

The Pandemic and Lessons to Share In Long-Term Care

JUSTIN HINKER

It will come as no shock to professionals in long-term care, but among the most important lessons our team learned in recent weeks is the uniquely fluid nature of time. At Avera Prince of Peace Retirement Community in Sioux Falls, South Dakota, we have 114 skilled nursing facility beds, 60 assisted living beds and 74 independent living beds. Our residents are why we do the work we do.

As a long-term care team, we leaned into the challenges we faced with a dynamic response, but it was one that we developed with short-term, 24-hour goals in mind. As days turned to weeks and months, we gleaned more insight on this unprecedented time in health care and history. The strangeness of the pandemic's sudden beginning and the reality of this new normal offer a good place to start in sharing what we learned facing COVID-19.

March 11, 2020, when we first started visitation restrictions related to the COVID-19 pandemic, is a day I remember vividly. I remember almost every detail of March 31, when we had our first positive case of the virus, too. The celebration we held when that resident recovered and returned to their home in our community is another intensely familiar recollection. But remembering every detail in the months that followed up to today is challenging.

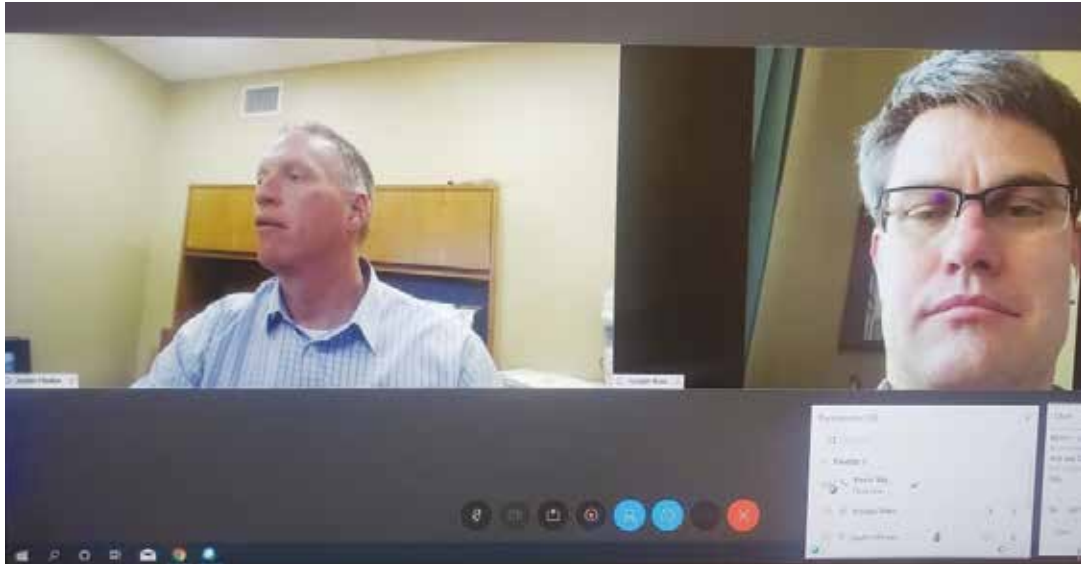
START WITH COMMUNICATION

Like many long-term sites around the United States, our communications in the “before times” were traditional and straightforward. When we

needed to, we'd pick up the phone and call the loved ones of a resident to report a change or get more information. If we were changing visiting hours, it was pretty simple to get that word to residents.

COVID-19 changed all that. We realized the deep value of our health system's communications teams over those first days. Our facility was the first long-term care center in South Dakota to report a positive case. Hundreds of residents needed timely information on what we were going to do. The media was on the phone. Thousands of people who had loved ones in our care were calling, emailing or seeking more information on what was next. Many were scared — some were angry.

We learned we were not prepared for the sheer volume of calls. Any ongoing plan for a long-term care facility should involve communication first and foremost. We overcame the call volume with the help of our health system's communicators, and we came to realize the effectiveness of what we call virtual “town hall” meetings. We invited all families to email us their questions; we compiled and answered them in advance, with the



Avera Prince of Peace Retirement Community in South Dakota has been holding virtual “town hall” meetings to answer questions emailed in advance from residents’ families and staff. The facility’s administrator, Justin Hinker, left, and a medical director, Joseph Rees, DO, talk to about 100 participants during a May 28, 2020, video call.

help of our facility medical leadership; and then we hosted a call-in setting where we could go through the questions and answers.

The feedback on this approach has been overwhelmingly positive. We reached hundreds at once in a timely manner. We had more than 130 participants and several dozen questions during the first session.

