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THE QUÉBEC OMBUDSMAN'S FINAL REPORT

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

Identify the causes of the crisis, act, remember

Québec, November 23, 2021

November 2021

Mr. François Paradis
President of the National Assembly
Hôtel du Parlement
Québec (Québec) G1A 1A4

Mr. Paradis,

In accordance with section 27.3 of the *Public Protector Act* (CQLR, c. P-32), I am submitting the Québec Ombudsman's special report titled *COVID-19 in CHSLDs during the first wave of the pandemic: Identify the causes of the crisis, act, remember*.

Yours respectfully,

Québec Ombudsperson

The Québec Ombudsman's mission

The Québec Ombudsman ensures that the rights of citizens are upheld by intervening with Québec government departments and agencies and the various bodies within the health and social services network to request redress of situations that are prejudicial to a person or groups of persons. It also handles disclosures 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 independently and impartially, whether an intervention is undertaken in response to a complaint, report or disclosure, or on the institution's own initiative.

Respect of people and their rights and the prevention of harm are at the heart of the Québec Ombudsman's mission. Its preventive role is exercised in particular through its analysis of situations that cause harm to a significant number of citizens or harm that is systemic.

Pursuant to the powers conferred upon it, it can propose amendments to acts and regulations and changes to directives and administrative policies with a view to improving them in the best interest of the people concerned.

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MESSAGE FROM THE QUÉBEC OMBUDSPERSON

The causes of an unbearable human tragedy

On December 10, 2020, I released a progress report by the Québec Ombudsman on how the COVID-19 health crisis unfolded in residential and long-term care centres (CHSLDs) during the first wave of the pandemic. The title is *Learning from the crisis and moving to uphold the rights and dignity of CHSLD residents*.

Given the gravity of the events, for the first time ever the Ombudsman produced a progress report. This made it possible for us to is react with immediacy, pending the results of an in-depth investigation—the second phase of our examination—into how government handled the crisis in CHSLDs. To zero in on the consequences of the health crisis during the first wave of the pandemic and to identify action priorities, we collected witness statements from the people who experienced the events firsthand. The progress report is available on our website. I urge you to read it. Given the compassion and rigour which my team invested in the document, the findings could not be anything but accurate. The report announced that the conclusions of the final investigation would be released in Fall 2021.

So here we are.

The purpose of the special investigative report is to identify the causes of this human tragedy that plunged thousands of vulnerable CHSLD residents and workers into a morass of botched health and administrative moves that wreaked death and calamity.

For this special report, the Québec Ombudsman interviewed Ministère de la Santé et des Services sociaux authorities, CISSS and CIUSSS managers, various experts and key decision-makers. And, in that regard, I want to say that if the dedication of healthcare workers during the crisis was lauded, and rightly so, that of public servants and government directors also deserves praise. The monumental endeavour they were tasked with meant that many of them had to work at lightning speed, and with the unrelenting presence of the challenge of contributing to the war effort.

The present and the future for CHSLDs

The analysis of the causes of the crisis compelled us to look back at the sequence of events in the spring of 2020 and at significant pre-existing and long-known systemic flaws. However, our special report is intended to focus on the future of CHSLDs by dissecting the situation, forging ahead and recommending solutions. This is precisely the purpose of the Québec Ombudsman, an independent and impartial institution which sees to it that the rights of those who interact with public services are upheld. In other words, we are not seeking to cast blame. To do so would be to fail to recognize the extremely unusual character of a global pandemic.

Today, what needs to be done urgently is to project ourselves into a very near future to give CHSLDs and the health and social services network that oversees them means which are commensurate with their missions. What I am referring to is the necessary robustness and indispensable agility of structures and services at the very heart of the ability to provide

appropriate, continuous and compassionate care. These are strengths that fell by the wayside during the first wave of the pandemic.

The duty to remember

More than 18 months after Québec ground to a halt because of COVID-19, the memory of the crisis in CHSLDs lingers. Aside from remembering the people who were most afflicted, we are duty-bound to recall what happened, so that elderly people never again experience such dehumanization of care in residential resources. That is why I have recommended annual acts of commemoration of the losses and suffering sustained, which would also be an opportunity to highlight the generous contribution of those who struggled to keep care and services afloat during this period of turmoil.

I also intend for the Québec Ombudsman to use its Annual Report, tabled in the National Assembly, to comment on how the implementation of the recommendations in this special report is faring. With a desire to make certain that, at long last, improvements will be sustainable, in 2022, 2023 and in the following years, the Québec Ombudsman will ensure that promises are kept and that our seniors' living environments reflect this.

I would like to close with a statement by senior officials at the Ministère de la Santé et des Services sociaux, dated March 4, 2020, showing how the virus sprung a surprise attack on us: "*Remember that, to date, there has only been one confirmed case in Québec. The overall risk of being infected by the coronavirus is still considered small in Québec.*"[1] This position expresses the distance all of us had regarding an unknown virus that erupted on the other side of the world. However, the unthinkable happened and today the lessons we are learning are lessons of compassion. We are more than ever convinced that those who succumbed to COVID-19 and the caregivers who attended to them, often at their own peril, must remain in our thoughts and imbue our actions.

Marie Rinfret, Québec Ombudsperson

[1] MSSS, « *COVID-19 – La ministre McCann fait le point sur la situation au Québec* », News release, March 4, 2020.

SUMMARY

IDENTIFY THE CAUSES, ACT, REMEMBER

On May 26, 2020, the Québec Ombudsman announced that it would be conducting a special investigation into how government handled the COVID-19 crisis in residential and long-term care centres (CHSLDs) during the first wave of the pandemic in Québec.

