FOR THE RECORD: AN ANALYSIS OF THE EXCHANGE OF INFORMATION BETWEEN NEW BRUNSWICK LONG-TERM CARE FACILITIES AND FAMILIES DURING THE COVID-19 PANDEMIC

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Abstract

The COVID-19 pandemic illuminated the vulnerabilities which exist within the long-term care sector. Canada, unfortunately, has the dubious distinction of having some of the highest COVID-19 long-term care facility death rates in the world. As this study purports, efficient management of a pandemic outbreak is dependent, in part, on effective communication strategies. This type of information not only transmits public health guidance but can also play a role in reducing negative social, psychological, and health impacts. The purpose of this research project was to study how individuals with a family member/sponsor living in a New Brunswick special care home or nursing home accessed information during the first and second waves of the pandemic. Participants in Survey I (n=101) conducted during the first wave and Survey II (n=110) undertaken during the second wave completed an online questionnaire about their experiences accessing information from the long-term care facility of their family member/sponsor. Participants in Survey I reported high levels of satisfaction with the adequacy of information provided; however, this declined in Survey II. Participants in Survey I reported that "great" staff and the use of technology were key to obtaining information. Participants in both surveys reported that poor-quality communication, lack of staff, and uninformed personnel were challenges to accessing the information they sought about their family member/sponsor. It was suggested by participants that regular updates, clear and concise information, and a stronger digital presence would improve communication. These findings can be useful to inform policies and procedures for communication strategies implemented in the future.

Résumé

La pandémie de COVID-19 a mis en lumière les vulnérabilités qui existent au sein du secteur des soins de longue durée. Le Canada a, malheureusement, la distinction peu enviable d'avoir des taux de mortalité parmi les plus élevés dans les établissements de soins de longue durée liés à la COVID-19 au monde. Comme le soutient cette étude, la gestion efficace d'une épidémie pandémique dépend, en partie, de stratégies de communication efficaces. Ce type d'information transmet non seulement des conseils de santé publique, mais peut également jouer un rôle dans la réduction des impacts sociaux, psychologiques et sanitaires négatifs. Le but de ce projet de recherche était d'étudier comment les personnes dont un membre de la famille/parrain vivant dans un foyer de soins spéciaux ou un foyer de soins infirmiers du Nouveau-Brunswick accédaient à l'information pendant les première et deuxième vagues de la pandémie. Les participants au sondage I (n^o=101) mené au cours de la première vague et au sondage II (n^o=110) entrepris au cours de la deuxième vague ont complété un questionnaire en ligne sur leurs expériences d'accès aux informations de l'établissement de soins de longue durée où résidait le membre de la

famille /parrain. Les participants à l'enquête I ont déclaré des niveaux élevés de satisfaction quant à la pertinence des informations fournies, mais cela a diminué dans l'enquête II. Les participants au sondage I ont indiqué qu'un « excellent » personnel et l'utilisation de la technologie étaient essentiels pour obtenir de l'information. Les participants aux deux enquêtes ont signalé qu'une communication de mauvaise qualité, le manque de personnel et un personnel mal informé créaient des difficultés d'accès aux informations qu'ils recherchaient pour le membre de leur famille/ parrain. Les participants ont suggéré que des mises à jour régulières, des informations claires et concises, et une présence numérique accrue amélioreraient la communication. Ces résultats peuvent s'avérer utiles pour éclairer les politiques et les procédures des stratégies de communication mises en œuvre à l'avenir.

Introduction

The COVID-19 pandemic has permeated every aspect of Canadian life. Most notably, and arguably most severely, the impact of the pandemic has been particularly ruthless on those living in long-term care facilities (LTCFs). The death rates in Canadian LTCFs were the highest in the world and were described by some as a "national disgrace" (Webster 183). COVID-19 deaths in Canadian LTCFs were roughly 50% greater than those in LTCFs in Italy, Spain, the United Kingdom, and the United States (Akhtar-Danesh et al. 2) Regrettably, New Brunswick and the other Canadian provinces did not escape this reality where the COVID-19 death rates in LTCFs were nearly twice the average calculated by the Organization for Economic Cooperation and Development (OECD) (Akhtar-Danesh et al. 2).

