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THE QUÉBEC OMBUDSMAN'S STATUS REPORT

*COVID-19 in CHSLDs during the
first wave of the pandemic*

**LEARNING FROM THE CRISIS
AND MOVING TO UPHOLD THE
RIGHTS AND DIGNITY OF
CHSLD RESIDENTS**



Québec City, December 10, 2020

THE QUÉBEC OMBUDSMAN'S MISSION

The Québec Ombudsman sees to it that people's rights are upheld by intervening with Government of Québec departments and agencies and with health and social services network institutions to request corrective measures in situations that harm people or groups of people. It also handles disclosures of wrongdoing relating to public bodies and reprisal complaints stemming from disclosures. Appointed by at least two thirds of parliamentary members and reporting to the National Assembly, the Québec Ombudsman acts with complete independence and impartiality whether its interventions arise from its processing of complaints, reports, or disclosures, or from action on its own initiative.

Respect for people and for their rights is at the heart of the Québec Ombudsman's mission. Its preventive role is expressed primarily through its analysis of situations that cause harm to great numbers of citizens or harm that is systemic. Pursuant to the powers conferred on it, it may also propose amendments to acts and regulations and changes to directives and administrative policies in order to improve them in the interest of the people concerned.

This report was made possible through the collaboration of:

Data collection and analysis

Julianne Pleau and Julie Roussy, Delegates – Direction des enquêtes en santé et services sociaux

Coordination and management

Nicolas Rousseau, Coordinator – Direction des enquêtes en santé et services sociaux

Marie-Claude Ladouceur, Coordinator – Initiative de réalisation des interventions spéciales (IRIS)

Hélène Vallières, Deputy Ombudsperson – *Affaires institutionnelles et prévention*

Interviews

Brigitte Carrier, Jacinthe D'Amours, Lyne Deschênes, Marise Lapointe, Johanne Savard and Hélène St-Amour, Delegates – Direction des enquêtes en santé et services sociaux

Analysis and support

Mohamed Jeddy and François Ross, Adviser – Direction du soutien à la gouvernance

Edith-Farah Elassal and Caroline Moulin, Legal Advisers – Direction des affaires juridiques et des interventions spéciales

Jeescy Pouliot, Executive Assistant – Vice-protectorat *Affaires institutionnelles et prévention*

Text

Francine Legaré, Communications Adviser – Direction des communications

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Summary

Background

Management of the COVID-19 crisis in CHSLDs during the first wave of the pandemic drew stinging criticism, mainly concerning the disorganization, deterioration and dehumanization of care. On May 26, the Québec Ombudsman therefore announced that it would conduct an independent and impartial investigation into the crisis and how the government managed it in CHSLDs. Work will continue until the fall of 2021. In the meantime, it became obvious that the floor had to be given to the witnesses—residents, informal caregivers, healthcare staff and managers—who had experienced the events firsthand.

The Québec Ombudsman based its findings on:

- The observations of the 1,355 people who responded to its call for witness statements and input;
- Sixteen briefs from unions, research groups, not-for-profit organizations, and users' committees;
- Interviews with residents, family members, CHSLD staff, and CISSS and CIUSSS managers;
- The complaints and reports it received and those received by service quality and complaints commissioners;
- The large quantity of documents and literature it consulted.

Using the findings from these sources as a starting point, the Québec Ombudsman has already identified lessons to be learned from the first wave in CHSLDs. It has gone on to pin down the priorities for action that must be implemented immediately so that care and services in CHSLDs are a worthy response to the needs of residents and their families.

Portrait of the situation

The statements gleaned and the Québec Ombudsman's investigation show that:

- CHSLDs were the blind spot in preparing for the pandemic, with efforts massively concentrated on hospitals;
- Faced with an unknown virus, authorities sharply underestimated COVID-19's virulence, its ability to spread and cause death, its impact on elderly people and staff, and the challenges of testing;
- Personal protective equipment was insufficient and unequally distributed;
- Staff mobility contributed to the spread of the virus;
- The fact that informal caregivers were shut out took a heavy toll on residents' mental and physical health;
- Basic care and services (hygiene, assistance with eating and mobility, and hydration) were postponed or cancelled;
- CHSLDs were not equipped to provide the same intensity of care as in hospitals, but this is what was expected of them at the height of the crisis;
- Relief teams from outside were late to arrive in CHSLDs;
- CHSLD decisional power was far from the outbreaks of the virus.

We will not soon forget that healthcare staff, universally praised for their dedication, were heavily hit physically and psychologically. In this respect, the figures speak volumes: between March 1 and June 14, 2020, 13,581 healthcare workers contracted COVID-19, a full 25% of cases reported during the first wave. Eleven of them died. Many of them were made soul-sick by the health crisis and the suffering and death that occurred before their very eyes for weeks on end.

Act now

In its Progress Report, the Québec Ombudsman emphasizes five priorities for action:

1. Focus CHSLD care and services on the needs of residents in order to respect their rights and dignity, and acknowledge the role of informal caregivers;
2. Ensure a stable workforce in CHSLDs and sufficient numbers of staff;
3. Continue to deploy a local manager to each CHSLD who can exercise strong local leadership;
4. Establish a rigorous culture of infection prevention and control within CHSLDs that is known by all;
5. Strengthen local, regional and Québec-wide communication channels in order to convey clear information and directives and facilitate sharing of best practices.