The following December, it published a progress report on the reality of what had happened in CHSLDs during the crisis. It was a most alarming portrait. Titled *Learning from the crisis and acting to uphold the rights and dignity of CHSLD residents* (available on the Québec Ombudsman's website), the report gives the floor to those who experienced the crisis on the front line: residents, their loved ones, CHSLD staff, and CISSS and CIUSSS managers. These people attested to living environments that were completely disorganized and battered by COVID-19, leading to ruptured care delivery, isolation, more and more deaths of residents, and staff burnout. The Québec Ombudsman's report includes five action priorities for urgent measures to correct CHSLD management.

Further to this first phase of the report, now comes a special report that pinpoints the causes of the events. To produce it, the Québec Ombudsman obtained the versions of government authorities and experts in managing health and social services institutions, geriatrics, crisis management, epidemiology, and infection prevention and control.

THE CAUSES OF AN UNPRECEDENTED HUMAN AND HEALTH CRISIS

The Québec Ombudsman's report identifies numerous factors behind the crisis in several CHSLDs.

These include

A "hospital-centrist" concept in bracing for the pandemic. At the outset, Ministère de la Santé et des Services sociaux (MSSS) authorities assumed that hospitals would be the epicentre of the COVID-19 crisis. This concept was based on what had happened in Italy, a country where hospitals were overflowing because of the influx of patients who had contracted the virus. However, this was not what was occurring in Québec. Here CHSLDs were called on to contribute to the move to empty hospital beds without being given additional measures or means to cope adequately with the outbreaks to come. In the Québec Ombudsman's opinion, this shows that the vulnerability to the virus of the residents of these living environments was sorely underestimated.

CHSLDs as the blind spot in preparing. CHSLDs are complex living environments and care environments. This dual role was not clear to MSSS authorities, and as result, CHSLDs were their blind spot in planning priorities. More specifically, risk management was carried out by a directorate that did not have the expertise to properly assess risk. The lack of joint action and coordination prevented the dissemination of truly operational directives in a timely fashion on the ground.

Staff shortages. CHSLDs, which were suffering from chronic and long-known understaffing to begin with, were further weakened by the abrupt spike in their client population and by the care that particularly vulnerable people required. Added to this was fact that a substantial number of staff contracted the virus and had to suddenly stay home.

Lack of knowledge about IPAC. Practices and knowledge about infection prevention and control (IPAC) were not entrenched as much as they should have been before COVID-19 hit CHSLDs. Taking these environments hostage, the virus brought this lack of knowledge into sharp relief. This shortcoming was not detected or resolved by MSSS when it prepared for the pandemic.

Lack of local governance. The lack of an on-site manager in numerous living environments led to service disarray and often made it impossible to implement the numerous health instructions and directives that flooded in from MSSS.

Lack of PPE. At the beginning of the first wave, staff in numerous CHSLDs did not have access soon enough to the personal protective equipment (PPE) needed to effectively keep the virus from spreading. One of the reasons was supply disruptions due to Québec's reliance on foreign manufacturers. Supply was centralized in order to better distribute equipment. However, lack of a computer system to provide reliable daily data about inventory, coupled with the severe PPE shortages, hindered MSSS's ability to satisfy needs efficiently.

Obsolete information technology. Far from being limited to data about available PPE, lack of information affected numerous spheres of activity in managing the pandemic. Grappling with obsolete technology, authorities could not count on up-to-date data to support daily decision-making.

THE QUÉBEC OMBUDSMAN'S RECOMMENDATIONS

In its report, the Québec Ombudsman makes 27 recommendations for ensuring that the initiatives undertaken are sustainable and regarding the solutions that remain to be implemented.

Considering the extent of the crisis during the first wave and the dramatic consequences that marked Québec, the Ombudsman recommends that MSSS establish various tools for the health system's fundamental mission regarding residential and long-term care for the elderly at all times, as much as in times of turmoil.

The report emphasizes the importance of a **risk assessment and management policy** concerning CHSLDs and of a **detailed plan for strengthening CHSLDs' capacity** to apply IPAC measures. An **IPAC strategy** should also be created to solidify supply chains.

A **provincial emergency staff deployment plan** within the health and social services network would make it possible to optimize back-up resources. **Protocols for deploying supplementary workers under exceptional circumstances** should be arranged with professional orders, federations and professional associations in the field of health and social services, and with unions and educational institutions. Partnerships with bodies able to dispatch last-resort back-up must also be forged.

The Québec Ombudsman also recommends a **Québec strategy for combatting labour shortages** and for promoting health and social services trades and professions.

It is clear that decisions by authorities failed at times due to ineffective communication channels. The changes that need to be made must necessarily involve **updating computer systems so that they are reliable and performant.**

In the Québec Ombudsman's opinion, MSSS should produce and adopt **a Québec action plan** aimed at recognizing the **complexity of care and service provision in CHSLDs** and at improving these living environments (e.g. more compassionate care and services, adequate work conditions, stable work force, professional development, physical environment).

Moreover, the Québec Ombudsman considers that the guiding principles in terms of living environment quality and organization must be governed by **legislative measures.**

Lastly, a new **advisory and oversight committee** should be struck to counsel MSSS about concrete, developmental and sustainable measures for improving service quality in CHSLDs.

The Québec Ombudsman's recommendations

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Remembering

In closing, the Québec Ombudsman recommends that the Minister of Health and Social Services propose annual acts of commemoration of COVID-19 victims in CHSLDs and of the people who worked with them directly or indirectly. The Ombudsman feels that it is important to remember what these people went through so that their experiences are the catalyst for sustainable action and change.

