Minimizing COVID-19 in Nordic Eldercare Challenges and Solutions

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Minimizing COVID-19 in Nordic Eldercare
Challenges and Solutions

(first preliminary version 30. December 2020)

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1. Minimizing COVID-19 in Nordic Eldercare - Challenges and Solutions

In this report the Danish, Swedish and Norwegian research teams present preliminary findings from a Nordic eldercare research project[1] concerning practical experiences from Nordic eldercare leaders about how to avoid COVID-19 and how to cope with it once it has entered the eldercare unit.

Our findings are based on data generated through online interviews and surveys from May to November 2020. A questionnaire was distributed to first line managers (FLM) in municipal and private eldercare in Denmark (September), Norway (November) and Sweden (November). The questionnaire was based on online interviews with eldercare managers conducted May to August 2020. Further details of the research project can be found in the final more comprehensive report from the project, which will also include findings from Finland (forthcoming first quarter 2021).

The primary challenge in managing eldercare during the pandemic is how to avoid the COVID-19 disease to enter the eldercare unit and, if it enters, how to minimize the contagion within the eldercare unit. Both the degree of hospitalization and mortality due to COVID-19 are very high for elderly citizens [1][4]. We recognize that there are other important challenges in managing eldercare such as enhancing an active and rewarding social life among older people, but our main concern in this report is on measures to minimize the diffusion of the disease.

The findings are organized in a number of themes and are all presented in the form of a challenge related to minimize COVID-19 contagion in eldercare and one or more possible solutions to this challenge. The solutions is a catalogue of ideas to expand the "tool box" for eldercare managers in a difficult crisis. We recognize that these challenge-solution packages sometimes cause new challenges or involves difficult dilemmas and trade offs (e.g. loneliness among older people, frustrated relatives and/or exhausted employees) and we discuss briefly how to cope with them.

[1] The project has received funding from the Velux foundation, Denmark, Aalborg University, Denmark, Nord University, Norway and University of Borås, Sweden. We would like to thank the many managers in eldercare who, despite the long working hours caused by the COVID-19 crisis, took the time to participate in the study.

The toolbox presented here are "tools in use" in the practice of Nordic eldercare. They are all applied, though to varying extent (see section 6), to cope with the COVID-19 pandemic in the three Nordic countries. But how well each of the measures works to minimize COVID-19 is uncertain for each specific activity. In the present project we are not able to answer questions about to what extent each of the applied measures has worked in avoiding, minizing or reducing contagion.

A quick glance at the current available evidence suggest that the Nordic efforts presented here as a whole have been relatively efficient in low or medium incidence areas and time periods, but that they have been insufficient in high incidence areas and time periods like the greater Copenhagen region in November and December 2020. For example, 67 percent of all nursing homes in Denmark in 2020, had not had a single registered COVID-19 infection in 2020 up to and including week 52 [2]. However, within the greater Copenhagen region only 27 percent of the Nursing homes had no registered COVID-19 infections in 2020, while in the rest of Denmark excluding the Copenhagen region, 77 percent of the nursing homes had no COVID-19 infections in 2020 [2].

But in the present report we are not able to answer questions about the extent to which each of the measures used has been effective to avoid, minimize or reduce infection.

To provide solid evidence concerning which pratices works best in which contexts would require much more time and funding than we have here and will hopefully be answered in future research projects. What we provide here is a toolbox of practices which should be carefully adapted to local contexts by employees and eldercare leaders with knowledge of local circumstances.

The report is written to leaders of eldercare at the operational level (Nursing homes, home care, etc.), the socalled first line managers (FLMs), and summarize the experience of Nordic eldercare leaders generated from surveys and interviews in 2020. Some of the findings may be of most relevance to leaders in Nursing homes/special housing for older people (e.g. reorganizing physical space), but many of the findings should be broadly relevant to all Nordic FLMs, top managers and politicians responsible of eldercare. The findings are generated in a Nordic context but will hopefully also be usefull in other countries.
Some of the solutions will be well known to many FLMs, but hopefully a number of solutions will be new and immediately useful in the winter 2021. The findings we present

here should also prove usefull in a long-term perspective, since local epidemics and global pandemics are likely to happen more often in the future.
For the sake of good order, we would like to emphasize that the examples and experiences that are disseminated should not involve disregard for measures, recommendations and instructions from national and local health authorities in connection with COVID-19.

