of residents require assistance with eating. Of residents in long-term care facilities, 65% are diagnosed with hypertension, 28% with diabetes and 26% with gastrointestinal disease.[1] On average each pair of PSWs has one hour to assist 20 residents with eating and drinking. That's roughly three minutes per resident.

After breakfast, each pair of PSWs is responsible for:

- Providing two to three of their residents with bathing or showering assistance (residents receive two baths/showers per week and more if incontinent). Assistance with bathing also includes assistance with nail care, weighing the resident and measuring their height (monthly).
- Providing all of their assigned residents with varying degrees of assistance with toileting and/or incontinence care (including the emptying of any collection devices such as catheter and ostomy bags). On average, 79% of residents have bladder incontinence and 59% have bowel incontinence.[1]
- Assisting roughly half of their assigned residents into bed or a reclining chair for a morning rest. This may require the use of mechanical lifts or other transfer aids.
- Serving a morning snack to each resident (and providing eating and drinking assistance to those who require it)
- Assisting residents to activities within the care home

On average, each set of PSWs has roughly two hours to complete all of these tasks for or with their assigned residents before getting their residents back to the dining room for lunch. That's roughly six minutes per resident per pair of PSWs. During this time, each PSW is to have taken a 15-minute break.

Lunch is a repeat of breakfast.

After lunch, each set of PSWs is to provide their

assigned residents with toileting assistance and/or incontinence care (including the emptying of any collection devices such as catheter and ostomy bags) and assist roughly half of their assigned residents into bed or a reclining chair for an afternoon rest. This may require the use of mechanical lifts or other transfer aids. Any baths/showers that were not completed earlier in the shift are completed now.

On average, each set of PSWs has roughly two hours to complete all of these tasks for or with their assigned residents. That's roughly six minutes per resident per pair of PSWs. During this period, PSWs are to have taken a 30-minute lunch break and a 15-minute afternoon break.

Before the end of their shift, PSWs must have documented the following:

- Assistance provided to their residents during their shift
- Application of any treatment creams, compression garments and/or visual or hearing aids
- Use of any fall prevention equipment and/or oxygen therapy provided
- Amount of food, fluid and nutritional supplement intake of each of their residents
- Behaviours exhibited by their residents and whether or not their resident complained of or displayed signs of pain or impending or actual skin damage
- Amount of urinary output and/or their weight and height

Evening Shift

On evening shift, each set of PSWs serves afternoon snacks to their assigned residents (and provide feeding and drinking assistance to those who require it). They provide assistance with toileting and/or incontinence care (including the emptying of any collection devices like catheter and ostomy bags) and assist residents to activities within the home. Like their colleagues on the day shift, PSWs on the evening shift must also ensure fall prevention strategies are in place, oxygen tanks are filled and set properly, and pressure redistribution and positioning devices are in place and properly used.

On average, each set of PSWs has roughly two hours to complete all of these tasks for or with their assigned residents. That's roughly six minutes per resident per pair of PSWs. During this period, PSWs are to have taken a 15-minute break. Residents are assisted to the dining room by 5:00 p.m.

Dinner is a repeat of breakfast.

After dinner, each set of PSWs is responsible for:

- Assisting residents to activities within the home
- Providing two to three of their residents with bathing or showering assistance, including nail care and weighing of the resident and measuring their height (monthly)
- Providing all of their assigned residents with varying degrees of assistance with toileting and/or incontinence care (including the emptying of any collection devices such as catheter and ostomy bags)
- Assisting their assigned residents with evening care—oral care, application of treatment creams, removal of compression garments, removal of glasses and hearing aids, changing into night clothes
- Assisting almost all of their assigned residents into bed. This may require the use of mechanical lifts or other transfer aids
- Serving an evening snack to each resident (and providing eating and drinking assistance to those who require it)

On average, each set of PSWs has roughly three hours to complete all of these tasks for or with their assigned residents. That's roughly nine minutes per resident per pair of PSWs. During this

period, PSWs are to have taken a 30-minute dinner break and a 15-minute evening break.

Before the end of their shift, PSWs must complete the same documentation as their day shift colleagues (see above).

This level of care is dictated by the Long-Term Care Homes Act, and compliance is monitored by the provincial ministry of health and long-term care—in this case Ontario's.