The report concludes that the lessons from the pandemic are clear and concrete. There is now no excuse for lateness in making decisions that enable action. The rights and dignity of the people who live in CHSLDs must be paramount.

Like all Quebecers, the Québec Ombudsman thanks all the workers who remained, despite the extent of the outbreak which is documented in this report, so that no one would be left uncared for.

1. BACKGROUND

1. From the onset of the COVID-19 pandemic in March 2020 and throughout the ensuing months, the alarming situation in several residential and long-term care centres (CHSLDs) was roundly criticized. Residents and their families expressed their dismay to the Québec Ombudsman. Mainly, they decried staff shortages, major shortcomings in basic care, surging outbreaks and residents' deaths, informal caregivers being shunted aside and the residents' isolation, lack of information to families and deterioration of living conditions. As a result, investigations were announced.
2. On May 26, the Québec Ombudsman let it be known that it would be conducting an impartial and independent investigation about the COVID-19 crisis and how the government managed it in CHSLDs. A progress report was slated for the fall of 2020 and a final report for the fall of 2021.
3. In the Québec Ombudsman's opinion, given the extent of the problems and the complexity of the challenges, the investigations announced by various organizations are relevant in bringing to light information about problems as well as possible solutions. Once these investigations are completed, improvement of living environments such as CHSLDs will necessarily hinge on additional findings and concerted action.
4. In the context of this progress report, the Québec Ombudsman has taken on the goal of being part of the solution, notably by giving the floor to people who experienced the crisis first-hand and who faced what many have described as a loss of control and a dehumanization of care in CHSLDs. Many of these people approached the Québec Ombudsman. They were the catalysts of its investigation, in keeping with its mission that includes handling of complaints and reports in order to determine whether public services respect the rights of people, who are the very reason for the existence of these services. Moreover, the Québec Ombudsman's call for witness statements and briefs drew many participants.
5. By giving these witness the utmost attention in the progress report, the Québec Ombudsman aims to document how the crisis unfolded, its impact on services, care system responses and the workings of the decisional chain.

1.1. CHSLDs and the first wave under scrutiny

6. The Québec Ombudsman's investigation focuses on public and private CHSLDs and the first wave of the pandemic (from March to June 2020). But why limit the investigation to one residential resource category and the first months of the crisis?
7. It bears remembering that the vast majority of COVID-19-related deaths occurred in CHSLDs during the first wave¹. In comparison, there were fewer deaths in the other types of resources (private seniors' homes and intermediate resources). Hotspots for outbreak and death, during the first wave, CHSLDs were the epicentres for events that cry out for urgent changes.

¹ As at June 30, 2020, Institut national de santé publique du Québec (INSPQ) data indicated that 69% of the people who had so far died of COVID-19 in Québec lived in CHSLDs (3,890 out of 5,629 deaths).

8. These residential environments are home to people with severely impaired physical and cognitive health and autonomy, thereby making them extremely vulnerable. Hence the Québec Ombudsman's decision as to the scope of the investigation, whose findings could then be extrapolated to other residential resources for the elderly and to subsequent waves.

1.2. A systemic investigation that, exceptionally, includes a progress report

9. Usually, the Québec Ombudsman's investigations do not entail progress reports. This time, an exception was made because of the extent of the crisis and the need for an investigation spread over many months, as well as the necessity to dissect the crisis in the short term and to prioritize the needs that must be addressed immediately.
10. As soon as the pandemic began, the complaints received by the Québec Ombudsman pertained most often to systemic issues. For example, many informal caregivers lamented the fact that they were not allowed into the residences to help their loved ones, or that it was impossible to obtain adequate information. The authorities in charge were already apprised of the various grounds for complaint in the context of the acute crisis. It was therefore appropriate for the Québec Ombudsman to produce an overall picture, which would involve in-depth analysis, in addition to targeted action in individual situations when it was possible. It began by identifying the main themes of the investigation, namely:
 - Preventing and controlling COVID-19 outbreaks in CHSLDs;
 - Maintaining adequate provision of care and services in CHSLDs.
11. This report makes it possible to present the goals of the investigation, how the work is progressing, the viewpoints of the witnesses and of those directly affected by the crisis, the main lessons learned from the first wave, as well as priorities for action, from a constructive improvement-centred vantage point.

1.3. Work progress

12. The following activities have been carried out so far:
 - Selection of a sample of ten public and private CHSLDs in various regions of Québec;²
 - Launch of a field investigation in residential centres and into the integrated health and social services centres to which they report;
 - Analysis of the complaints and reports received by the Québec Ombudsman since the onset of the pandemic in the CHSLDs;
 - Analysis of the complaints and reports received by the service quality and complaints commissioners;
 - Exploratory exchanges with MSSS representatives;
 - Call for input from CHSLD residents and their families, as well as from health network staff across Québec who worked in a CHSLD between March and June 2020, and quantitative processing of the data obtained;
 - Invitation to organizations, associations and experts to submit their findings and recommendations concerning the management of COVID-19 during the first wave of the pandemic by means of briefs, and analysis of the briefs obtained;
 - Survey of articles in the media;
 - Survey and analysis of administrative and scientific documents.

² Montréal, Laval, Capitale-Nationale, Mauricie-Centre-du-Québec.

13. The following activities are underway or will be carried out:
 - Field investigation of the selected CHSLDs to be completed;
 - Investigation regarding MSSS and public health authorities;
 - Analysis of all the documentation received from MSSS and from various sources;
 - Comparative analysis of the management of the COVID-19 crisis in long-term care homes in other Canadian provinces;
 - In-depth analysis of the scientific literature;
 - Comprehensive analysis of the information collated during the investigation;
 - Production of the final investigation report.