On 11 March 2020, the World Health Organization declared COVID-19 a global pandemic (Cucinotta and Valelli 157). This was more than three months after they were informed by China of an existing "mysterious illness" (Cucinotta and Valelli 158) and several weeks after the first Canadian case was identified on 25 January 2020 (Ogilvie). By late March 2021, the pandemic was still raging, with the hope that vaccines would restore "normalcy" by the fall of 2021. As was the case of previous pandemics, this one came in waves, with the first wave established to have occurred between 1 March and 31 August 2020, with the peak period being 1 March to 30 June 2020 (CIHI, *The Impact of COVID-19 on Long-Term Care*). The second wave is suggested to have begun on 1 September 2020 and ended approximately on 28 February 2021 (CIHI, *COVID-19's Impact on Long-Term Care in Canada*). This was followed by a third wave beginning on 1 March 2021 and ending on 15 August 2021 (CIHI, *COVID-19's Impact on Long-Term Care in Canada*). There have been subsequent waves: the fourth wave (16 June–7 December 2021), the fifth wave (8 December–28 February 2022); and a sixth wave, which began on 1 March 2022 (Province of Nova Scotia, *COVID-19 Weekly Data Report, Sixth Wave*).

COVID-19 and Long-Term Care

Global Long-Term Care

Residents of LTCFs are particularly vulnerable to contracting disease, not the least a viral respiratory disease like COVID-19. Several factors contribute to this, such as congregant living conditions and the weakened immune systems of the frail older adults living in these types of residential facilities (Sepulveda et al. 1572; Thompson et al. 2). As a result, an alarmingly high rate of COVID-19 deaths in LTCFs was experienced around the globe. During the first wave of the pandemic, residents of LTCFs in many countries represented a large portion of COVID-19 deaths (Inzitari et al. 1046). An examination of

COVID-19 death rates for twelve OECD countries[1] (including Canada) reported that nursing home deaths accounted for 90% of deaths in all thirty-seven OECD countries and 56% of all global deaths during the first wave of the pandemic (Sepulveda et al. 1572). The proportion of LTCF death rates varied widely, from 4% in Slovenia to 83% in Norway (CIHI, *Pandemic Experience in the Long-Term Care Sector* 2). It is necessary to note that definitions of what constitutes long-term care and reporting criteria for LTC-related COVID-19 deaths vary widely from country to country (Comas-Herrera et al. 3) and thus the data reported here is not definitive.

Canadian Long-Term Care

It has been suggested that the first case of COVID-19 in a Canadian LTCF was in Quebec on 12 March 2020 (Picard 15). As the pandemic progressed, the number of LTCF deaths during the first wave was staggering, but it varied from province to province. During the first wave, Newfoundland and Labrador, Prince Edward Island, and the Territories had not reported any LTCF COVID-19 related deaths (CIHI, *Pandemic Experience in the Long-Term Care Sector* 2). However, in Quebec, Ontario, and Alberta, LTCF deaths related to COVID-19 accounted for over 70% of the total provincial pandemic casualties, and in Nova Scotia, for 97% (CIHI, *Pandemic Experience in the Long-Term Care Sector* 2). The death rates became so alarmingly high that in the spring of 2020, the Canadian Army was called into Quebec LTCFs that were unable to care for residents due to staff illness and absences (Webster 183). During the peak of the first wave, 81% of COVID-19 deaths in Canada occurred in LTCFs (CIHI, *Pandemic Experience in the Long-Term Care Sector* 1) and by the end of it, that number had dropped to 78.2% (Thompson et al. 5). This high rate of LTCF COVID-19 related deaths was extremely disconcerting when compared to a twelve-country OECD LTC death rate average of 47.3% during the same time (Sepulveda et al. 1573). By March 2021, Canadian LTCFs accounted for more than 50% of all COVID-19 deaths in Canada (Clarke 2).