The PSW tasks noted above are usually possible to accomplish if no resident falls, becomes acutely ill (40% of residents need monitoring for an acute medical condition) or exhibits responsive behaviours, an unrealistic expectation in the average LTC facility. Over 90% of residents in long-term care today have some form of cognitive impairment (64% have a diagnosis of dementia), and nearly half of all LTC residents exhibit some form of responsive behaviours (45%).[1] Interpreting the needs of residents who cannot effectively communicate is challenging, and requires diligent assessment, investigation and intervention—which take significant time. PSWs are doing the bulk of this work. Physical and chemical restraints (e.g., antipsychotic drugs) are not the solution to responsive behaviours. In fact, LTC homes are penalized for such interventions.

Even under normal circumstances, this is a very stressful working environment and involves a tremendous amount of physical labour and psychological and emotional resilience on the part of the PSWs. PSWs strive to provide more than the basic level of care, while treating their residents with respect and dignity, allowing them to express themselves and participate in decisions, encouraging independence and providing for their safety and privacy. During peak COVID-19, the demands and consequences were overwhelming, and it is no surprise that the Canadian Armed Forces reportedly observed, in the LTC homes where they were assigned, neglect, improper care (including wound prevention and care), unsafe and unclean environments, and a lack of resident respect and dignity.

Wounds Canada's Response to the Canadian Armed Forces' Report on Their Experience in LTC During the Pandemic

By Amanda Thambirajah, Director of Government Relations, Wounds Canada

The recent news about the Canadian Armed Forces' reports on long-term care homes in Ontario[2] and Quebec[3] has been eye-opening for many people, but we are not surprised. Wound prevention and care have been problems across Canada in all health-care settings for some time—a point that Wounds Canada and other organizations have repeatedly raised in the past with governments and other decision makers.

Many of the observations in the military's report relate to horrific pressure injuries. For wounds to reach stage 4 or to be unstageable means that basic, common-sense risk assessment and prevention measures were not carried out. As health-care professionals know all too well, the sight and smell of such a wound are horrifying, and the distress, pain and harm to the resident are immeasurable. The fact that our long-term care homes had such severe wounds points to unconscionable gaps in a number of areas, among them a lack of expertise on site, poor co-ordination between long-term care, acute care and wound care experts, and inadequate policies or implementation of policies designed to provide even baseline care.

The military's report succinctly points out that long-term care staff have not been provided with the proper equipment, supplies

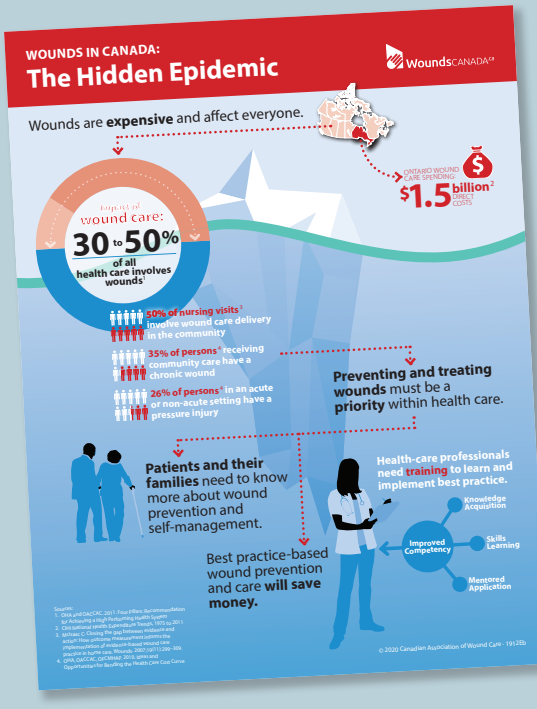
and training to prevent and manage wounds. To make matters worse, they seem not to have access to appropriate skin and wound care supplies as basic as barrier creams and dressings or adequate access to wound care experts. Instructions on repositioning to prevent and manage pressure injuries are not being followed. Inspections have been inadequate.