INTRODUCTION

A special investigation into disturbing events

1 On May 26, 2020, alarmed by the events of the preceding weeks and the seriousness of the alleged failings, the Québec Ombudsman announced that it would be conducting a special investigation into how the government managed the crisis in residential and long-term care centres (CHSLDs) during the first wave of the pandemic in Québec. In keeping with the Ombudsman's mandate, the angle from which it examined the problems was the impact of the crisis on service quality and respect of CHSLD residents' rights.

2 In December 2020, the Québec Ombudsman published a progress report about the reality of the events in CHSLDs during the crisis, while planning for a final report that would follow in the fall of 2021 to pinpoint the causes of this crisis.

3 The Québec Ombudsman made the decision to cover only one residential category and the first months of the crisis because during the first wave, the most COVID-19-related deaths by far occurred in CHSLDs. Data from the Institut national de santé publique du Québec (INSPQ) indicate that as at June 30, 2020, 69% of those who died from COVID-19 in Québec (3,894 of the 5,634 deaths for the period in question[2]) were living in CHSLDs or had been on a hospital long-term care unit. These places are intended for people with serious physical and cognitive problems and reduced autonomy, putting them in a very vulnerable position. These factors explain the scope of the Québec Ombudsman's investigation.

The pandemic and an avalanche of complex problems

4 The Québec Ombudsman is a neutral, independent organization that conducts its investigations with impartiality and integrity. Given the crisis in CHSLDs, its analysis had to take into account the complexity of the sudden, unprecedented and global problems.

5 In taking such a situation in hand, the approaches used may complement each other or collide. The same holds true for scientific, administrative, clinical, political and populational points of view. The backdrop was one in which every hour counted, communication channels had never had to react so quickly and the knowledge about the nature of an unknown virus was piecemeal and painstakingly slow to emerge.

6 As one witness said during the Québec Ombudsman's investigation:

> *We were dealing with two distinct visions: that of managers who had to accept that the information was imperfect but who needed something to go on in*

[2] *Données COVID-19 au Québec*, *Tableau 2.1 Évolution du nombre cumulatif de décès liés à la COVID-19 au Québec selon le milieu de vie et la date de décès, données au 30 juin 2020 CHSLD-CH*, Institut national de santé publique du Québec, [Online] consulted on Sept. 8, 2021.

order to make decisions, and that of the scientists who said slow down, we have to wait until we have an accurate picture before acting.

7 Insofar as the virus's unpredictable nature complicated any decision-making, and considering factors such as limited resources and means, citizens' expectations about how the first wave of the pandemic should have been managed must be realistic.

8 First and foremost, this exercise provides the opportunity to learn and improve so that residents and the people who take care of them have quality and compassionate living and working environments, services and conditions.

9 If we seize this opportunity as we rightfully should, the concrete actions taken on that front will remain the most significant legacy of the crisis.

1 THE QUÉBEC OMBUDSMAN'S INTERVENTION IN THE CONTEXT OF A HEALTH CRISIS IN CHSLDS

1.1 Step 1: field investigation

- Document the consequences of COVID-19 for care and services in CHSLDs and how the residents' rights were violated;
- Describe what led to some living environments' failure to fulfil their fundamental missions during the first wave of the crisis;
- Give the floor to the people who experienced the crisis first hand: the residents, their families, CHSLD staff, and integrated health and social service centre (CISSS and CIUSSS) managers.

10 Its analysis was based mainly 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;
- 250 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 vast body of literature it consulted.

11 The Québec Ombudsman's Progress Report brought into sharp relief a very disturbing picture of what occurred in CHSLDs at the height of the crisis. Suffice it to say that the people quoted, whose statements were corroborated by other sources, went so far as to call it "battlefield medicine" in which they "didn't know where to put the bodies anymore. Residents died alone, distressed and suffering."

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

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

The Québec Ombudsman's Progress Report, titled *Learning from the crisis and moving to uphold the rights of CHSLD residents*, is available at protecteurducitoyen.qc.ca.

1.2 Step 2: the investigation involving MSSS, experts and other jurisdictions

13 Among all the upheaval, gains, backsliding, and reversals that rocked the first wave of the pandemic in many CHSLDs, what caused a health and human crisis so serious that ultimately it resulted in loss of control of the outbreaks and deaths?

14 As part of the investigative process, the Québec Ombudsman obtained the versions of government authorities and experts in health and social institution management, geriatrics, crisis management, supply, epidemiology and infection prevention and control.[3] The purpose was to seek to understand and contextualize the decisions made between January and June 2020, often in the thick of the fray, in a bid to beat back COVID-19 in care settings and in CHSLDs. The goal was also to obtain the opinions of specialists about cutting-edge knowledge and best practices pertaining to:

- Clinical aspects of the elderly population;
- Infection prevention and control (IPAC) requirements;
- Logistics in residential environments;
- Personal protective equipment (PPE) supply.

15 Furthermore, to understand and compare practices elsewhere that could have changed outcomes and been success factors, notably concerning these elements, the Québec Ombudsman also analyzed how other provinces, particularly Ontario and British Columbia, prepared for and managed the first wave of the pandemic.

16 Note that anyone whom the Québec Ombudsman approached cooperated fully throughout the investigation.

17 The Québec Ombudsman's goal in this report is to:

- Provide an update on what the authorities have already done to rectify the failings observed;
- Make recommendations so that the initiatives undertaken are sustainable and note the solutions that remain to be implemented;
- Reiterate the need to make residential care and services more robust in terms of how they operate and react, whether day-to-day in "normal" times or during periods of upheaval;
- Affirm as a cornerstone value the importance of CHSLD services that are safer and more human-centred, whether for the residents or staff.

[3] Some 30 interviews took place with MSSS and various experts.