2. PORTRAIT OF THE SITUATION: SHORTCOMINGS AMPLIFIED BY THE SPREAD OF AN UNKNOWN VIRUS

14. The Québec Ombudsman launched a call for witness statements and input on the management of the COVID-19 crisis in Québec CHSLDs. The exercise took place from September 2 to October 2, 2020. In all, 1,355 people answered one of Québec Ombudsman's three electronic questionnaires: one for workers (822 respondents), one for informal caregivers (498 respondents) and one for residents (35 respondents).
15. In its call for briefs (from September 2 to October 16, 2020), the Québec Ombudsman received 16, mainly from unions, researchers, not-for-profit organizations, and health and social services network users' committees.
16. The field investigation of the CHSLDs that formed the sample began on August 27, 2020, and is still underway. So far, nearly 250 interviews of residents, their families, staff and managers have taken place.
17. The Québec Ombudsman has given the floor to these people, as well as to those who sent in complaints and reports, but wants to make it clear that:
 - The statements from the testimony received and reported here do not represent the Québec Ombudsman's final findings because the investigation is still underway. However, they were corroborated by other people who experienced similar events, by CISSS and CIUSSS managers who acknowledged the gravity of the problems, and by the studies and documents consulted.
 - As a whole, the comments collected report immense dedication by CHSLD staff, as well as internal disorganization for more systemic reasons.
 - The comments at this stage of the investigation aptly illustrate reality in CHSLDs heavily hit by the pandemic. However, the picture is not complete.
 - The Québec Ombudsman feels that it is important to remember that not all Québec CHSLDs, even in the more critical zones such as Greater Montréal, experienced acute crisis.

FIRST WAVE: BRIEF TIMELINE OF EVENTS

DATES / 2020	EVENTS
February-early March	<ul style="list-style-type: none"> Hospitals in preparation mode Hospital users transferred to CHSLDs
March 11	<ul style="list-style-type: none"> Travellers from outside Québec isolated
March 13	<ul style="list-style-type: none"> Health emergency declared in Québec MSSS sends CISSSs and CIUSSSs the <i>Guide d'adaptation de l'offre de services en CHSLD</i>
March 14	<ul style="list-style-type: none"> CHSLD visits prohibited
Around March 20	<ul style="list-style-type: none"> Start of outbreaks in CHSLDs CHSLD residents confined Order in council : suspension of collective agreement working conditions to allow staff transfers and cancellation of vacations
Early April	<ul style="list-style-type: none"> The number and size of outbreaks increase: hot zones overspill Difficulty putting in place infection prevention and control measures (equipment, testing, training, etc.) Increased absenteeism by contaminated staff and managers, or those having been in contact with a positive case Difficulties with communications with families
Mid April	<ul style="list-style-type: none"> Massive testing in some CHSLDs affected by major outbreaks Substantial withdrawal of staff and managers further to their positive test results or the appearance of COVID-19 symptoms Support teams from other activity sectors organized
Mid-late April	<ul style="list-style-type: none"> Relief staff and managers from all sources deployed and integrated (reassigned staff and management, <i>Je contribue</i> program)
May	<ul style="list-style-type: none"> Situation stabilized Regular CHSLD staff return progressively Significant informal caregivers allowed to return
June	<ul style="list-style-type: none"> CHSLD open for visitors End of the first wave

2.1. CHSLDs were the blind spot in preparing for the pandemic.

18. In the opinion of managers and staff in the trenches, a colossal effort was made to brace hospitals for the pandemic, but the same did not happen in CHSLDs.
19. This order of priority is no different from public service efforts in recent years that emphasize hospitals rather than substitute living environments and home care.
20. This time, in order to widen hospital centres' room to maneuver, CHSLDs were pressed into service to quickly and massively take in hospitalized people. These transfers rapidly exerted an adverse affect on the ability of CHSLDs to contain the outbreaks. For example, there was a shortage of rooms available for isolating positive cases. Furthermore, people who could have been infected were moved to CHSLDs without being tested or isolated when they arrived.
21. The ministerial directives concerning adapting the service offering in CHSLDs in the context of the COVID-19 pandemic were only transmitted on March 13, at the same time that the health emergency was declared in Québec.
22. Residential resources, where the first outbreaks were to occur a week later, were thrust into "reaction" mode to the events, without having the required resources to wage an effective battle.

I recall a nursing assistant calling for help. He'd just finished a 12-hour night shift and was alone in a hot zone. No orderlies and no doctors.

2.2. Faced with an unknown virus, the threat was underestimated.

23. In March, the lack of knowledge about COVID-19 meant that CHSLDs had no choice but to implement existing plans for managing influenza epidemics. Before long, it became obvious that the intended courses of action were not suited to the nature of the illness. For example, the rapid spread of contamination to users, staff and managers was completely unexpected.
24. Nor had health authorities anticipated the tens of thousands of screening tests that would have to be done every day and processed within 24 to 36 hours.
25. On top of the lack of knowledge on the scientific and clinical level, there was the lack of an infection prevention and control culture in CHSLDs. Staff were not accustomed to following strict standards in that regard, and they had minimal training in it.

When planning, we never imagined the extent of what lay ahead. We never thought that there would be CHSLDs where 25% to 50% of the residents would be infected at the same time as half the staff was out.