The challenge-solution findings from Nordic eldercare leaders are organized in the following themes:

- Physical contact and Social relations
- Internal Communication
- External Communication
- Management and Leadership

In the following pages we present challenges and solutions ordered in the themes above. However the overall challenge and spirit of many Nordic eldercare units is perhaps best covered by the following quote from a Norwegian eldercare first line manager:

> *"I am really impressed by my employees who have managed to readjust, manage new knowledge and routines that are changing continously. We have had to change our mindsets, every day. We have made use of digital communication platforms earlier than we could imagine. We have had TEAMs-meetings, been skyping with next-of-kin, had live streamings of church service, and speeches on our national day celebration (17.mai), on TV screens in the sitting room. We have practiced infection preventioning, and taken e-course in hand sanitation." (...) "We have learnt how to make golden moments for our residents even if gatherings and parties are prohibited. We have become good at finding small spaces in everyday life, where we can enjoy song, music, games, exercise, and do baking."*

2. Physical contact and social relations

The main method to avoid contagion from a highly contagious disease like COVID-19 is to avoid direct or indirect physical contact with carriers of the disease. Since COVID-19 can be contagious while carriers are asymptotic (one can spread the infection without having any symptoms of the disease), it involves avoiding contact with potential carriers [3] [4]. In high incidence localities, this means avoiding contact with most, if not all, people. The many instructions on 1) distance, 2) use of face masks and other protective equipment, 3) avoidance of overcrowded places, 4) compliance with high hygiene standards to avoid indirect contact, 5) frequent ventilation, etc. are all measures to avoid contact with potential carriers.
But they do create challenges for our social life and care. Below are a number of challenge-solution practices related to physical contact and social relations in eldercare is presented: #

Challenge 2.1 Contact: Avoid that COVID-19 get into the eldercare unit (e.g. Nursing home, home care)

Solution 1 - external relations: Close down or minimize all forms of external access and contact for some weeks:

1) No or minimized visits from relatives
2) If visits from relatives are allowed restrict their access to specific areas, use protection mask and good hygiene.
3) Avoid or minimize use of volunteers and substitute workers, strive for continuity i.e. a smaller amount of different care workers for each user/older person.
4) Cancel, minimize or postpone all appointments with therapeuts, dentists, hairdressers, etc.
5) Cancel, minimize or postpone appointments with craftsmen and plans for building renewals

Solution 2 - employees: Minimize the risk of contagion from employee disease carriers in the eldercare unit

1) If the least symptoms of possible COVID-19 the employees stay home and get tested
2) Regular and frequent testing of employees in high incidence localities
3) Track the risk of contagion from/to the employee

Solution 3 – residents and citizens: Minimize the risk of contagion from residents /citizens in the eldercare unit:

1) If the residents show symptoms of possible COVID-19 they selfisolate and get tested

2) Regular and frequent testing of residents in high incidence localities

3) Previously hospitalized homecoming residents are tested and/or temporarily located in isolation

4) Increase the standard of house cleening including spraying of door handles, toilets, etc.

5) Inform all residents / citizens of the need of good hygiene and frequent venting.#

Challenge 2.2 Loneliness: Loneliness among older residents due to COVID-19 restrictions on social relations

Solution 1: Rearrange physical areas to establish ”contact-islands” where sufficiently safe one-to-one contact can take place between residents, eldercare workers and/or a relative

Solution 2: Help establish social contact with relatives and friends through online platforms (Skype, face-time, etc.)

Solution 3: If possible, help establish COVID-19 secure physical social activities – e.g. out-door activities with safe distance, in-door activities in zones with few participants and frequent venting.

Challenge 2.3 Instructions: To ensure that all guidelines and instructions are remembered and followed by all employees, relatives and citizens once the Nursing home/organization is reopened again.