18 For readability, the interviews and documents used by the Québec Ombudsman will not be quoted extensively. The findings, which have been substantiated and corroborated by several separate sources, present the Québec Ombudsman's independent view of the actions and decisions by Québec authorities during the first wave.

19 Similarly, the quotations are all taken from accounts by MSSS directors, CISSS and CIUSSS managers, and various experts and key decision-makers involved in managing the first wave of COVID-19.

2 THE EVENTS

Timeline of certain events during the first wave of the pandemic

2019	
Late December	Outbreak of atypical pneumonia (coronavirus) in Wuhan, China
2020	
Late January	- MSSS and health network civil security bodies mobilized - Inventory made of institutional PPE at MSSS's request - Screening test developed by the Laboratoire de santé publique du Québec (Institut national de santé publique du Québec) - Epidemiological investigation (screening, tracing) launched by Québec's Public Health Director
February 27	First COVID-19 case detected in Québec
February 29	Beginning of the spring break
February-March	- Hospitals get prepared: protocols, screening, patients' trajectories, rooms and equipment - Tactical unit put in place by MSSS to develop a PPE supply strategy - Departmental strategy drafted for PPE use in the context of a shortage
March 2	First confirmed COVID-19 case in a CHSLD in Québec
March 4	News conference by the Minister of Health and Social Services: the risk of infection by the coronavirus is still considered low in Québec
March 9	- Opening of COVID-19 clinics announced in anticipation of a rise in the number of screening tests - Public Health does not yet detect any community transmission

	- The *Plan actualisé de lutte contre une pandemic d'influenza* is updated by the MSSS's civil security committee - The hospital overflow situation in Italy heeded: preparation in hospitals speeded up, based in particular on a strategy to discontinue certain activities
March 11	The World Health Organization (WHO) declares COVID-19 a global pandemic
March 12	- MSSS sends CISSSs and CIUSSSs the *Guide pour l'adaptation de l'offre de service en centre d'hébergement et de soins de longue durée en situation de pandémie COVID-19* - MSSS non-retroactive directive about mandatory isolation of health workers who travel as of March 12
March 13	Health emergency declared in Québec
March 14	Non-essential visits to CHSLDs prohibited, including visits by informal caregivers, except for humanitarian reasons
March 15	*Je contribue* platform launched to enable people to provide support as part of the means deployed
March 16	First IPAC directives from MSSS sent to CHSLDs
Around March 20	- Transfer of alternative care patients (NSA)[4] in hospitals to CHSLDs begins to pick up speed in order to free up beds - Outbreaks begin in CHSLDs
March 21	Order-in-council 2020-007 amending certain collective agreement provisions and authorizing the suspension of working conditions to allow staff reassignment and vacation cancellations
March 23	- Probable community transmission, especially in the Montréal region - General confinement begins New screening priorities, including symptomatic CHSLD residents, travellers and their symptomatic contacts
March 29	Additional CHSLD resources to control the flow of people (security guards)
March 30	Reminder to health workers to use PPE sparingly and only when necessary
April 4	Health authorities announce that community transmission has now spread throughout Québec
April 9	- INSPQ opinion: masks mandatory for staff in all CHSLDs

[4] NSA: service users who no longer need active hospital care who remain there while waiting for a place in a residential or rehabilitation facility.

	MSSS issues reminders about the instructions concerning the transfer of infected CHSLD residents to hospitals, notably that CHSLD residents must remain in their living environment, health permitting
April 10-11	Wake-up call about the crisis in CHSLDs for administrative and political authorities and government announcements: - Investigation into CHSLD Herron - Assessment visits of private CHSLDs that are not under contract - Intervention to support CHSLDs in implementing IPAC measures (deployment of teams) - Reassignment of human resources to CHSLDs announced - PPE provided to all CHSLD staff - No more alternative-care (NSA) users admitted to CHSLDs Screening priority update: residents and staff of residential facilities must now be tested as soon as a new positive non-isolated case is identified
Mid-April	- Massive screening in some CHSLDs affected by major outbreaks - Sizable removal of staff and managers due to positive testing for COVID-19 or to COVID-19 symptoms - Hydro-Québec and Revenu Québec teams provide support to contact people registered on the *Je contribute* site - Relief staff organization, deployment and integration: o Staff from other service programs reassigned o The Premier asks specialized physicians to help out in CHSLDs o Health sector students and teachers arrive o Social economy workers arrive - Informal caregivers known by the CHSLD allowed to provide support and meet certain basic needs as before the pandemic, provided they tested negative, among other specific conditions - The Premier of Québec asks the Canadian Armed Forces for assistance Resource-pooling operation by MSSS: clinical teams from cold regions deployed to hot regions
April 20	Canadian Armed Forces begin to be deployed to CHSLDs
May	The situation is stabilizing in CHSLDs, staff return progressively, and significant informal caregivers return
May 11	Informal caregivers who provide significant help and support are allowed in, subject to special precautions. CHSLDs which want to be exempted from the new directives must receive prior authorization from MSSS
May 15	All public and private CHSLD workers are tested, including asymptomatic ones

May 16	On vous écoute launched by MSSS to enable health workers to express how they feel about what is happening in the workplace
June 2	A massive recruitment campaign begins in order to fill 10,000 care attendant positions in CHSLDs
June 18	Visitors and informal caregivers who provide significant help or support allowed in CHSLDs
June 19	The government announces the CHSLD deconfinement plan
June 29	Canadian Armed Forces deployment to CHSLDs ends
July 6	Red Cross teams deployed to certain CHSLDs
August 18	Second-wave action plan unveiled by MSSS

3 INVESTIGATION RESULTS: FINDINGS AND RECOMMENDATIONS

3.1 A "hospital-centrist" concept: CHSLDs as the blind spot in bracing for the pandemic/Equip CHSLDs according to their missions and issues specific to the Québec model

"What we expected of CHSLDs was to promote a living-environment approach. What happened with COVID-19 was like shutting the barn door when the horse had already bolted."