2.3. Personal protective equipment (PPE) in insufficient amounts were distributed unequally.

26. At the beginning of the first wave, the shortage of personal protective equipment (PPE), such as masks, visors and smocks, was a significant cause of the general insecurity that prevailed and, furthermore, of the spread of the virus.
27. Subsequently, reserves adjusted to needs, but distribution was not immediately effective or able to halt contagion. As a result, confusion arose as to how to use PPE, along with a certain resistance to complying with the means employed to fight the pandemic. On the ground, doubt began to proliferate: were the authorities transparent about the real availability of PPE? According to observers, a period of disorganization ensued during which there was major understaffing and ruptured care continuity.
28. Staff members also had this to say about the shortage of material:
 - As part of our call for input, 48% of healthcare workers reported not having enough PPE, mainly because of shortages.
 - A good many of them were limited to two, or even one, mask per day, especially in March and April;
 - PPE was distributed piecemeal in CHSLDs;
 - Some material was defective or not adapted: mistakes in sizing, poor quality smocks;
 - The directives for using PPE seemed to be based more on the quantities available than on safety standards;
 - PPE was unevenly distributed in the various regions of Québec.

I reported to the CHSLD on April 19. At a clinical team meeting, I learned that there were 200 smocks on reserve when, normally, we should have used 1,800 a day.

2.4. Staff mobility contributed to spreading the virus.

29. In the opinion of healthcare staff and managers, human resource management based on the mobility of staff between CHSLDs and internally, from sector to sector, was an established practice well before the pandemic. Maintained at the beginning of the crisis, this practice increased the spread of the virus and could not be suspended in a timely manner because those in charge were afraid that a break in care and services would occur.
30. In the weeks that followed, efforts were made to stabilize teams, with an emphasis on keeping staff in a single CHSLD. This was never totally achieved. Ten per cent of workers who answered the questionnaire report having worked in more than one centre between March and June 2020.³
31. Movement between hot zones and cold zones in a same centre continued to worry many workers but proved necessary given the shortage of staff, especially nursing staff.

³ This figure is consistent with data in the *Enquête épidémiologique sur les travailleurs de la santé atteints de la COVID-19 au printemps 2020*, Institut national de santé publique – Direction des risques biologiques et de la santé au travail, 2020, p. 19 (figure 5 b).

Already there were several cases in the building and staff members were still sharing the employees' lounge without distancing. I talked about it to my manager, who replied that it was no big deal. I also complained that the employees were made to go from floor to floor, merrily moving from cold zones to hot zones. Despite the complaints, it continued and the infection spread throughout the building.

2.5. The ban on visits by informal caregivers created anxiety and distress.

32. Many residents and their families, as well as professionals and managers, feel that the complete prohibition of visits to CHSLDs by informal caregivers on March 14 was a mistake and exacted a heavy toll on residents' physical and mental health.
33. Informal caregivers confided that they had experienced intense anxiety, mainly from the end of March until mid-April. Not only were visits no longer possible, but families were unable to obtain the least information about their loved one's health or the services provided. Residents—often among those with a severe loss of autonomy or serious cognitive impairments—facing solitude and no longer being comforted, stopped eating and in some cases, even let themselves die.
34. Some families managed to see their loved ones on humanitarian grounds just before the resident died. When the virus was running rampant, others were not given that opportunity.
35. The separation of visitors from loved ones was partly resolved in mid-April when staff were assigned to organize virtual visits and provide information to the families. Teams of professionals (physicians, occupational therapists, psychologists, social workers and administrative assistants) were dispatched to CHSLDs and assisted in providing information. This was greatly appreciated.

The lack of phones or tablets on the care units for communicating with our family member before it was too late was absolutely heartbreaking. We couldn't talk to him even once after his fever started, let alone say good-bye. We could only imagine his distress and our only consolation is knowing that one of the people who cared for him regularly was able to be with him at the end.

Sanitary rules were repeated constantly and issued as orders. "Go to your room. You're not allowed to go out. We're going to tie you down." These rules were drilled into us and ended up by affecting our morale and making us angry when we were told that there wasn't time to go get our hot water, for example.

2.6. Care and services were postponed or cancelled.

36. In its call for input, the Québec Ombudsman questioned residents and their families about whether care delivery and quality remained the same or deteriorated between March and June 2020: 46% of residents and 60% of families reported poorer or insufficient quality.
37. The Québec Ombudsman also asked healthcare workers if they had seen shortcomings in the care and services to the residents of the CHSLD or CHSLDs where they had worked between March and June 2020. To obtain these answers, it listed the main kinds of care and services in CHSLDs. The respondents were asked to specify whether there were failings in each of the care and service categories and if so,

what they were. Most (83%) of the 554 staff members who answered this question identified on average at least four failings. The most frequent categories concerned the following services:

- Activities and recreation (60%);
- Basic care and support (53%);
- Personal care (47%);
- Psychosocial care (44%);
- Rehabilitation services (42%).