Wounds Canada has contacted various levels of government and put forward a series of recommendations that could be implemented quickly to help Canadian LTC homes. Wounds Canada recommends the following actions be taken immediately by the government ministries responsible for long-term care:

- Provide wound education and training to staff, for both regulated and unregulated health-care professionals
- Increase staffing,[1] equipment and supplies in long-term care homes, especially for wound prevention and care
- Ensure that regular and surprise quality inspections of long-term care homes are carried out by inspectors with working experience in long-term care, and that action is taken on identified issues. Inspectors should be equipped with the knowledge and skills to advise homes on strategies to improve quality.
- Ensure best practices related to wound prevention and management are implemented in all long-term care homes
- Improve access to wound care experts
- Ensure better co-ordination between long-term care, acute care and community care, and implement wound care pathways from hospital to home and community care with set measurables, monitoring and evaluation
- Develop policies that prevent wounds such as pressure injuries and infected wounds in long-term, acute and community care

Wounds Canada: Continued Advocacy

The wound care issues outlined in the military's report have long existed and been overlooked in LTC homes across Canada, as well as in acute care and community care. Wounds Canada has started hearing from health-care professionals that pressure injuries, amputations and infected wounds are on the rise across the health-care system because of pre-existing issues and the additional pressure that COVID-19 has placed on health-care resources.



Wounds Canada continues to advocate for a higher priority for wound prevention and care with all governments across Canada. Right now, Canada spends $4.3 billion on wound care. By investing in prevention and better management earlier on, if a wound occurs, patients will see improved health outcomes, and significant savings will result. We are asking the federal government to work with the provinces and territories to create national standards on wound care, and to ensure that any standards on long-term care include wound care.

We will continue these activities until governments across Canada provide the type of universal, accessible care that our most vulnerable citizens—and wound care patients—deserve.

References

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"Up-to-date knowledge dissemination, it's free, excellent case studies, excellent presentations."

– Participant

Project ECHO®

WoundPedia - Ontario Skin and Wound

"The interaction between the presenters and spokes. I gained a lot of new, valuable information that I will integrate into my practice."

– Participant

Dr. R. Gary Sibbald is a dermatologist/internist, wound care specialist. Recognized internationally for his research and clinical work, Dr. Sibbald helped launch ECHO (**E**xtension for **C**ommunity **H**ealth Care **O**utcomes) Ontario Skin and Wound Care.

We sat down with him to discuss ECHO

Q: Please describe ECHO. What attracted you to the model for skin and wound care?

A: Skin and wound care has traditionally been practiced in silos. Providers often work independently of each other, whether acute care, long-term care, nursing homes, complex continuing care, home care or other sectors. Doctors, nurses and allied health professionals are working in different locations under various models. This creates obstacles in providing integrated interprofessional care.

ECHO helps address this. ECHO moves knowledge, not patients. We connect with 20+ clinics at once via Zoom in weekly 2-hour sessions. We use a 'Hub and Spoke' model. The 'Hub' teaches a short didactic lecture based on International Interprofessional Wound Care Course (IIWCC) curriculum, RNAO Best Practice Guidelines and other expert resources. We then collectively discuss real, de-identified, patient cases submitted by 'Spoke' participants.

Q: How is ECHO different than telemedicine?

A: ECHO is designed to build capacity in the community and to link together the three key wound care professional groups: doctors, nurses and allied health. We do not take over responsibility of care of patients. Instead, we help participants care for their own patients, in their own communities.

Q: Who are the partners in this ECHO program and who is on your "hub" team?

A: Our program is funded by the Ontario Ministry of Health and Long-Term Care, through the Mississauga Halton LHIN. The three partners are WoundPedia, Queen's University and the RNAO. The Hub team includes family doctors, advance practice nurses, and allied health providers. We also have a roster of guest experts. Our program is part of a collective of over 20 ECHO programs in Ontario. We are accredited by Queens University and award CME credits to attendees.

Mississauga ECHO Hub Team

Q: What can a participant expect to gain? What are the obligations?

A: Participants gain experience through situational learning with an interprofessional collaborative approach. We discuss their patient cases. Many participants have found this extremely helpful for their wound care patients with complex needs who were not meeting expected care pathway milestones. We ask in return for regular attendance and we do expect participants to present at least one of their own cases for discussion. For more information visit our website.

Q: Is there a tuition fee and are there openings?

A: There is no charge for Ontario based providers. We have openings for October 2020, when we will discuss lower leg and foot ulcers and we have openings in January 2021 for pressure injuries.

ECHO Session

Topics discussed

Diabetic foot ulcers, leg ulcers, pressure injuries, wound bed preparation, infection, malignant, post-surgical wounds, traumatic injuries, peristomal, lymphedema, acute infection and other wound and skin care topics.