"At the time, we saw what was happening in Italy. The hospitals couldn't keep up. We went with the information available to us then."

"At the start of the COVID-19 pandemic, we saw once again that concerns, resources and PPE were directed towards hospitals rather than towards CHSLDs."

"Normally, in epidemiology, when faced with a virus, we don't simply copy what's done elsewhere. We study the virus's behaviour and analyze the impact it will have on our society based on the characteristics of our population. It was a mistake to base what we did on Italy."

3.1.1 The Québec Ombudsman's findings

A "hospital-centrist"concept and an Italian scenario as the template in bracing for the pandemic

20 In Québec, the Physical health service program,[5] predominantly present in hospitals, alone accounts for the biggest chunk of the health service program budget (37.1%[6]). Part of this is due to the influence that this mission exerts on the authorities. It is indeed important for society as a whole that the accidents and serious illnesses which people experience be treated as quickly as possible by highly qualified professionals by means of cutting-edge equipment. The fact of concentrating the health and social services network's resources in hospitals is a concept sometimes called "hospital-centrist." [7]

21 In February and March 2020, even before COVID-19 spread in Québec, Europe had been hard hit by the virus. Foreign and local media were quick to pick up the story about overflow and panic in hospitals. Italy, in the foreground, faced an exponential increase of COVID-19 cases requiring intensive care. According to the reports, more and more people were being turned away from Italian hospitals due to lack of resources.

22 At the same time, the State of Washington, in the United States, and the province of British Columbia, in Canada, witnessed outbreaks in seniors' residences in late February and early March 2020, before Québec was affected. This does not seem to have influenced MSSS's strategy in preparing for the pandemic.

23 Québec health authorities report that all they had was fragmented and ever-changing information about the virus and its transmission. The civil security machine mobilized within MSSS and its network since March 2020 was already busy gearing up for testing, finding PPE, and securing the health system's capacity to have hospitals treat COVID-19 patients. Anticipating problems that would be similar to those in Italy when COVID-19 reached Québec in early March 2020, senior authorities within MSSS decided to:

- Use emergency procedures to free up thousands of hospital beds, in particular through the transfer of hospital patients to CHSLDs; and therefore
- Protect hospital capacity should the virus spread throughout the population;
- Strengthen intensive care department operational capacity;
- Establish a protocol for the hospital emergency room intake of users likely to present with serious respiratory problems.

24 These actions clearly show that MSSS felt that, if there was a crisis, hospitals would be the epicentre. As a result, the means that were deployed were for hospitals first and

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[5] In Québec, the health and social services system is divided into service programs and support programs. Currently there are nine service programs: **Public health, General services – clinical and assistance activities,** Support for elderly autonomy, Physical disabilities, Intellectual disabilities and autism spectrum disorders, Troubled youth, Addictions, Mental health and Physical health. https://www.msss.gouv.qc.ca/reseau/systeme-de-sante-et-de-services-sociaux-en-bref/programmes-services-et-programmes-soutien/, [Online] consulted on Sept. 20, 2021.

[6] For the Physical health program, 37.1%, and 16.5% for the Support for elderly autonomy program. Source: MSSS, *Comptes de la santé 2018-2019 2019-2020 2020-2021*, 2021, p. 20, Table 14, [Online] consulted on Sept. 8, 2021.

[7] According to the thesaurus of government activity, hospital-centrism means a vision of the health system geared towards hospitals that assume roles that other types of institutions which offer local general medical services could take on. http://www.thesaurus.gouv.qc.ca/tag/terme.do?id=17279, [Online] consulted on Sept. 13, 2021.

foremost. This vision only served to confirm the place of hospitals in the grander scheme of things. Strong leadership was exercised first by the MSSS directorate responsible for hospital care,[8]which in early March struck a committee that brought together multiple health stakeholders and experts (clinical steering committee). At the time, the MSSS directorate responsible for CHSLDs[9] was not called to the table.

25 Then came general confinement efforts in Québec. To the astonishment of many, the expected influx of COVID-19 patients to hospitals proved to be overestimated, CHSLDs being the main locus of outbreaks and deaths.

26 At first this may have misled authorities into thinking that the situation was under control. However, this was an illusion created by the lack of real-time data about the healthcare system as a whole. For a time, the authorities, ill-served by the information available, underestimated the upsurge in CHSLDs.

CHSLDs: conspicuous by their absence from the planning scenarios

27 While Québec's eyes were turned towards Italy, no risk analysis tailored to Québec's residential-resource model and its specific features was carried out in crafting the strategy in response to the pandemic. This is how CHSLDs slipped through the cracks of any scenario.

28 MSSS maintains that this omission was due to the need for urgent action. In the Québec Ombudsman's opinion, this oversight was also caused by clinical planning done in a vacuum by different directorates, as was their wont, despite the fact that civil security committees had been struck.

Governance structure during the pandemic

29 We see that civil security bodies were quickly mobilized when a strategic committee meant to coordinate the response to the pandemic within MSSS was put in place. However, according to the information obtained, the committee was not mandated to make policy concerning the network's various clinical missions, which was done by each of MSSS's clinical directorates10 within distinct crisis committees or cells. Civil security bodies, which were mandated primarily to support the general directorates, could not play their role, which should have been to eliminate compartmentalization so that joint clinical orientations could be established.