38. It is particularly disturbing to see that more than half (53%) of respondents pointed to failings in basic care and support. The most frequent comments concerned the lack of time to assist at mealtime, lack of time to give residents water, and lack of time to get residents out of bed or to take them out of their room because of the shortage of staff to help residents with their mobility.
39. More than half of respondents (47%) also noted deficient hygiene care. Understaffing and its impact on care are mentioned in almost all the comments. The respondents pointed out in particular that personal care decreased or that corners were cut. Baths and showers were less frequent or replaced by a bed bath. In many cases, dental care was reduced or ceased altogether.
40. While it was not a widespread phenomenon, people reported that the staff shortages caused by major COVID-19 outbreaks in some CHSLDs created ruptures in basic care, especially during the first weeks of April, when there was a massive and sudden exodus of staff due to COVID-19. As a result, residents did not get the help they needed with eating and drinking properly. They received only very partial personal care and had to wait to have their incontinence briefs changed.
41. Because they needed help moving about and getting dressed, some residents remained in bed in their hospital gowns for several days, and sometimes, for several weeks. At times this led to irreparable damage to their physical or cognitive health and to bedsores for which the nursing staff had no time to change the bandages as needed.
42. It also speaks volumes that overall, 71% of healthcare workers said that they had tried to denounce one or several situations which they considered unacceptable.

Certain residents didn't receive full personal care (bath, shower) or have their hair washed for several weeks.

From early to mid-April, staff shortages were glaring. I remember a few days when I even found myself alone with one orderly for a unit of 50 residents. Obviously, we couldn't help everyone eat. The residents remained undressed in bed all day, sometimes only with their incontinence briefs on without any other clothing. No mobilization. They all stayed in their beds. We didn't have time to turn them to prevent bedsores.

2.7. CHSLDs were not equipped to provide the same intensity of care as in hospitals.

43. From the very beginning of the pandemic, it was obvious that CHSLDs were not equipped to turn themselves into places where hospital care could be provided, whether in terms of material, PPE, clinical knowledge or staff ratios. This is what they were asked to become in a matter of days.
44. The CISSS and CIUSSS managers interviewed reported that initially, they believed that they could transfer residents who had COVID-19 to designated hospitals, which was not the case. CHSLD staff

therefore experienced high stress levels knowing that they could not provide the appropriate care. Several had to make wrenching decisions as to which person would receive end-of-life care rather than another.

We lacked medical equipment—infusion pumps, oxygen concentrators and other instruments that are not normally used in CHSLDs.

Because of the lack of equipment, sometimes we had to choose between two patients in respiratory distress to decide which one the care protocol would be used on. It was unbearable. I had to go into therapy because of it.

2.8. Relief teams were late to arrive at CHSLDs.

45. Because of the urgent need for more staff in CHSLDs, hospital and CLSC workers were re-assigned to lend a hand. Others volunteered by means of the *Je contribue* platform. The Canadian Armed Forces and the Red Cross also provided workers.
46. In the opinion of many witnesses, assignment of these additional resources, albeit highly appreciated, happened late (in late April). In some cases, the crisis had already been raging for several weeks.
47. According to certain CISSS and CIUSSS managers, their cries for help came early in the game, but the arrival and concrete intervention of ground support was late. Moreover, often these people did not have the appropriate training to be quickly operational and autonomous.

2.9. CHSLD decisional power was far from where the action really occurred.

48. The numerous problems in the most affected CHSLDs should have been managed locally, in other words, by people who exercised strong leadership on the ground where the outbreaks and staff shortages were happening. The fact of receiving trickle-down directives or of awaiting directives that never materialized weakened the decisional chain considerably. Nursing staff witnesses criticized the lack of agility needed to act appropriately, directly and in a timely manner, particularly in the context of a crisis.
49. Given that there were no managers in the living environments, the challenge was not only to ensure the safe delivery of care, but also to integrate relief workers from outside and to ensure that they obeyed the directives.
50. Testimonies show that at the height of the pandemic, CHSLDs often first heard decisions by the Direction générale de la santé publique and the government during the premier's press conferences, decisions that could not be applied on the spot given the unwieldy governance structure.
51. Many staff members and relief volunteers reported that they were left to their own devices despite being there to provide assistance in an unknown environment. Teams had to self-manage and organize care without a band leader who could ensure cohesion. Managers were also dispatched from other environments. They encountered the same challenges related to their lack of knowledge of the context.

There were no managers and no clear directives. The orderlies had to decide which residents would get oxygen equipment.

2.10. Healthcare staff were heavily affected physically and psychologically.

52. Some figures are especially telling: between March 1 and June 14, 2020, 13,581 healthcare workers contracted COVID-19 (25% of reported cases during the first wave). Eleven of them died. Their risk of contracting the disease was ten times higher than that of the population at large.⁴
53. Numerous testimonies to the Québec Ombudsman expressed workers' fear of COVID-19, an unknown virus that was wreaking havoc in the client population and colleagues before their very eyes. Many staff members felt distressed and very powerless because their work environment was now grappling with:
- general disorganization;
 - an increasing death toll;
 - numerous cases of people who no longer received the required care and services.
54. Twelve-hour work shifts over a long period of time were common, with no prospects for a break or a holiday anywhere in sight. The heaviness of the task that was already significant before the pandemic was exacerbated. Another obstacle staff had to surmount was strong pressure from the media that focused primarily on the most catastrophic situations. Staff reported that they threw themselves body and soul into their job, but the media seemed to disregard this and show only the negative aspects.

I was horrified at being at the deathbed of so many people I'd become attached to. There are images I'll never be able to un-see. My colleagues and I often cried together because it was too hard to see these people go.