Solution 1: Rearrange physical areas and common rooms – for instance arrange furniture in small groups that invite to distance between people.

Solution 2: Screens with current guidelines placed on visible places

Solution 3: Distance marks on the floor in relevant areas

Solution 4: Make it part of the job description of one or more dedicated employees to ensure dissemination of COVID-19 information and instructions

Challenge 2.4 Meals: Minimize the risk of COVID-19 contagion during meals, while maintaining mutual cozy social relations as much as possible.

Solution 1: New routines for meal provision. The food is portioned before serving and the residents are divided into smaller groups, so that the residents continue to have a social

experience at the meals. But ensure their contacts are limited to a small, fixed group of residents.

Challenge 2.5 Zones: Avoid or minimize contagion within the Nursing home/eldercare unit in case some employees or residents has the disease without knowing it (asymptotic disease)
Solution 1: Employees no longer work across the organization, but are assigned to permanent areas and permanent residents. For example, employees are assigned to permanent floors or houses. The intention is to restrict contagion to a specific unit if COVID-19 enters the Nursing home/eldercare unit.

3. Internal Communication

Covid-19 is a new disease and instructions concerning how to cope with it has been constantly changing. This has created a number of communication challenges presented below. Like many other places in society, a key tool has been increased use of digital media.

Challenge 3.1 Digitalization: How to communicate fast and efficient to employees while minimizing physical contact
Solution 1: Make a CORONA hotline for immediate communication with employees. When employees are unsure about how to handle specific situations, the existence of a hot-line contributes to a sense of security.
Solution 2: Use digital communication solutions such as TEAMs, SKYPE or ZOOM for oral communication.
Solution 3: Increase the use of written communication to minimize misunderstandings concerning what to do when and how (if possible use Intranet or other "secure" communication platforms that are documentation signed when read).

Challenge 3.2 Speed: How to ensure that important new instructions and information get to the employees immediately
Solution 1: Use an online communication platform that is wellknown to employees and safe to use (e.g. in Denmark Facebook was used by several eldercare units since it was well known and used regularly by all employees) and instruct them to always read it before they start at work (it should be possible to check if they did read it).

Challenge 3.3 Translation: Guidelines from National Health and Social Care authorities are often difficult to understand for employees – both in terms of meaning and implications for daily work.

Solution 1: Local leaders and/or municipal eldercare authorities must translate them into clear brief instructions – both orally and (as soon as possible) in the form of written brief action cards/instructions.

Solution 2: Some employees within eldercare are immigrants with limited language skills. In such cases, very concrete direct translation of instructions is needed.

Solution 3: If possible fewer employees for each first line manager is preferable. It increases the possibility for the leader to be available at the unit to coach, answer questions, acknowledge and be supportive towards understandable worries and promote a positive spirit despite the challenges.

Challenge 3.4 Changing guidelines: Frequent changes in guidelines from National Health and Social Care authorities is a huge challenge for employees as well as leaders.

Solution 1: Monitor current guidelines real-time on screens in every unit. This will prevent the need of next shift for reading countless emails with the last updates. It will also secure that staff and residents and their next-of-kin have the same information.

Challenge 3.5 Online instructions: To ensure that all employees have the necessary knowledge concerning contagion and hygiene and knowledge concerning how to avoid and cope with the disease.

Solution 1: The leaders provide brief how-to e-learning programs and ensure that all relevant employees use them – for instance: 1) how to wash hands; 2) How to disinfect an area; etc.

Solution 2: Use the app ”MyMedCards” (in Denmark) or a similar tool, which can be downloaded for free. Here all updated municipal instructions can be uploaded and disseminated. All employees has access to this app through their smartphones (thus the solution require a smartphone) and leaders can ensure that they use it and integrate it in their daily routines.

Challenge 3.6 Question hours: Confusion among employees concerning the many new and changing instructions

Solution 1: Regularly scheduled (daily or weekly depending on the situation) question hours where employees can ask all the questions they may have. A “room” where it is OK to ask ”silly” questions and expose ones doubts. Such meetings provide time for reflection on how things have been handled and how they should handled.