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[8] Direction générale des affaires universitaires, médicales, infirmières et pharmaceutiques (DGAUMIP).
[9] Direction générale des aînés et des proches aidants (DGAPA) includes the following sections: Secrétariat aux aînés, Direction de la bientraitance et de la lutte contre la maltraitance et l'isolement social, Direction du vieillissement actif, Direction des services aux aînés, aux proches aidants et en ressources intermédiaires et de type familial, Direction de la qualité des milieux de vie, and Direction du soutien à domicile.
[10] MSSS's general directorates with a clinical vocation are the Direction générale des affaires universitaires, médicales, infirmières et pharmaceutiques (DGAUMIP), the Direction générale des aînés et des proches aidants (DGAPA), the Direction générale des programmes dédiés aux personnes, aux familles et aux communauté (DGPPFC) and the Direction générale de la santé publique (DGSP). Other general directorates have a supportive or administrative mission.

30 Be that as it may, during the first wave, the committee nonetheless developed the COVID-19 Appendix of MSSS's Plan actualisé de lutte contre une pandemic d'influenza. The first version of the Appendix (March 2020) did not contain targeted measures for CHSLDs, but, instead, laid out a strategy and actions for the entire population, and not specifically for residents in health network facilities. It also provided for a governance structure adapted to managing a pandemic. The fact that the general directorate responsible for CHSLDs (DGAPA)11 does not figure in this structure in the document's first version speaks volumes. Alongside the mobilization of civil security mechanisms, which are not decisional, MSSS's usual governance structure was active via its strategic and coordinating bodies (steering committee (CODIR) and management committee (CGR)),12 which continued to play their respective roles.

31 Moreover, MSSS's general directorates held regular meetings with their respective sector-based advisory bodies.13

32 In addition to the MSSS's administrative committees and players, there was a government crisis cell that defined the broad orientations for all sectors of society, consisting of the Premier, Québec's Public Heath Director, the Minister of Health and Social Services and the Minister of Public Security, as well as various advisers. MSSS's Deputy Health Minister and certain Assistant Deputy Ministers also attended the meetings upon invitation.

33 Given the pandemic, DGAPA was to conduct risk assessments to prepare living environments for the crisis. Ordinarily, it is not responsible for addressing issues of infection prevention and control or medical care for the elderly, nor is it required to have any particular expertise in those areas. Instead, its mission is to ensure that CHSLD residents have a quality living environment. DGAPA's expertise lies in its in-depth knowledge of the specific features of the various living environments under its governance (CHSLDs, RPAs, and RIs-RTFs) and of the elderly client population.

34 Despite its lack of IPAC expertise, the directorate felt that the living environments were equipped to deal with influenza and gastroenteritis outbreaks. Also, it believed that the pandemic would be short-lived. There were concerns about elderly CHSLD residents, but the information obtained during the Québec Ombudsman's investigation indicates that no concrete and specific action on site to prepare CHSLDs occurred before mid-March 2020.

35 As the Québec Ombudsman sees it, CHSLD residents' vulnerability to COVID-19 was grossly underestimated. In other words, the fact that CHSLDs were considered first and foremost as living environments, and that risk assessment was conducted by a directorate that did not have the clinical skills needed to carry out a thorough

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[11] See Appendix 2.
[12] CODIR is the decisional structure within MSSS. CGR is in contact with the President-Executive Directors of CISSSs and CIUSSSs.
[13] For example, the *Table Soutien à l'autonomie des personnes âgées* (SAPA), consisting of Support for Elderly Autonomy program managers of the institutions to which CHSLDs report.

evaluation, means that CHSLDs were forgotten when it came to deploying measures and tools for strengthening areas needing improvement.

Hospital-CHSLD transfers: weakened living environments

36 Québec hospitals generally have a certain number of service users considered as needing alternative care (NSA). This means that they occupy a bed in a hospital care unit, but their condition does not call for the level of services provided on that unit. These people are usually awaiting a place in a residential or rehabilitation facility. In addition to people whose surgeries were delayed, this client population was also part of the plan to free up beds between mid-March and late March 2020. Transfers to CHSLDs and to other places occurred, and many of these users experienced the discomfort of a hasty move, without being accompanied by their family.

37 The goal was to free up 80% of NSA beds to bolster hospital capacity.

38 Within MSSS, DGAPA coordinated these transfers, which was part of its usual functions. This strategy of freeing up so many hospital beds weakened CHSLDs by putting them in a position of overcapacity for vulnerable elderly people. In addition, these people would increasingly become targets for the virus.

39 According to MSSS data obtained during the investigation, between March 1 and 31, 2020, there was a significant increase (32%) in admissions to CHSLDs compared with the other one-month periods in 2019-2020. This represents 1,714 people admitted to CHSLDs, including 865 from hospitals. Ordinarily, an average of 1,311 people are admitted to CHSLDs.[14]

40 As of mid-March, the transfers to CHSLDs raised concerns: lack of PPE, problems setting up confinement areas and hot and cold zones, contamination of residents, removal of virus-infected staff. Under the circumstances, the measures provided for in the *Guide pour l'adaptation de l'offre de service en CHSLD*,[15] sent to the health and social services network on March 12, 2020, as well as the IPAC directives that followed, could not be implemented.

41 Worried about the situation, certain people within the network went so far as to challenge senior MSSS authorities between mid- and late March. Today, they consider that they were not heard because the strategy which entailed discontinuing hospital activities remained the priority. These people consider that as outbreaks began to erupt in living environments, the transfers should have stopped in late March while CHSLDs

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[14] Computer system for regional coordination of admissions (SICRA), Data from the *Mécanisme d'accès à l'hébergement de chacune des régions*, *Admission en hébergement pour une place en CHSLD 2019 2020* table; *Admission en hébergement pour une place en CHSLD-Localisation au moment de l'admission 2018-2019 P13 à 2019-2020 P02 & 2019-2020 P13 à 2020-2021 P12* table.