2.11. This is what the CHSLDs spared from the crisis did differently.

55. Even in Greater Montréal, Québec's and even Canada's most hard-hit region during the first wave, some CHSLDs were spared from COVID-19 outbreaks. Testimonies provided an overview of how they dealt better with the events by establishing strict control over:
- movement within the premises;
 - who entered and exited the CHSLD;
 - staff who had travelled;
 - staff with COVID-19-like symptoms;
 - ongoing and stringent application of infection prevention and control standards, notably by means of the constant presence of managers on the premises (local management);
 - the admission of external staff to ensure that no one had worked in a high-risk care environment before.

⁴ *Enquête épidémiologique sur les travailleurs de la santé atteints de la COVID-19 au printemps 2020*, Institut national de santé publique – Direction des risques biologiques et de la santé au travail, 2020, p. 1.

3. EPICENTRE OF THE CRISIS: REAL-LIFE EVENTS IN CHSLDS

56. Wanting to give the floor to the witnesses, the Québec Ombudsman has transcribed the following selected comments because they illustrate events or observations that corroborate what was said overall.

3.1. An orderly's experience

Staff training and availability

Before March, the management of the CHSLD made a point of assuring us that COVID-19 would not make it into our environment. But I didn't feel safe. I had absolutely no training in infection prevention and control.

At the beginning, we were like in a battlefield unit. We had no support and there were three to four deaths per day. We didn't know where to put the bodies anymore.

3.2. A nursing assistant's experience

Staff availability

During some night shifts, one nurse and one or two nursing assistants were in charge of several floors. I often pulled double shifts because there was simply no more staff. It was like a battlefield: we didn't have time to take care of everyone and we felt like we were abandoning them. At the height of the crisis, the staff and the residents were left on their own. It was a total state of emergency. It was like the boat was sinking.

Availability of material

I was comfortable with the infection prevention and control measures, but the staff were misinformed. The first few days, we couldn't wear masks because the managers said that it would scare the residents and the virus wouldn't throw itself at people. Later, we had to wear the same mask all day long.

Delay in applying prevention and control measures

At first, staff who had symptoms weren't removed. It only happened later.

Every floor of the CHSLD had COVID-19 cases, one of the reasons being the elevators, when we were taking infected residents to the red zone, which had changed floors twice.

3.3. A nurse's experience

Staff training

When I got to the CHSLD unit, I was given an orderly's job. I saw immediately that the situation was much worse than in the CHSLD I was coming from. Residents in respiratory distress an hour or two before they died should have been given morphine to relieve them. But the nursing staff hadn't been trained to administer comfort care. All they could do was give them analgesics. No palliative care unit had been set up.

Staff availability

At one point, massive testing was ordered for the residents and the entire staff, including kitchen workers, managers, and caregiving staff. After the results came in, half the staff was gone.

Because of staff shortages, some users spent 12 hours in their soiled incontinence briefs. Meals were skipped and medication wasn't administered. Residents died alone, distressed and suffering. Pathetic and unacceptable.

PPE use

Right away I noticed that the nursing team was very anxious, and that created bad habits when it came to infection prevention and control. For example, using two or three layers of masks when in fact there was a shortage. Even though instructions about PPE were repeated over and over, it's as if no one really heard them because everyone was running on adrenaline. People were so afraid to get COVID-19 that they didn't want to enter certain rooms anymore.

Transfer of infected residents

I believe that more residents should have been transferred to hospitals where there were more staff to at least provide comfort care. But the managers were trying to put out fires, mainly to find staff and limit spread of the virus. Quality of care came second.

3.4. CIUSSS managers' experience

Staff availability

I always felt that the virus was way ahead of us. During the first wave, I had to work 7 days a week for 12 hours a day.

We were lacking staff and we had to find replacements for dozens of employees. Human resources did its best to recruit people, but no one wanted to work in CHSLDs. In early April, we were finally able to use the order in council and relief staff arrived.

Between March 14 and April 10, we dealt with several work reorganizations, repeated outbreaks, red zones set up hastily, and the departure of key people within our structure because they'd caught the virus. On top of that, we had to cope with some families' distress and anger.

Preparing for the pandemic

Clearly, we underestimated the extent of the virus, its severity, gravity and level of contagion. We trained staff in infection prevention and control, and in wearing PPE. But we were completely short on equipment. For example, sometimes the same mask had to be worn all day because there weren't enough to comply with best practices.

Directives started to change continually. We had to keep up to date, make sure that we had the right instructions, digest them and implement them. It was a full-time job. All day long I ensured that the instructions reached the CHSLD teams, public or private.

With COVID-19, every hour counted. If it took a residence 12 hours or 24 hours to react, it could mean that an entire floor became contaminated.

3.5. An informal caregiver's experience

Involvement of family members and friends

For three years, other informal caregivers and I took turns at his bedside noon, evening, and at bedtime to help him eat and drink, take his medication, stimulate him and support him in general. He'd had Alzheimer's for ten years and had major heart and pulmonary problems that made him vulnerable to COVID-19.

After a month of confinement, and the exclusion of his loved ones, and after the three days he was dying, he passed away alone, dehydrated, in distress and in unimaginable conditions due to the lack of staff. I was able to view the last minute of his life because of the surveillance camera installed in his room before the pandemic. Many weeks after his death, I'm still haunted by what I saw.

4. LESSONS FROM THE FIRST WAVE AND PRIORITIES FOR ACTION

57. In the wake of the first wave, government authorities, CISSSs, CIUSSSs and CHSLDs deliberated and put measures in place in order to understand the difficulties encountered, repair mistakes, and counter the effects of a second wave for which we were given much advance notice. The question was never whether there would be a second wave, but rather, how to properly prepare for its arrival and its gravity.
58. As these lines are being written, numerous elements of the Québec Ombudsman's investigation remain to be collated, analyzed and assembled. Its final report will include its recommendations. But even at this stage, priorities are being shaped by the lessons from the first wave.

