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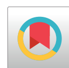
Letters to the Editor

COVID-19 and Nursing Home Residents' Rights



To the Editor:

Prior to 1987, nursing home residents had no explicit rights. It was the Nursing Home Reform Act that brought a bill of rights for residents out of recognition of the steep power imbalance between residents and staff,[1] and the development of learned helplessness by those who live in such settings.[2] Born from a time when nursing homes residents were subject to physical restraints and sedation, these rights sought to give residents greater control over daily routines and social interactions.[2] Could COVID-19 be sending residents' rights back to those times?

As soon as the story about the Kirkland, WA, nursing home and COVID-19 became national news, the Centers for Medicare & Medicaid Services (CMS) took swift action to protect nursing home residents.[3] Their press release on March 13, 2020, characterized their directives as the most aggressive and decisive, and they certainly were. They immediately restricted all visitors, volunteers, and nonessential personnel from entering nursing homes and canceled group activities and communal dining.

Although the COVID-19 pandemic seemed urgent and the risks to nursing home residents were real, these directives superseded and countered residents' rights. One of the core resident's rights is the right to spend time with visitors of your choosing. "You have the … right: To spend private time with visitors. To have visitors at any time, as long as you wish to see them, as long as the visit does not interfere with the provision of care and privacy rights of other residents."[4]

The restriction of rights is concerning, even in the face of a global pandemic. Nursing homes are required by federal regulations to provide maximal quality of life. As defined in the federal register, §483.24, "Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care."[5]

How can residents maintain the highest practicable mental and psychosocial well-being when they are not able to connect with other human beings, including loved ones? CMS made exceptions for "compassionate cases," which were left to the nursing homes' discretion.[3] The example they gave was for end-of-life situations.[3] But what about the mental health effects of being cut off from spouses and children? Weren't residents more likely to become ill and die if they didn't feel like they had something to live for? As many of us have learned through this COVID-19 pandemic and the subsequent isolation at home, the absence of normal markers of daily life including connection with others can leave people feeling disoriented and disconnected. It is too soon to know the long-term impacts of this isolation on the mental and cognitive health of residents, but there is no doubt that physical and mental health are intertwined. Resident's rights are essential for quality of life, autonomy, and health for nursing home residents. Dr Penny Shaw, a nursing home resident in Massachusetts, has written extensively about how exercising about her rights has improved her life, and her health outcomes.[6]

So where is the line? How can we keep residents safe while protecting their right to self-determination and choice? It is a difficult balance. As the country tentatively reopens, community-dwelling citizens are making their own calls on some of these things such as where is it safe to venture, with whom, and whether or not to wear a mask. So what is the different about congregate care settings, especially nursing homes? The challenge lies in the ever-present balance between individual rights and the common good and the desire to protect those in care. Nursing homes and policy makers need to consider ways to allow nursing home residents control over their visitation preferences without increasing risks to all of the residents in the nursing home. Guidelines are beginning to be developed to allow nursing homes to reopen to visitors, and we can look to these guidelines for recommendations to increase safety and improve choice. Recommendations for safer reopening are outlined in Table 1.

I will also add that if the facility as a whole has not reopened to visitors, consider cohorting residents who are interacting with the outside world from residents who are remaining isolated.

Many nursing home residents who are aware of the COVID-19 crisis are feeling frightened and vulnerable.[9] A nursing home social worker reported that staff are also feeling frightened of the idea of additional people and chances for infection coming into facilities. Nursing homes themselves fear liability and citation. These fears should be addressed through the practice of prudent precautions. Fear should not keep residents from exercising their rights.

Table 1
Visitation Recommendations

Visit practices	
	• Screen all visitors for symptoms of COVID-19, such as taking temperatures[7,8] • Mandatory hand hygiene upon entering the facility[7,8] • Social distancing during the visit[7,8] • Require face coverings for residents and visitors during the visit[7]
Facility practices	
	• Require appointments to control the number of visitors in the facility[7,8] • Consider time limits to control number of visitors[8] • Create designated visiting areas[8] • Consider outside visiting if feasible[7] • Consider physical barriers[7]

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Nancy Kusmaul, PhD
University of Maryland Baltimore County
Baltimore, MD

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Care Aides Working Multiple Jobs: Considerations for Staffing Policies in Long-Term Care Homes During and After the COVID-19 Pandemic

Keywords
Care aides
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The ongoing COVID-19 pandemic has disproportionately affected older adults living in long-term care (LTC) homes, who have less functional immune systems, multiple comorbidities, and high levels of immobility and dementia. In Canada, 85% of COVID-19 deaths were LTC residents as of early May 2020—the highest among 14 countries.[1] In response, provincial health offices have issued numerous emergency orders and one focused on restricting health care aides to working at only 1 site.[1–3]

Health care aides represent up to 90% of the direct care workforce in LTC,[4] and they are generally middle-aged women, with a high school diploma, and speak English as their second language.[5] The COVID-19 pandemic has placed significant demands on care aides because of increased complexity of care and adjustment to unprecedented changes in care practices and regulations as well as a significant risk for being infected. Here we comment on implications of the single-site order issued to control the COVID-19 spread. We used data from our Translating Research in Elder Care (TREC) program that surveyed 3765 care aides from 94 randomly selected and stratified LTC sites in western Canada between September 2019 and February 2020.[6] Several questions specifically focus on work arrangements.

Restricting care aides to a single work site may result in an abrupt decrease in care aide staffing. As shown in Table 1, nearly a quarter of care aides (24.3%, 915/3765) reported that they worked at more than 1 LTC site. On average, they worked for 16 hours a week at sites other than the primary LTC home where they held a regular position. The LTC sector was challenged by care aide shortages before the pandemic,[4] and the current single-site order poses additional challenges to staff assignment at both the LTC home level and the provincial or regional health care system level. The British Columbia Ministry of Health has initiated a centralized staffing approach that manages staff resources at the provincial level based on the weekly updated data of worksite preference reported by employees.[7] Although the single-site order and the resultant staff assignment initiatives are implemented at the provincial level, adaptability to the local context—given the variation in the rates of using part-time and casual care aides across regions and owner-operator models—needs to be addressed. For example, according to our data, public not-for-profit and private for-profit homes had significantly higher proportions of care aides working at multiple LTC homes compared with voluntary not-for-profit (eg, faith based) homes (30.6%, 26.8% vs 18.8%).

The single-site order does not restrict care aides from employment outside their care aide vocation.[2] Our data show that

Table 1
Care Aides Working in Multiple LTC Homes and Additional Job(s) in Non-LTC Locations (N = 3765)

Variable	Frequency	Percent
Working in multiple LTC homes	915	24.30
Working additional job(s) in non-LTC locations	560	14.87
Reason for working additional job(s) in non-LTC locations* (n = 560)		
Financial	410	73.21
Cannot get a full-time position	96	17.14
Lighter workload	40	7.14
Transition to a new role	36	6.43
Other reasons	122	21.79
Hours working in the LTC home(s) other than the primary home in the past 2 wk (n = 915), mean ± SD	31.34	17.75
Hours working additional job(s) in non-LTC locations in the past 2 wk (n = 560), mean ± SD	35.24	23.81

*This is a "check all that apply" question.

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