[15] MSSS, *Guide pour l'adaptation de l'offre de service en centre d'hébergement et de soins de longue durée en situation de pandémie COVID-19*, March 12, 2020, [Online] consulted on Sept. 9, 2021. This guide provided mainly for the activities that could be discontinued in CHSLDs should there be staff shortages, as well as for very general orientations for preparing for a pandemic, such as updating residents' care level and setting up hand-disinfection and protective-material distribution stations.

got organized to better deal with events. In the meantime, there was leeway, since NSA service users could remain in hospital a few extra days because of the number of beds that were still available. As at March 29, approximately 6,000 beds were available in Québec hospitals because of the services that had been discontinued, including surgeries and transfers.

42 It was only on April 11, as MSSS was backed against the wall when CHSLDs lost control of the situation, that new admissions of NSA service users came to a halt. According to certain people, despite DGAPA's involvement with civil security committees, it did not have the influence, expertise or the ear of MSSS needed to reverse the strategy that was already being put in place in preparation for the pandemic. However, the situation changed around mid-April when the crisis gathered steam and several living environments spun out of control, with rampant outbreaks and deaths.

43 As MSSS saw it, the fact of emptying hospital beds was consistent with an approach that applied ordinarily, namely, that if people no longer need hospital treatment, they must, insofar as possible, be referred to services adapted to their condition. The Québec Ombudsman agrees with this vision of hospital management under usual circumstances. It bears remembering that it was believed that hospitals would be the first places affected by the spread of the virus. Should this have occurred, the idea was to reduce the risk of NSA service users (by definition, vulnerable) contracting COVID-19 by keeping them out of hospitals.

44 **The fact of having freed up hospital beds is not the issue. Rather, the problem is that CHSLDs' capacity to play the radically different role expected of them in the context of a pandemic was not properly assessed. Furthermore, they were not provided tools or protected adequately given that they were not sturdy enough to cope with such conditions and given the vulnerability of the residents.**

45 Corrective action was taken during the crisis and in bracing for the second wave, in particular concerning the assessment of CHSLDs' intake capacity as hospital services were discontinued. Furthermore, the Québec Ombudsman noted that compartmentalization has ended and there is more fluid collaboration and coordination among MSSS's various missions. For example, a subcommittee attended by DGAPA, and reporting to the COVID-19 clinical steering committee of the general directorate responsible for hospital care, was created ahead of the second wave. The subcommittee is tasked to supervise medical coverage in CHSLDs.[16] Because of the rampant outbreaks in CHSLDs, there are now daily meetings between DGAPA and the Direction générale de la santé publique (DGSP). All agree that now that it is operational, this close collaboration is beneficial. The critical situation in CHSLDs was a catalyst. This way of

[16] One of the things it made possible was to, on April 13, 2020, send the network the Guide pour la prise en charge des résidents en centres d'hébergement et de soins de longue durée (CHSLD) dans le contexte de la pandémie de la COVID-19, [Online] consulted on Oct. 28, 2021. In December 2020, directives were issued about medical coverage in living environments for seniors in the context of the COVID-19 pandemic, [Online] consulted on Sept. 28, 2021.

doing things should become the default setting in managing crises or in any situation that requires pooling of expertise.

Risk management in living environments in times of crisis: does MSSS have the required expertise?

46 Does MSSS properly support the residential and long-term care mission and provide the required resources and expertise in high-risk situations? This question arose during the investigation. Various stakeholders, from inside and outside MSSS, expressed their misgivings.

47 The Québec Ombudsman gathered from their statements that ordinarily, external expertise is frequently solicited and relevant in drafting health and social service policy and orientations. However, in a time of emergency, this way of doing things did not enable crucial decisions to be made quickly enough, notably in matters of risk management for CHSLDs when there was talk of the possible emergence of the virus.

48 It was only in the second week of April, when the crisis in CHSLDs was confirmed, that the Minister of Health and Social Services and the Minister responsible for Seniors presented strengthened protection measures for living environments. They also established an advisory committee of experts for MSSS and public residential facilities. These precautions proved to be too little too late for several CHSLDs. As mentioned before, DGAPA did not have the required IPAC expertise. For their part, the Direction générale de la santé publique and the general directorate responsible for hospital care were not overly knowledgeable about these living environments and their residents.

49 The investigation showed that DGAPA wrote and revised documents to support IPAC or organize services, transmitted to the institutions in mid-March 2020, followed by numerous daily updates. However, these general documents did not yield real and operational results on the ground. This finding was corroborated by numerous witness statements during the Québec Ombudsman's investigation. The need to pool the expertise found in the various MSSS directorates made timely transmission of coordinated and operational directives difficult.

50 Furthermore, to be fully effective and efficient, means and resources for these directives should have been deployed more quickly, given these environments' pre-existing fragility.

51 Moreover, having questioned several people about the application of the precautionary principle,[17] the Québec Ombudsman realized that this principle is not understood as being an integral part of the risk-management process and is not disseminated. The

17 "When risk is complex, uncertain or ambiguous, it is useful to adjust management approaches accordingly." (section 3.1.2.3). In particular, "the precautionary principle enables decision-makers to adopt precautionary measures when scientific evidence about an environmental or human health hazard is uncertain and the stakes are high. (European Parliamentary Research Service, 2015, p.1) in La gestion des risques en santé publique au Québec : cadre de référence, Institut national de santé publique du Québec (INSPQ), 2016, p. 61. Also see INSPQ's Le principe de précaution, [Online] consulted on Sept. 9, 2021.

Québec Ombudsman considers that this principle must systematically be the centrepiece of any risk assessment and management initiative.