4.1. People-centred care and services – Humanization of care and esteem for informal caregivers

59. In light of the first wave of the pandemic, it is clear that maintaining a slate of care services that respect the dignity and integrity of CHSLD residents is a fragile matter, especially in the context of major outbreaks. Long-term care residents must always receive care that is humane, ongoing, safe, of good quality and centred on their needs and rights. CISSSs and CIUSSSs must use adequate and timely means so that CHSLDs can provide this response.
60. The pandemic alone cannot justify the dehumanization of care and services or breaches in protecting our society's most vulnerable persons. Instead, it should give rise to greater safety for these people and a personalized approach that is maintained.
61. All interventions regarding residents must strive to achieve a balance between, on the one hand, the response to their needs and respect for their freedom and autonomy, and on the other, protecting their individual and collective safety. Striking this balance is a daily challenge for the healthcare teams in CHSLDs. CISSSs and CIUSSSs must therefore support them by ensuring that they have an adequate environment, that their knowledge is adequately developed and that the necessary tools are available.

62. In this respect, it is important to always remember that under the law,⁵ residents are the very reason for the health services that they require. Hence the overall response to their needs must be the centrepiece of the concerns and decisions within their living environment.
63. One of the leading lessons from the first wave is that for these living environments to be humanized, CHSLD residents must have access to their informal caregivers.
64. It will be remembered that to prevent outbreaks, public health authorities prohibited these visits temporarily. CHSLD workers quickly realized that the barrier intended to fight the virus also spawned harmful consequences. It is evident that informal caregivers must remain partners of the CHSLDs. Their role with their loved ones must be maintained and strengthened, based on new approaches however. Here is the conundrum: how can contact be allowed while minimizing the risk for outbreaks and getting informal caregivers to fully endorse safety objectives in the common interest?
65. **One lesson from the first wave is that CHSLDs must maintain care that is humane and centred on the residents. Contact between residents and informal caregivers, even in times of pandemic, is essential and contributes to this humanization.**
66. **The authorities must establish the necessary training and guidance so that informal caregivers in all living environments can assume their role as partners in providing humane and personalized care, in times of outbreaks as well as in normal times. This is a priority for action.**
67. **For informal caregivers and families who cannot be there physically, technological means—digital platforms and equipment—must be available and operational for regular contact through social distancing.⁶**

4.2. Staff – Stable workforce in sufficient numbers

68. Not surprisingly, understaffing was one of the main weaknesses in CHSLDs during the first wave of COVID-19. At the peak of the crisis, back-up came from various places and was most useful in providing indispensable assistance. However, this was an emergency response and not a solution to staff shortages.
69. It is essential that there be a significant increase in human resources so that the health network has real room to manoeuvre. It is imperative to act and to tackle the challenges of attracting and retaining staff so that there is a stable pool of workers in CHSLDs and better care and service continuity. Measures must incite and persuade and be concrete and immediate.
70. During the crisis, the government had to increase salaries for network staff and fast-track training of orderlies.
71. This occupation struggles to attract candidates and to keep them. Resolving the problem of a shortage in this worker category hinges on greater esteem for the job they do in assisting people in residential

⁵ *Act respecting health services and social services*, CQLR, s-42, s. 3

⁶ COVID-19 et la socialisation à distance entre les personnes hébergées et les proches aidants en contexte d'interdiction de visite, Institut national d'excellence en santé et services sociaux (INESSS), 2020.

resources.⁷ Orderlies are an indispensable part of the healthcare team. They work closely with residents and their families, and this makes it possible to forge a bond of trust and a feeling of security. Their stable presence in CHSLDs is a priority.

72. The shortage of nursing staff in CHSLDs is also an element that weakens the organization of care in these living environments, especially during what is described as "unfavourable" work shifts: evenings, nights and weekends. In fact, CISSSs and CIUSSSs expressed great concern to the Québec Ombudsman about this subject. This context impedes team stabilization and reduced mobility within teams.
73. **A lesson from the first wave is that the understaffing in CHSLDs is a prime factor in the failings observed in the care and service offering to residents.**
74. **It is urgent that this systemic understaffing be resolved, especially for orderlies and nursing staff, by means that reflect the essential character of these functions. CHSLDs must have a competent and qualified staff in sufficient numbers whose working conditions are appropriate. This is a priority for action.**

4.3. Local management – True local leadership

75. The testimonies and analyses are consistent: in many CHSLDs, between March and June, there was a shortage of managers on-site experienced in making locally-based decisions, pointing the way, indicating which practices to apply, mobilizing the staff, and ensuring that care was reorganized according to needs.
76. In a time of crisis, when every minute may count in an emergency situation, local management is crucial in order to, among other things, motivate and emphasize the worth of staff, coordinate efforts, enable clear communication of directives and oversee application of instructions.
77. In the opinion of many respondents, on-site management would have helped curb outbreaks. The investigation by the Québec Ombudsman showed that when local crisis teams were deployed, staff were better aligned, and this made it possible for action to be better structured. Among other advantages, such teams could have included an on-site coordinator, infection prevention and control advisers, as well as hygiene and cleanliness advisers, a physician, other professionals and unit leaders.
78. The Québec Ombudsman has noted the government measure announced on August 18, 2020, whereby there would be a manager at every CHSLD. This was welcome news for many.
79. **A lesson from the first wave is that the CHSLDs which could count on support and supervision from a manager were able to act and ensure better leadership that contributed to cushioning the crisis.**
80. **The authorities must continue to put a local manager in every CHSLD who can exercise strong local leadership with his or her clinical and administrative team. The manager must have a genuine ability to make decisions and to establish flexible and adapted operations within the CHSLD. This is a priority for action.**

⁷ Plan d'action pour l'attraction et la fidélisation des préposés aux bénéficiaires et des auxiliaires aux services de santé et sociaux, Ministère de la Santé et des Services sociaux, 2020, Mesure 14 : Mesures de valorisation des métiers d'assistance à la personne.