During the second wave, deaths of residents in Canadian LTCFs decreased to 69% (as of 15 February 2021), reaching the proportion of 1 in 5, down from more than 1 in 3 in the first wave (CIHI, *The Impact of COVID-19 on Long-Term Care in Canada* 12). Although the death rates in Canadian LTCFs were on the decline, they remained alarmingly high compared to a 41% (based on twenty-two countries) death rate in LTCFs around the globe (Comas-Herrera et al. 21). The decline of death rates in Canadian LTCFs may, in part, be attributable to provincial governments accepting recommendations that once a vaccine was secured, residents and staff of LTCFs would be given priority for immunization (National Advisory Committee on Immunization).

New Brunswick Long-Term Care

In Canada, the definition of LTC and LTCF varies from province to province. This has resulted in a sector without a continuity of standards and practices, which became painfully obvious during the pandemic. In New Brunswick, LTC operates under the auspices of the Department of Social Development. LTC services include home support, adult day centres, relief care, and adult residential facilities. These residential facilities, designated as special care homes and nursing homes,[2] are licensed by the province, and provide various levels of care. In the seven New Brunswick health zones, there are a total of 404 special care homes ranging in size from two to 130 beds, with approximately 6,905 clients (New Brunswick Special Care Home Association) and seventy licensed nursing homes (Government of New Brunswick), providing a total of 4,925 beds.

The trajectory of COVID-19 related deaths in New Brunswick LTCFs did not follow the national trend. As noted in Table 1, there was one COVID-19 death in an LTCF during the first wave. These death rates were much lower than those that occurred in other parts of the country. For example, Quebec was experiencing the highest mortality rates in LTCFs at 43.2 deaths per 100,000 population and Ontario reported 13.5 LTCF deaths per 100,000 population during the first wave (CIHI, *COVID-19's Impact on Long-Term Care in Canada*). In the second wave, there were sixteen identified COVID-19 related deaths in New Brunswick LTCFs, and in the third wave, eight COVID-19 related deaths. During the second wave, New Brunswick LTCFs maintained the second lowest rates of COVID-19 related deaths at 11 per 100,000 population. However, the number of deaths began to increase during the third wave, when of eight provinces reporting, New Brunswick had the second highest rate of COVID-19 deaths in LTCFs at 0.9 per 100,000 population, second only to Quebec at 1.6 per 100,000 population (CIHI, *COVID-19's Impact on Long-Term Care in Canada*).

Table 1. New Brunswick LTCF COVID-19 Deaths*

Wave**	Total Deaths Province-Wide	NB LTCF Deaths	Deaths – NB 65 years and older
First Wave	2	1 [1=SCH***]	2
Second Wave	25	16 [1=SCH;15=NH]	20
Third Wave	19	8**** [6=SCH; 2=NH]	14
Fourth Wave	88	–	68
Fifth Wave	25	–	15
Total	159	–	119

* As of 30 December 2021 (GNB Public Health, Press Releases)

** First Wave [1 March–31 August 2020]; Second Wave [1 September 2020–28 February 2021]; Third Wave [1 March–15 August 2021]; Fourth Wave [16 August–7 December 2021]; Fifth Wave [8 December 2021–28 February 2022]

*** SCH = special care home; NH= nursing home

**** By June 2021, outbreaks and deaths in New Brunswick LTCFs were no longer reported in GNB press releases.

The Importance of Communication During a Pandemic

The World Health Organization acknowledges that communication is a key element to effective pandemic management (WHO, *Outbreak Communication Guidelines* 1). This includes being attentive to factors such as establishing trust, making announcements early, being transparent, understanding the target population, and planning (WHO, *Outbreak Communication Guidelines* 2–7). These goals can be demonstrated through "empathy and caring, competence and expertise, honesty and openness, and

dedication and commitment" (Reynolds and Crouse 135). Effective communication during a global pandemic not only transmits public health guidance but can also reduce negative social, psychological, and health impacts (McClelland et al. 127). To the contrary, a lack of communication can heighten negative outcomes in an already volatile situation (McClelland et al. 128).