4. External Communication

Challenge 4.1 Innovation and Adaptation: How to use networks to ensure that the leader and the eldercare unit is updated with knowledge of novel solutions and new instructions

Solution 1 – formal networks: Hierarchical dissemination and exchange of information through daily or weekly (depending on the situation) online meetings with relevant higher-level leaders as well as other operational leaders of eldercare units within the municipality.

Solution 2 – informal networks: online exchange of experience in informal networks based on personal trustful relations and often mobilized to solve specific challenges – sometimes also involving relatives to the older person.

Solution 3 – regional networks: Eldercare managers at varying levels in different municipalities within a region meet online regularly to exchange information about challenges and solutions

5. Management and Leadership

Challenge 5.1 Leadership style: How should different types of leadership style [5] [6] be balanced and prioritized during the COVID-19 crisis?

Solution 1: The three most important leadership styles in relation to the employees – especially in the early stage of the pandemic was to a) Explain the situation, goals and expectations; b) provide instructions and ensure they where followed; and c) provide support and encouragement

Solution 2: However to explain, instruct and support required extensive external communication in order to a) get immediate information about changing instructions and recommendations; b) external collaboration about aligment and mutual solutions.

Solution 3: A leadership style with a delicate balance between internal and external priorities. On the one hand to stay close to the employees to be supportive and solve

problems and on the other to use time on external networks to ensure alignment with national and municipal instructions and recommendations.

Challenge 5.2 Relatives: How to cope with relatives with contradictory frustrations over the restrictions for visits to their loved ones? Often for understandable reasons one group of relatives and residents require much stronger restrictions while another group require much easier access

Solution 1: It is a dilemma and there is no easy solution, but the basic way to cope with the dilemma is through communication - to patiently listen, to show empathy, to patiently explain and again and to basically stick to the restrictions

Solution 2: Co-production/co-creation can contribute to better solutions in some cases. The involvement of relatives and residents in finding safe ways to meet physically with minimal risk of contagion is important. Low local infection levels, easy access to high quality tests and physical facilities with good possibilities for safe distance increase the likelihood for this solution to work. But if the local infection level is high and physical space is scarce it is very difficult for eldercare managers to accommodate such wishes without running a high risk of contagion.

Challenge 5.3 Employees: How to cope with employees with different frustrations with the situation? Often for understandable reasons one group of employees are scared and require to stay at home to avoid contagion while another group is more loose and tend to forget to follow instructions for minimizing contagion

Solution 1: Ensure a firm aligned policy at the municipal level that is easy to explain and stick to that. Then every employee knows the rules for when to stay at home and when not to stay at home.

Solution 2: Constantly communicate and explain the importance of strictly following all the simple rules for avoiding contagion

Solution 3: Create and/or look for opportunities for “microcommunication”, or “micropleasures” that demonstrate you see your employees and understand their challenging situation. E.g. serve some goodie (e.g. sweets, muffins, pizza) for lunch every now and then

Challenge 5.4 Ressources: Ensure appropriate ressources for solving the problems. First line managers (FLMs) in homecare often have sixty or more employees in their span of

control divided in different groups. In some municipalities tracking persons exposed to COVID-19 and find and deliver safety equipment was done by the FLM in the first phase (March and early April).

Solution 1: Reorganize to ensure that tasks are solved. For instance provide administrative support from the local municipality with "administrative things" such as tracking persons who have been exposed to COVID-19 and find and deliver safety equipment.