4.4. Infection prevention and control – The right resources at the right time

81. The first wave and the proliferation of outbreaks brought into sharp focus the importance of creating and applying an internal culture of infection prevention and control in CHSLDs that is rigorous, familiar to all, and solidly entrenched in practices and decisions. This assumes the following:
 - Ensuring compliance with infection control and prevention measures within the living environment at all times;
 - Providing sufficient amounts of PPE;
 - Strictly controlling access to the living environment through a careful triage process (informal caregivers, visitors, staff);
 - Having rapid testing ability for residents, staff and families if necessary;
 - Having the human and material resources needed to deal with an outbreak and to reorganize accordingly at all times.
82. **A lesson from the first wave is that the CHSLDs where decisions were made and actions occurred based on solid infection prevention and control measures dealt better with the first wave of the pandemic.**
83. **Each CHSLD must be able to maintain a culture of prevention and infection control everywhere with its staff but also with informal caregivers, visitors and anyone involved in the living environment. This is a priority for action. To do this, each living environment should be able to:**
 - **Access the expertise of an infection prevention and control advisor;**
 - **Implement professional development;**
 - **Constantly promote protection within the CHSLD;**
 - **Limit staff mobility;**
 - **Have premises that can be quickly and effectively adapted to any possible outbreak or endangerment to the residents.**

4.5. Communication and collaboration – Effective channels for conveying clear messages

84. One particular metaphor was often used during the first wave of the pandemic: building an airplane while it is airborne.
85. In other words, knowledge about the virus, application of these new notions, the ensuing decisions, constant adaptation of resources and the organization of services and care, all of this changed from day to day, if not from hour to hour, at a time when confirmed cases of COVID-19 continued to climb, with alarming figures concerning daily deaths.
86. Given this haste, in the opinion of many witnesses, the transmission of information and instructions that would have led to best practices was chaotic at a time when vertical communication (filtering down from MSSS experts and authorities to CISSSs and CIUSSSs and then to the local level) should have better equipped and reassured CHSLD staff as well as residents and their families.
87. The objective should have been to convey a clear, uniform and adapted message, in order to avoid any confusion or perceived contradictions.

88. The sharing of knowledge and good practices among the CHSLDs must also be strengthened. Some were able to fight the virus during the first wave and were able to learn from their experience, but this knowledge was not shared enough. During the second wave of the virus, regions and living environments that were spared during the first wave and could have benefitted from the experience of other environments were hit.
89. **A lesson from the first wave is that to ensure service and care continuity, information and knowledge transfer are crucial factors in understanding issues, in carrying out cohesive action and in agile responses to change.**
90. **Strengthening of local, regional and Québec-wide communication channels is necessary in order to convey clear information and directives. A mechanism for sharing best practices between living environments is also indispensable for informed decision-making and improving professional practices during pandemics and at all other times. This is a priority for action.**

CONCLUSION

91. In Québec and during the first wave, not only was the general public confined as never before, but the current model for residential resources for vulnerable elderly people was stretched to the limit.
92. It is obvious that in many living environments and in the healthcare system, the means employed were sorely incapable of ensuring respect of the residents. Here, we are referring to respect of their dignity, their need to receive personalized care and their desperation because their loved ones could not be there.
93. In addition to the unknowns attached to COVID-19 was the picture repeated time and time again of people made fragile because of their age and sickness, left on their own in living environments on the brink of a precipice.
94. This report stems from the statements of people who were, in one way or another, all victims of the dereliction of duty by too many CHSLDs whose mission was to create genuine living environments.
95. **Considering what the pandemic has taught us, there is no more excuse for delays in decisions that would enable action to uphold the rights of people living in CHSLDs.**

ACKNOWLEDGEMENTS

96. The Québec Ombudsman wishes to thank the many people who opened up to it to talk frankly, honestly, poignantly and often forcefully about what they experienced in CHSLDs during the first wave of the COVID-19 pandemic. These people hope that their words will incite change for a better tomorrow. There is no doubt that their contribution has laid the groundwork for continued work by the Québec Ombudsman.
97. Like all Quebecers, it thanks all the workers who remained, despite the extent of the outbreak which is documented in this report, so that no one would be left behind.



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Québec Office
800, place D'Youville, 19^e étage
Québec (Québec) G1R 3P4
Phone : 418 643-2688

Montréal Office
1080, côte du Beaver Hall
10^e étage, bureau 1000
Montréal (Québec) H2Z 1S8
Téléphone : 514 873-2032

procteurducitoyen.qc.ca
Toll-free : 1 800 463-5070
Fax : 1 866 902-7130
procteur@procteurducitoyen.qc.ca