At the beginning of the COVID-19 outbreak, public health messaging was limited to reporting the number of cases, deaths, and ways to mitigate transmission of the virus by wearing a mask, physical distancing, and handwashing. However, as the pandemic progressed, and provinces began to implement different strategies, the volume of information provided by government agencies was at "infodemic" proportions (Chief Public Health Officer of Canada 16). As the guidance became more complex, it was difficult to have consistency in messaging (Chief Public Health Officer of Canada 52). Unlike the 1921 Spanish flu pandemic where the mediums of communicating public health messages were limited to newspaper, telephone, and word of mouth (MacDougall 85), the technologies of the twenty-first century made the transmission of pertinent public health information a significant challenge. To say the least, there was a deluge of information, both official and unofficial, based on fact and fiction, which spread in a nanosecond across official news organizations and social media (Chief Public Health Officer of Canada 16).

Effective communication during a pandemic is particularly important for vulnerable populations. In the case of older adults, increased age has been linked to higher mortality rates from COVID-19 (Sharma e72). Although there is not one universally accepted definition, vulnerability can be defined simply as "an increased potential for loss in a hazardous situation, including reduced capability to respond effectively" (Vaughan and Tinker S329). Public Health New Brunswick defines a vulnerable population as a "group or community at a higher risk for poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability" (Public Health New Brunswick 1). It may be safe to assume that many individuals seeking information about family living in LTCFs would be in an older demographic. Older adults would therefore fall within the vulnerability criterion, whether they are residents of a LTCF or living in the community. The government of New Brunswick provides guidance for the preparation of information to be disseminated by including the following practices: "Prepare and practice calm, reassuring and accurate communication with residents, their families and other stakeholders. Acknowledge the seriousness of the situation and the feelings of fear and anxiety that might produce" (*COVID-19 Management Guide for Adult Residential Facilities and Nursing Homes – Version 1.1* 10). Therefore, any attempt to mitigate undue health, social, and psychological hardship would seem prudent.

Providing information through a variety of platforms is essential when communicating with older adults. Although web-based information is efficient and wide-ranging, there can be inequities in accessing information for older adults who do not own a computer or smartphone and are unfamiliar with the Internet (McClelland et al. 132). As a result, the format in which information is delivered can have a direct impact on the ability of an older adult to access it. Unlike younger age groups, older adults also consult more traditional communication media—which would include radio, television, and word-of-mouth—to obtain information (Rosales and Fernandez-Ardevol 51). With respect to the consultation of web-based sources of information (such as searching the Internet or using a smartphone), age is not a sole determinant of use, but it is a factor. For example, the young old (65–75 years) use the Internet more often than the old-old (75+ years) (Hülür and Macdonald 555). Furthermore, older adults may not have the interest, resources, or skills necessary to access digital information (Yuan et al. 163). This is evident in Canada, where Internet usage is 97.2% for the fifteen to sixty-four-year-old age group compared to 68.2 % of those aged sixty-five years and older (Davidson and Schimmele 6).

Not only can technology use vary by age, but there can also be regional differences in the Canadian context. In 2018, 79.1% of older Canadians reported access to the Internet at home, compared to a higher rate of 81.9% in Atlantic Canada (Statistics Canada). In addition, research shows that only 51.8% of individuals aged sixty-five years and over living in Atlantic Canada have a smartphone for personal use, compared to 60.4% of the national sample (Statistics Canada). In New Brunswick, although the proportion of those of age sixty-five and older with Internet access at home has increased to 85.7% (New Brunswick Health Council), there are challenges around access to reliable Internet service. The Canadian Radio-Television and Telecommunications Commission reports that only 45.6% of rural households have access to 50/10 megabits per second speeds with unlimited data, compared to 87.4% in urban areas of the country (CRTC, *Broadband Fund*). There are 67,000 New Brunswick rural households that do not have access to Internet (Auditor General of New Brunswick, 2021 Report 3).

The purpose of this research project was to study how individuals with a family member/sponsor living in a New Brunswick special care home or nursing home accessed information during the COVID-19 pandemic. Specific attention was given to examining how the delivery of information in the digital age impacted the exchange of information. The findings presented here are part of a larger study, which investigated communication strategies used by administration and staff in LTCFs during the pandemic.

