Experience of Working at a "COVID Facility"

Irfan Aslam

York University

For Correspondence:
Irfan Aslam, RN
School of Nursing
Email: iaslam@yorku.ca

Abstract
In the month of February and March, I closely followed news about the spread of Coronavirus (COVID-19), first in other parts of the world, followed by Canada. It was devastating to read about the havoc that the virus was causing. In this manuscript, I will outline my observations starting with the spread of COVID up till 30th of Oct, 2020.

Keywords: Covid_19, Canada, facility, PPE, observation.

Submitted: May 28, 2020 Revised: October 6, 2020 Accepted: November 20, 2020

In the month of February and March, I closely followed news about the spread of Coronavirus (COVID-19), first in other parts of the world, followed by Canada. It was devastating to read about the havoc that the virus was causing. My first direct encounter with COVID-19 patients was on March 16th, 2020. At the time, I was working as a clinical course director (CCD) for the integrated practicum and I visited a few students at a large downtown Toronto hospital. I learned that suspected COVID-19 patients were admitted on the unit. I informed this to the placement office and with the help of similar reports from other CCD's, York University ended nursing students' placements. Shortly thereafter, information spread surrounding the struggles within various long-term care facilities due to COVID-19. Numerous health care workers contracted the virus. According to Public Health Ontario (2020), almost 20 percent of all confirmed COVID-19 cases in Canada were health care workers, almost double the percentage of the global average of healthcare workers infected (Alam, 2020). On April 7th, 2020, the Ontario government launched "Health Workforce Matching Portal"; a tool to help match skilled frontline workers with employers (Ontario Public Services, 2020). After signing up through the portal, I was contacted by a human resource personnel. Following the initial phone screening, in which they inquired about my health status, education, experience, and living conditions including my ability to self-isolate. I was later asked to provide documentation including: my current Curriculum Vitae, three references with names, titles, contact details and a completed "Authorization to Obtain Employment Reference" form. After the initial documentation was submitted, I was contacted by another HR representative from a nursing home facing COVID-19 outbreak. They confirmed my personal information, gave me a brief history of their challenges with COVID-19; disclosing that both residents and health care workers have contracted the virus. I was asked to visit the site to ensure that I was comfortable. That same day, I visited the site, and began work the following morning. My responsibilities within this facility is related to infection control which includes education staff regarding infection prevention and control (IPAC) guidelines, conducting biweekly IPAC audits to ensure staff are adhering to IPAC guidelines, identifying risk factors and finding ways to eliminate or control those risk factors. I am the sole person on the infection control team so I gave myself the title of "infection control lead". In the next few paragraphs, I will outline my observations starting with the spread of COVID up till 30th of Oct, 2020.

Staffing: Adequate staffing levels in nursing homes prior to COVID-19 was lacking (COVID-19 Commission, 2020). During night shifts between the hours of 2300 and 0700, one Personal Support Worker (PSW) was responsible for the Activities of Daily Living (ADLs) of 30 residents, with the support of one registered practical nurse (RPN) on the unit and one registered nurse (RN) for the entire institution. Numerous staff members have raised concerns about working these night shifts; expressing feeling unsafe with the minimum staffing ratio during nights and worry surrounding emergencies including fires, falls, emergency transfers to the ER. As one PSW is responsible for the physical care of 30 residents, a single incident overnight can disrupt the care and safety of others. A particular concern is the possibility of a fire during the night shift. The evacuation of all residents through stairwells even with a staffing of two per unit would be an impossible feat.

Compensation for employment within long-term care facilities is so low that they are unable to attract experienced RNs and RPNs (COVID-19 Commission, 2020). As a result, most nursing staff employed are novice. Staff members are taking care of residents whose care requirements have increased with each passing year. Unlike hospital settings, where the staffing ratio is higher and is a good mix of senior and junior staff, in these long-term care homes, novice staff cannot seek advice or support from senior employees.

After the start of the COVID-19 outbreak, some staff members simply walked away for various reasons; lack of personal protective equipment (PPE), low wage, worries about personal and familial health, etc. I am not in a position to pass a judgment on their decision; I empathize with staff who walked away or were left behind. This led to an acute shortage in staffing; remaining staff were faced with unsafe and unsustainable workload. Some staff members were infected with the virus, which did not help the situation. There were days when 20-30 residents were being cared for by 1-2 staff members. This is one key factor in the spread of virus, infection control protocols are only implementable when the workload is manageable.

Almost all the care facilities that are housing resident with COVID-19 are being labelled as COVID facilities by the media and general public. The label of so called "COVID facility" also makes it extremely difficult to fill vacancies as new applicants are afraid of catching the virus. The applicant rate is low, making it very difficult to replace staff that had left or were away due to illness. I have witnessed instances where people who applied to one of these facilities before the COVID-19 pandemic, declined job offers as a result of the outbreak.