TACTICS, TEACHING AND TRYING NEW THINGS

Grouping residents into COVID-19 positive and non-positive cohorts also was a key step in our efforts to prevent community spread. We cleared out a wing for COVID-19 care a few days after our first positive case was established. We had to move residents to do so, and we’re blessed to report that at the present, the steps we took — including universal masking, physical distancing efforts and effective employee communication — all came together and allow us to report we have not experienced patient spread.

One advantage we held was the robust Avera eCARE Senior Care telehealth program that we’ve used for several years. It allowed us to address medication questions, lab and X-ray reviews and many others on-site. The use of eCARE allowed us keep 97% of our residents on campus. Transfers for residents always add a burden and in this

time of pandemic, the technology we could apply really helped to remove another worry from our work.

We are thankful for the deft response that has come from our health system, with staff in other locations coming to help our teams. But we also see the limitations of having another “body” unfamiliar to the facility, residents and the staff — it’s good to have them, but their presence is not immediately equivalent to the person who left. We realize the value of working closely with those leaders who manage workforce. It pays to review and revise those protocols before a positive case occurs in your center or home.

While our virtual town halls have been beneficial, other approaches widely used, such as “window time” for visitors and residents, did not work as well. We had to stop this practice — which was a tough decision — because the window that was not to be opened indeed was opened too many times. That can lead to spread. Using technology to keep loved ones and residents connected has been successful, but the “FaceTime 101” sessions that come with it are time-consuming. We’re all getting better at Zoom — our residents love seeing the faces and hearing the voices of those they cannot see in person.

We realize we cannot address the acuity of sor-

row felt for those who miss loved ones they cannot see in person. We try, though, and it is the everyday, hour-by-hour effort of the frontline team that is making this new standard become more bearable and adaptable.

Emotional extremes are another challenge to prepare for. The sheer sense of victory we had when our first two positive cases recovered and returned to us was a huge relief, especially after so many weeks of feeling the pressure of having cases that were among those first documented in the state. Their return made us realize fully the sense of hope that had been elusive for weeks. Staff in personal protective equipment lined the entryway as they returned, and we all cheered. While we mourn any passing, we have only had one death due to COVID-19. That happened at the end of March, so anxiety was high. The uncertainty of what was happening or might happen was real for us. Staff were nervous for themselves and potentially for their families, and we did have some who chose to resign. As time moved forward, that fear and anxiety have decreased.

THE PERSON TO YOUR RIGHT AND TO YOUR LEFT

None of us have a playbook or protocol set to direct us in exactly how to face each predicament

that comes with a pandemic. As we turn to one another to share not just stories but good practices and lessons learned, we return to one fact that we already know: the quality of the care is directly reflected in the individual who provides it — their talents, skills, knowledge, experience, attitude and personal well-being.

This tough journey will continue and so will we. We will continue to realize the necessity of our work and the importance of our communication with one another, with our residents, their loved ones and our off-campus teammates and support. These extraordinary times call for seriousness in purpose and nimbleness in the face of new uncertainties. The initial shock has passed; now we must all carry on, ready in the face of the unknown, firm in our dedication to our residents.

Time will march on and the future will reveal lessons learned. But what we've learned in only these few months since everything changed is that good communication practices are a necessary part of good care.

JUSTIN HINKER is the administrator of Avera Prince of Peace Retirement Community, Sioux Falls, South Dakota.

QUESTIONS FOR DISCUSSION

People in long-term care facilities have been especially vulnerable to the coronavirus. Their plight is made so much worse since regular communication has been thwarted by pandemic restrictions. Justin Hinker of Avera's Prince of Peace Retirement Community in Sioux Falls, South Dakota, describes the efforts to prioritize and disseminate information to almost 250 residents, their care providers, families and the community.

1. Hinker states that any ongoing plan for a long-term care facility should have communications as a top priority. How does your ministry build its communications plan for disasters? Who should be at the table when the plan is being made so as many people and concerns are represented as possible?

2. How do you plan for the particular vulnerabilities of the frail and elderly — people who often have hearing loss, cognitive challenges or may have few or no technical skills? How can you ensure that they have advocates in cases of disasters like this?

3. The relationship of facility to health system in developing an efficient and functional communications system is described as mutually supportive and interdependent. How does your ministry measure up to that model? Do you have any suggestions for improvement or for keeping it a ready and nimble system?

4. Hinker has reflected on the lessons his long-term care facility and system have learned from this pandemic. How is your organization systematically debriefing and learning from the pandemic? How are you telling stories, capturing the lessons learned, and deciding which new practices should be adopted and standardized?

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