6. Selected findings from Denmark, Norway and Sweden

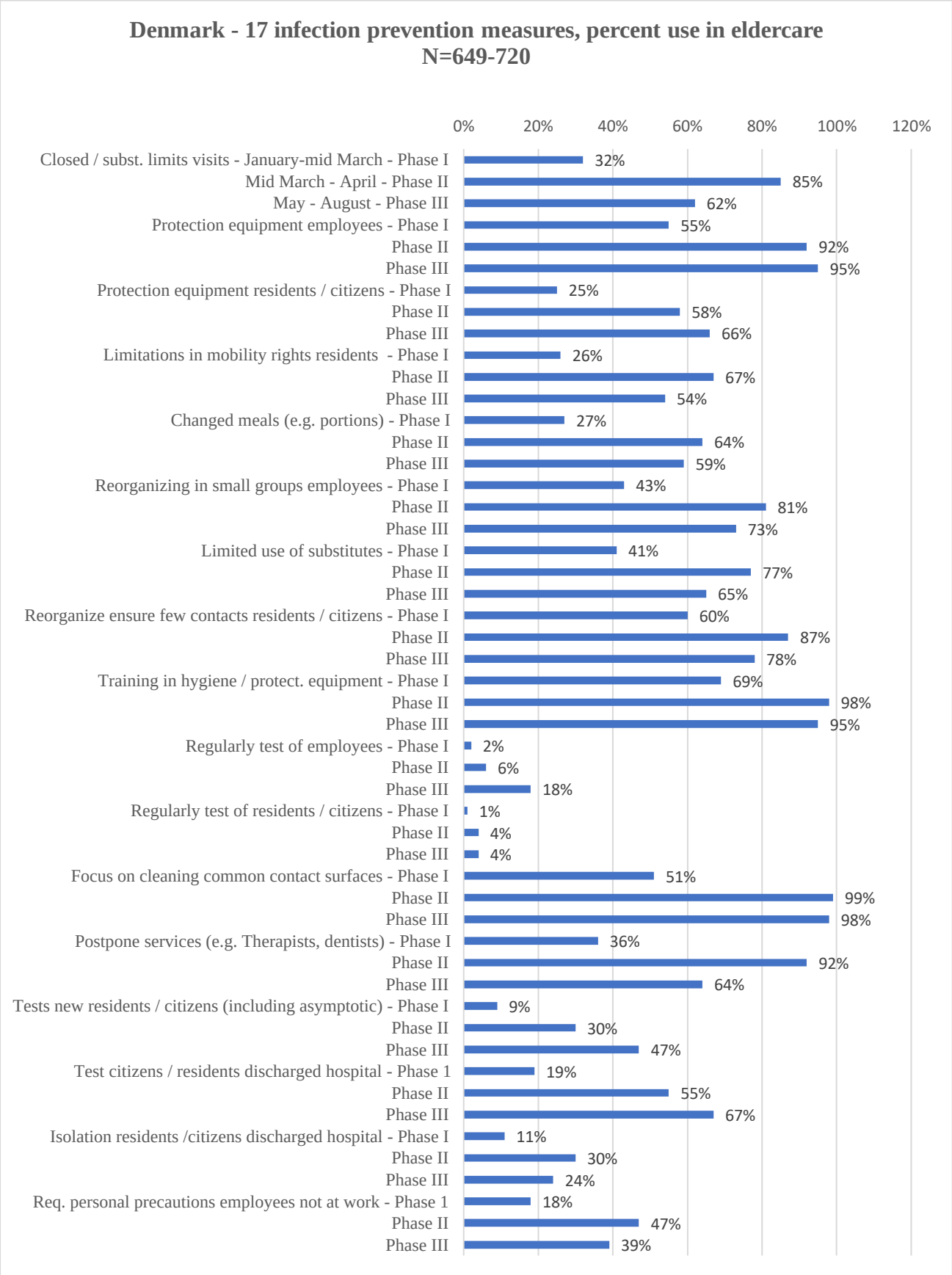
Below selected findings from the Danish, Norwegian and Swedish surveys are presented. The surveys where conducted September (Denmark) and November (Norway and Sweden) 2020. Respondents where first line eldercare managers (FLMs) in Nursing homes and home care.

The data we present here can be used for much more, and we will do so in forthcoming publications. But here we present some findings that indicate how widely used different solutions have been within eldercare in the three countries.