On the other hand, some retired staff volunteered to return to work. It is hard to imagine the facilities' survival without their support; most of these selfless staff members are over 60 years of age, at high risk for catching the virus, yet work tirelessly to ensure others' needs are being met (Pearce, 2020).

Personal Protective Equipment (PPE): At the beginning of the outbreak, there was a shortage of PPE. It took at least a month before staff were able to replenish their initial shortage. Community support played a huge role in this; volunteers donated more than 500 washable gowns for health care staff to wear while providing direct care to residents. Numerous anonymous donors supplied re-usable caps, face shields, face masks, gloves, etc. I will never know who these generous people were, but remain indebted to them.

On the other hand, various well-known companies increased prices for PPE tenfold. An N-95 mask that previously cost 20 cents pre-pandemic was being sold for two dollars a unit. Disposable gowns were being sold at $4 per gown, whereas pre-pandemic they were sold for 35 cents each.

Support from experts: Facilities also received support from experts from public health as well as large hospital systems. Without the expertise and day to day guidance from these experts, it would have been very difficult to implement changes at an effective pace.

COVID-Premium: Due to the shortage of health care staff, many long-term care facilities rely on outside agencies to supplement staffing. These agencies normally charge anywhere between $ 50–60 per hour for a personal support worker (PSW), while the PSW is paid anywhere

between $ 22–30. The hourly rate for registered practical nurses and registered nurses is much higher. Some staffing agencies are also charging "COVID-19" premiums, an extra $ 30 per hour for nurses. Staff, on the other hand, have only seen a very minimal increase in their salary.

While we are on the topic of health care agencies, I have also encountered agency PSWs with no background in health care; some of them are refugees while others are international students in fields such as computer science. In essence, the profits from COVID-19 premiums are being paid to agencies to send untrained individuals with little to no knowledge about infection control into these facilities. This practice not only increased the transmission of the virus as the workers with no background in health care are more likely to make errors while following the IPAC guidelines, endangering the lives of both residents and health care workers.

Cleaning companies: At the beginning of the outbreak, almost 30% of housekeeping staff contracted COVID-19. This led to a severe decline in the number of staff who were trained to clean and disinfect surfaces correctly. It was recommended that staff leads should contact companies to perform terminal cleaning of the entire building as well as to sustain cleaning practices until the in-house staff can get better and take over those responsibilities. Throughout the pandemic, cleaning companies are charging anywhere between $50,000 - $100,000 to disinfect 50–75 rooms. This is a 4-5 days long job with a cleaning crew of 3-5 people. The average cost pre-pandemic for this kind of work is $5000. Even with these exuberant costs, nursing homes had no choice but to hire these agencies because Toronto Public Health was reluctant to lift the 'outbreak' label until the environment was disinfected. In other words, these facilities are at the mercy of these companies. I spoke with some of the front-line cleaning crew that these companies had sent and discovered that they were being paid between $20 to $25 per hour, meaning that labor cost remained at $5000 per contract, and the rest was the law of supply and demand. I wonder whether the operators of these companies would cry injustice if we were to ask for more to administer our services when they are in need of health care.

Physical environment: No one would wish to spend the last few years of their life in a hospital. This is one of the main reasons why long-term care settings do not wish to look and operate like hospitals. These facilities try to give their residents a home-like (in my opinion, it appears more like a hotel) appearance; residents usually dine in a large dining area, staff move freely from one resident to the other, residents move around facilities throughout the day for group activities, etc. In the event of an outbreak, this environment is a severe limiting factor in combating, preventing and containing disease, especially among residents and staff that may be infected but are asymptomatic. In addition, due to budgetary factors, many older nursing homes only have double and ward rooms. This makes it difficult to isolate residents they become symptomatic.

Staff Competence: Most health care workers in the long-term facilities are PSWs, who require a six-month Personal Support Worker certificate, RPN's are the second most common employee at the facility, and there is usually one or two RNs in the entire facility. The workload for PSWs on a normal day even before the outbreak was exhausting; they are assigned to 8 – 12 residents and are responsible for all the personal care, feeding, as well as other activities of daily living (COVID-19 Commission, 2020). This

creates an environment where PSWs can experience burnout. Despite that, most PSWs are extremely committed and extremely knowledgeable about the residents. They know what residents like and dislike and how to keep them happy. However, many staff members lack basic knowledge about infection prevention and control.

Most of these staff members have developed muscle memory, enabling them to bathe 8 residents in 2 hours or feed 4 residents in 30 minutes. It is awe inspiring to observe them work, but these working habits are also a barrier in preventing infections. The inclusion of infection prevention and control policies severely disrupts their well-practiced routine; it slows them down and as a result, their first inclination is to resist. This makes it challenging to implement infection prevention guidelines in the midst of a pandemic as there is no time to conduct a thorough needs assessment with input from all individuals, wait for buy-in from the staff, and include them in preparation and dissemination of infection prevention and control guidelines.