Method

Participants

The participants in Survey I (n=101) and Survey II (n=110) were family/sponsors of residents living in either a special care home or nursing home in New Brunswick. An invitation with a link to the survey was posted on Facebook. In Survey I, most of the sample (67%) identified that their family/sponsor lived in a nursing home and 17% in a special care home, while 16% did not indicate the type of LTCF. Nearly all (99%) surveys were completed in English. In Survey II, most participants (62%) identified that their family/sponsor lived in a special care home, 13% in a nursing home, and 25% did not indicate the type of LTCF. Nearly all (95%) surveys were completed in English and 5% in French.

Measures

Survey I consisted of sixteen closed- and three open-ended questions about the experience of obtaining COVID-19 related information from the family/sponsor's LTCF during the first wave of the pandemic. For the purpose of this paper, only responses to the question about satisfaction with the information supplied will be included. Open-ended questions provided participants with the opportunity to comment on the effectiveness of communication strategies and recommendations for improvements.

Survey II consisted of two closed- and two open-ended questions about the experience of obtaining COVID-19 information regarding visitation rules/regulations. The closed-ended questions pertained to type of facility and satisfaction with the information on visitation rules/regulations. The two open-ended questions provided participants with the opportunity to comment on the challenges in obtaining this information and to propose recommendations for improvements.

Procedure

Potential participants were invited to take part in the surveys using Hosted in Canada (www.hostedincanada.com). After giving consent, the participants proceeded to complete the survey. Survey I was distributed in August 2020 at the end of the first wave of the pandemic, whereas Survey II was circulated in March 2021 at the end of the second wave of the pandemic.

The closed-ended questions in Surveys I and II were analyzed using SPSS v27. The text from the open-ended questions in these surveys was exported to NVivo 12 (QSR International, Burlington, MA, USA) and a thematic analysis (Braun and Clarke) was conducted to develop a coding frame of the content. Verbatim examples are included in the results to illustrate the themes identified.

Results

Survey I

The participants were asked to rate their level of satisfaction with information provided during the first wave. Table 2 indicates a very high level of satisfaction with the information provided and reveals that it answered their questions and concerns.

Table 2. Levels of Satisfaction with Information

	Survey I	Survey II
	How satisfied are you that the information provided is adequate to address your questions and concerns? [n=101]	How satisfied are you with the information you received regarding visitation rules/regulations during the second wave of the pandemic (October 2020 to present)? [n=110]
Not Satisfied	6% [n=6]	4% [n=4]
Satisfied	12% [n=12]	44% [n=49]
Very Satisfied	82% [n=83]	52% [n=57]
Mean	3.77	3.80
Standard Deviation	.955	.967

[not satisfied – 1; Satisfied – 2 and 3; Very satisfied – 4 and 5]

The participants were also asked to identify any positive aspects of communicating with the facility. Two distinct themes emerged from the analysis: appreciation for "great staff" and the use of technology to communicate with family (see Table 3). Terms such as "have their best interests at heart," sympathetic, empathetic, and helpful were used to describe interactions with LTCF staff. The participants indicated that staff were key in terms of providing information. Participants also reported that being able to use technology to communicate with family members on platforms such as FaceTime and Skype alleviated concerns about the well-being of family members.

Table 3. Survey I – Positive Communication Experiences

Theme	Responses
1. "Great Staff"	"If they ask her [staff member] for anything, they can trust she's on it and has their best interest at heart." "They have been very sympathetic, professional and helpful in really uncertain times." "She is empathetic and tries to work with you in problem solving." "Everyone has the best interest of their residents, staff are exceptional."
2. Use of Technology to Communicate with Family Members	"They facilitated us doing FaceTime visits, took pictures of him and sent to me regularly, and were always available by phone and email." "She told us our options for staying in touch (FB video messenger worked and works great for us)." "I like having the option of the nursing home having a tablet/iPad so that I could FaceTime my dad."

The participants were also asked to identify any challenges in communicating with the LTCF. Two distinct themes emerged from the analysis: poor quality communication and a lack of staff, which contributed to the inability to access information about family members/sponsors. The participants expressed concerns regarding poor-quality communication, such as inconsistent updates about the status of family members. In addition, it was suggested that the lack of staff contributed to the challenge of acquiring information (see Table 4).