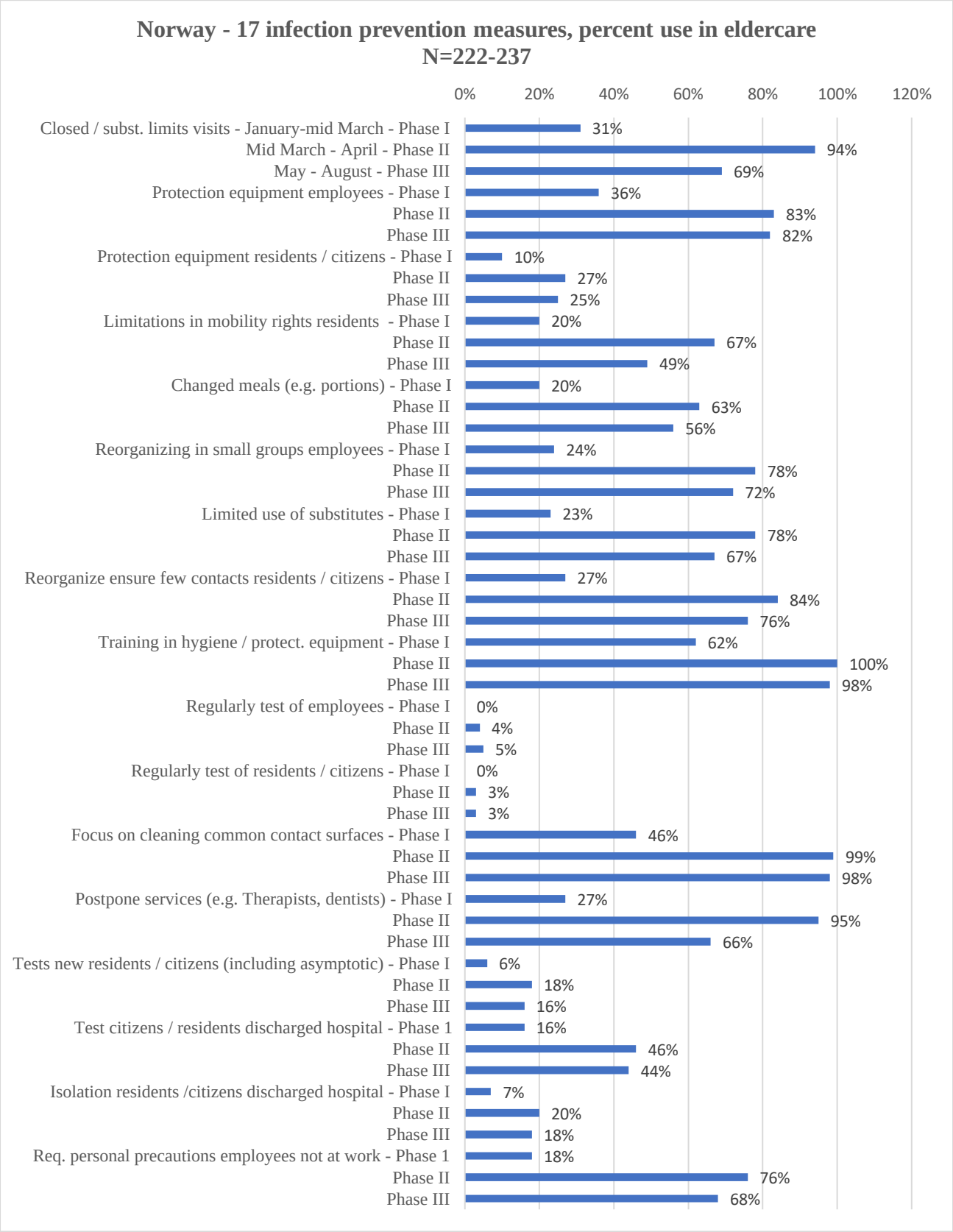
The tables refers to three phases in the pandemic:

- *Phase I refers to January to medio March 2020*
- *Phase II refers to medio March to April 2020*
- *Phase III refers to May to August 2020*