Job Security: Many of the staff members have complained about the lack of full-time positions. Some workers have been working for 20 years with no full-time position available. As a result, they have no choice but to seek employment in other institutions, increasing the risk of the spread of infection. Part-time staff have hopes of obtaining full time positions, however they are told by administration that no funds are available to increase staffing or offer full-time positions with benefits. Many staff admitted to remaining silent about concerns due to fear of being reprimanded. These factors lead to risk of spreading the virus and that has gotten a lot of media coverage, forcing government to implement temporary changes such as mandating health care workers to hold one job. This also leads to less publicized issues, such as financial worry, physical injury, and mental anguish for not being able to make ends meet. This points to what nurses have known for years; i.e. proper policies and training for staff are needed before expecting different results (Phillips, 2020).

Stress: All the challenges mentioned above create a lot of stress. In addition to front-line workers, I have also observed management teams being under tremendous stress. There is vocal support for front line health care workers as they are seen as putting their life at risk for the sake of others. Management, on the other hand is considered responsible for the current situation, therefore, no one empathizes with the management. Management is facing enormous challenges when it comes to procuring staff, PPE and various other supplies. There is pressure from the families as they voice concerns about the unpreparedness of facilities, about their loved one's care needs, and about not being able to visit. There are financial pressures exacerbated by the opportune behaviour that I mentioned above. There is pressure to house staff in hotels, from the board, the ministry, family council, workers union, and the list goes on. Management members have also fallen ill due to COVID-19, which leaves the task of handling these pressures on the shoulders of fewer people. For most front-line staff, the lifting of outbreak and "COVID Facility" label will bring a welcome relief but that would not happen for the management as they will have to face inquiries, investigations and law suits. I have never envied the job of management, and this experience has not changed my mind.

Heroes / essential workers: I have spoken with a lot of health care workers and all of them are dismayed with the titles (hero, angel, saviour, etc.) that are being touted in the media towards them and their work. A lot of these slogans feel empty, especially when considering that the pay raises for least paid workers like PSW and RPNs are temporary. They try to laugh it off with quirky comments such as "my grandkids will be proud to know that their dead grandmother was essential". Even if companies do not want to compensate nurses fairly, pay should be increased for PSWs. Some health care workers also expressed dismay over public gatherings against public health restrictions with comments like "go ahead and spread the virus. After all, you have designated heroes to face the consequences".

Most workers at nursing homes and retirement homes are extremely hard working, they are familiar with the residents and their families, they provide culturally competent care, and have developed strategic and efficient ways to complete the required tasks given their time constraints. Unfortunately, due to short staffing and the increased complexities of workers' responsibilities, sacrifices in quality of care and time spent with each resident is necessary to "survive" these shifts. Due to numerous COVID-19 related deaths among residents at various facilities, it is a sad reality that staff now find the time to really connect, interact, and bring smiles and laughter to the residents. Given the mental and physical stresses of such working conditions prior to the pandemic, witnessing the multiple deaths of residents they have diligently cared for many years, the fact that these workers have returned to work day after day is commendable. These workers care deeply for the residents, and it is time for us to do something for them. The call for changes at long term care homes is not new; the practices at the long-term care homes need to change, the laws regarding long term home need to change. Multiple reports that have identified many of the issues I mentioned above are gathering dust; while the new ones get ready to join the same fate (COVID-19 Commission, 2020). I hope maybe this time the result would be different. I hope the essential workers will be valued both with words and compensation. I hope facilities will prepare themselves better for the present and future challenges.

References

Alam, H. (2020). *Nearly 20 per cent of COVID-19 infections in Canada among health-care workers by late July.* Retrieved September 29, 2020, from https://www.thestar.com/news/canada/2020/09/19/nearly-20-per-cent-of-covid-19-infections-in-canada-among-health-care-workers-by-late-july.html

Ontario Long-term COVID – 19 Commission (2020). Retrieved Oct 25, 2020, from http://www.ltccommission-commissionsld.ca/

Ontario Public Services (2020). *Workplace Matching Portal.* Retrieved September 29, 2020, from https://healthcloudtrialmaster-15a4d-17117fe91a8.force.com/matchingportal/s/?language=en_US

Pearce, L. (2020, September 09). How COVID-19 is affecting nurses' mental health, and what to do about it. Retrieved September 29, 2020, from https://rcni.com/nursing-standard/features/how-covid-19-affecting-nurses-mental-health-and-what-to-do-about-it-159456

Phillips, J. (2020, May 04). Nurses Are Playing a Crucial Role in this Pandemic-as Always. Retrieved September 29, 2020, from https://blogs.scientificamerican.com/observations/nurses-are-playing-a-crucial-role-in-this-pandemic-mdash-as-always/

Public Health Ontario (2020). *COVID-19 in Health Care Workers in Ontario.* Retrieved September 29, 2020, from https://www.publichealthontario.ca/-/media/documents/ncov/epi/2020/07/covid-19-epi-health-care-workers-ontario.pdf?la=en