Table 4. Survey I – Challenging Communication Experiences

Theme	Responses
1. Poor-Quality Communication	"Communication is spotty. Messages left on voice mail take days to get return calls. Sometimes a week." "My mother had to suggest that they communicate something, anything between March and end of May or June. There have been at least monthly updates since then."
2. Lack of Staff	"I believe the struggle to have enough staff plays into communication as well." "I hated to call because it took staff from hands-on care. We did not have the leadership at our facility because our Head was out due to sickness and other staff were sent to a sister facility." "The staff do not have time to answer the phone if they are providing care to the residents who live there."

Survey II

The participants in Survey II were asked to rate how satisfied they were with the information received regarding visitation rules/regulations during the second wave. As noted in Table 2, slightly more than half (52%) indicated they were very satisfied, and the remaining participants were satisfied (44%) or not satisfied (4%).

The participants were also asked about their greatest challenge in getting accurate information about visitation rules/regulations from the LTCF. From the analysis of these responses three themes emerged: quality of information, inability to contact the facility, and uninformed staff (see Table 5). Participants indicated that a lack of clarity, inaccuracy, and inconsistency in the information provided was a source of frustration. This was further complicated by a lack of available information, which resulted in family members having to initiate contact with the facility. Participants also reported that once contact was made, staff seemed to be uninformed and unaware of the status of visitation guidelines and regulations.

Table 5. Survey II – Challenges Receiving Information Regarding LTCF Visitation Rules and Regulations

Theme	Responses
1. Quality of Information	"The biggest challenge in getting accurate information is there has been no clear line as to whom I'm supposed to speak with."
	"Understanding all the info that is coming in as it changes so many different times…. Would like it a little more in laymen terms, it is so confusing."
2. Making Contact	"Having to contact the home itself to get information. Shame they don't communicate better."
	"Always had to call in to ask for information, would have been appreciated to have a weekly update."
	"Facility does not reach out ever to provide any updates."
3. Uninformed Staff	"The nurses don't seem to understand what's going on."
	"Staff are busy and no time to talk. Also, they seem to be on the defensive rather than being sure they are meeting their client's needs. Managerial staff tell you what you want to hear rather than the actual fact."
	"Finding out who was responsible for decisions. I was told by Department of Health it was up to the nursing home and at the same time, the nursing home told me it was up to the Department of Health."
	"When family calls, they need an answer, not 'Staff hasn't been updated yet.'"

Family Recommendations for Improvement

The participants in both Surveys I and II were asked to make recommendations that could help improve communication between themselves and the LTCFs. Three distinct themes emerged from the analysis: regular updates, clear and consistent information, and having a digital presence (see Table 6). Family members repeatedly indicated that regular updates that contained clear and consistent information were essential. The participants also suggested that a stronger digital presence would enable more effective communication. This included recommendations for regular posts on Facebook and updated websites.

Table 6. Surveys I and II Recommendations for Improving Communication

Theme	Responses
1. Regular Updates	"Regular updates and information sharing. Although I understand this can be time-consuming. Other facilities provide updates without being prompted to do so. Also, one mass communication would actually be a time saver rather than addressing each individual family as the call or email." "Weekly update or more clarity, the difference in some procedures and policies between the homes."
2. Clear and Consistent Information	"Regular, consistent messaging to designated family members." "A must to be absolutely clear about what is being done and what the visitation policies are. Clear, honest, pertinent information is reassuring and helpful during these times."
3. Digital Presence	"Post changes on the facility website. Under a special tab." "Update Facebook page regularly—even just to say all is well." "Make any situation that can be made, via social media, radio, or other public means to get a message or announcement out right away. Of course, general information doesn't affect confidentiality. This could be followed up with phone calls or emails."

Discussion and Conclusion

The purpose of this research was to examine the transfer of information between New Brunswick LTCFs and the families/sponsors of their residents. The findings of two surveys conducted during the first and second waves of the pandemic provided insights into these experiences, which can be beneficial in shaping policy and practice within the LTC sector in New Brunswick.