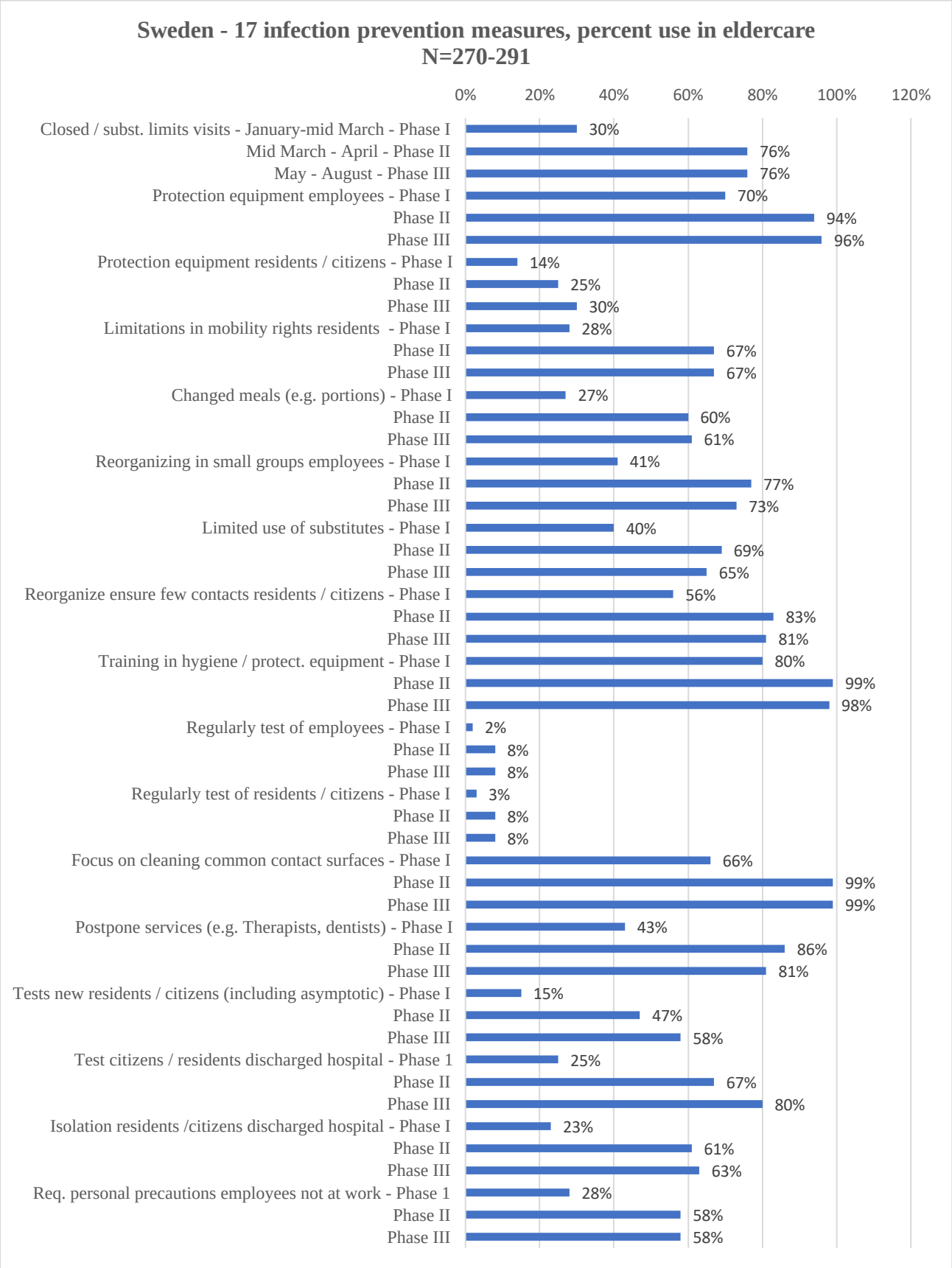
6.1 Denmark - percentage use of 17 infection prevention measures



6.2 Norway - percentage use of 17 infection prevention measures



6.3 Sweden - percentage use of 17 infection prevention measures



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