The findings from Survey I showed high levels of satisfaction with the adequacy of information provided. This was attributed to staff and the ability of family to use social media platforms, like Skype and FaceTime, to be in contact with their family member. It is important to consider that this survey was conducted at the end of the first wave when there had only been one LTCF death related to COVID-19 (see Table 1).

As the pandemic progressed into the second wave and the number of deaths increased in New Brunswick LTCFs, the population experienced frequently changing restrictions, which varied across the province. *The Quebec Ombudsman's Status Report* likened the pandemic period to "building an airplane while it is airborne" (18). New Brunswickers were subjected to changing restrictions, often with little notice. This may be reflected in the responses of participants in Survey II, who indicated lower levels of satisfaction with information. This corresponds to a decrease in levels of satisfaction compared to the higher rates reported in Survey I (see Table 2). It should be noted that by the end of the second wave the number of LTCF COVID-19 related deaths were on the rise (see Table 1). The participants in both surveys indicated poor-quality communication as a key challenge to accessing information about a family member. In addition, lack of staff and uninformed personnel were identified as additional obstacles. This may reflect information overload and the delivery of news or updates in a format that was not accessible.

There are lessons to be learned from examining the communication strategies used in LTCFs during the COVID-19 pandemic. The findings from this study are consistent with several reports that assessed the impact of COVID-19 in Canadian LTCFs. In most of these reports, communication was identified as a key factor in effectively managing a pandemic outbreak and improved cross-sector exchange was recommended (CIHI, *The Impact of COVID-19 on Long-Term Care in Canada* 23). Ontario's Long-Term Care COVID-19 Commission stated: "It is clear to the Commission that poor communication with staff, residents and families amplifies feelings of isolation and helplessness in a crisis." (*Final Report* 190). A key element to managing a pandemic is having effective communication that not only keeps populations informed but can reduce the impact of psychological stress caused by not knowing the status of family members (Patient Ombudsman, *Special Report* 6).

In this study, the experiences of New Brunswick families are in line with reports across the LTC sector during the pandemic period. In general, family members suggested that clear, consistent information and a greater digital presence would enhance the quality of communication received from LTCFs. In addition, families identified that LTCF staff were an important part in conveying information. This signals that not only does communication with families need to be clear and consistent but must also be delivered in a variety of ways. These suggestions can be used to inform public policy and practice. However, it should be noted that these basic practices are already identified as integral to proper pandemic planning. Clear and consistent messaging is in fact central to pandemic management. The Ontario Patient Ombudsman recommends that resources be dedicated to providing regular and timely communication to residents, staff, and families (Patient Ombudsman, *Special Report* 28).

The New Brunswick government should consider providing the LTC sector with the resources to enhance communication strategies. This includes education and funding for hardware and software programs that can assist in enhancing the dissemination of information. It must be recognized that location and size of the facility may also impact the ability to dedicate resources to such improvements. It is also important for the LTC sector to be considerate of target populations and tailor the delivery of information accordingly, while being mindful of those who do not or cannot use digital platforms to access information. The lessons learned need not be restricted to a pandemic period but are certainly applicable to the need for better communication in general.

Strengths and Limitations

The main strength of this study is that it provided an opportunity for the families of those living in New Brunswick LTCFs to express their experiences with the exchange of information during an unprecedented time. This information will prove fruitful for informing policy and procedure change as it relates to communication with LTCF stakeholders. This study is not without limitations. The restrictions imposed during the pandemic were particularly challenging and limited data collection options. The use of online surveys to collect data means that participation in the survey was limited to those who had access to social media and the Internet. Therefore, those who did not have access or those who chose not to use Facebook or the Internet were not represented in the sample. In addition, the lack of consistent and regular reporting of New Brunswick COVID-19 deaths in LTCFs throughout the entirety of the pandemic has limited the ability to understand the scope of the coronavirus's impact on the LTC sector.

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Notes

[1] Belgium, Canada, Denmark, France, Germany, Ireland, Italy, Netherlands, Spain, Sweden, United Kingdom, and the United States.

[2] Special care home—resident requires 24/7 assistance with activities of daily living and does not require 24-hour nursing care; nursing home—resident requires 24/7 nursing care and must be medically stable.

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