3.1.2 Recommendations

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-1 Establish a risk assessment and management policy for residential and long-term care centres that must have the following goals:

- Equip MSSS's general directorates with the medical, clinical and scientific expertise needed for managing risks adequately and comprehensively, so as to anticipate the impact on the client populations concerned;
- Plan safe transitions for users who have to be relocated in emergency and crisis situations in order to respond to their needs adequately and rapidly;
- Formally make the precautionary principle the centrepiece of risk assessment and management.

R-2 Formalize joint action and communication mechanisms in MSSS's general directorates in times of crisis or in any other situation requiring the pooling of expertise in order to prevent compartmentalization and to foster the understanding and overall consistency of actions.

3.2 Living environments unfamiliar with the infection prevention and control (IPAC) measures to apply during a pandemic / Establish a strong IPAC culture within CHSLDs

"There was ignorance about roles and responsibilities between two bodies when it came to putting infection prevention and control measures in place in CHSLDs. Was the Direction des soins infirmiers or Public Health in charge? When you blend the two, you get a perfect storm."

"Infection prevention and control is a part of everyone's life in healthcare. But so long as you don't get infected, it doesn't interest you. The fact is that IPAC has to become a way of life."

3.2.1 The Québec Ombudsman's findings

CHSLDs under seige and scanty knowledge about IPAC practices

52 While the COVID-19 pandemic is an unusual event, Québec's health institutions had already seen crises due to healthcare-associated infections, including the C-difficile crisis that gave rise to the Aucoin Report in 2005.[18] Many felt that these events marked a turning point that generated advances on the IPAC front. In response to the report,

[18] MSSS, *D'abord, ne pas nuire… Les infections nosocomiales au Québec, un problème majeur de santé, une priorité-Rapport du Comité d'examen sur la prévention et le contrôle des infections nosocomiales* (Aucoin Report), 2005, [Online] consulted on Sept. 9, 2021.

investments of $21.5 million were made to better equip institutions and better define IPAC roles, responsibilities and accountability.

53 However, it would seem that once a crisis has passed and the feeling of urgency has dissipated, human nature being what it is, we often tend to go on to other things and make way for other concerns. The reform of the health network in 2015 and the overhaul that occurred was a hard blow for IPAC management and expertise in health institutions. For example, nurses left IPAC jobs for other assignments and management positions were cut. Some experts feel that the centralization of IPAC management and expertise that occurred was a setback. Others also question the true extent of responsibility and accountability for IPAC within institutions.

54 The Québec Ombudsman notes the development of new practices such as programs to monitor healthcare-associated infections and to supervise hand hygiene, publication of a frame of reference,[19] publication of guides such as the one on managing influenza outbreaks in living environments,[20] and the presence of leading-edge expertise within CISSSs and CIUSSSs. Nonetheless, the following must be said:

- IPAC expertise is developed mainly in hospitals rather than in CHSLDs because hospitals are where acute care is delivered and, as a result, a highly aseptic environment is needed;
- The ratio of nurses specialized in IPAC is insufficient to adequately cover hospitals and other institutional facilities such as CHSLDs;
- Before the arrival of COVID-19, in the spring of 2020, IPAC practices and knowledge were not as entrenched as they should have been to handle such a virulent virus in CHLSDs. Because of the confusion surrounding the sharing of IPAC responsibilities and the lack of IPAC data or indicators, MSSS did not detect this weakness when preparing for the pandemic;
- No measures to strengthen IPAC were deployed in CHSLDs before the crisis;
- During the first wave, CHSLDs received roughly the same directives and at the same time as hospitals (for example, setting up hot and cold zones). However, CHSLDs did not have the same ability to put them in place effectively, notably due to issues of governance, knowledge, available resources and local expertise,
- Because of their responsibility towards all people within their territory, it was up to CISSSs and CIUSSSs to support private residential facilities. However, this responsibility and the kind of support expected were not clearly defined or truly understood by anyone at the beginning of the pandemic.

[19] MSSS, Cadre de référence à l'intention des établissements de santé et de services sociaux du Québec-Les infections nosocomiales, 2017. (First edition 2006, revised in 2017), [Online] consulted on Sept. 9, 2021.
[20] MSSS, Guide d'intervention influenza en milieu d'hébergement et de soins de longue durée. Prévention, surveillance et contrôle, Groupe de travail provincial sur l'influenza en milieu fermé, 2006, [Online] consulted on Sept. 9, 2021.

55 According to the information obtained through conversations between the Québec Ombudsman and organizations in British Columbia, when preparing long-term care institutions to act on the IPAC level, BC was very proactive at the beginning of the pandemic. As soon as the first outbreak occurred in a long-term care residence (March 7, 2020 or thereabouts), teams were quickly deployed to the long-term care centres struggling with an outbreak. In mid-March, a detailed guide customized to the IPAC issues of these environments was also produced. Authorities in British Columbia cited the ready involvement and support of regional public health authorities in establishing IPAC measures as an asset in managing the pandemic. The Québec Ombudsman considers that these measures are indicative of the authorities' foresight and the health network's ability to respond to the issues involved in implementing IPAC in long-term care environments.

CHSLDs: a double mission

56 Because CHSLDs were identified as facilities geared entirely to their mission as living environments, they were deprived of IPAC expertise and adequate preparation. In short, many said that the "living-environment approach" was inconsistent with IPAC measures. This is an apt illustration of the gap between two visions that should be inseparable: CHSLDs as living environments and care environments alike. According to this view, CHSLDs must be able to reconcile both components. For this to happen, they must be seen as facilities which:

- Are prone to outbreaks;
- Are home to people who are among the most vulnerable;
- Must have IPAC resources that are always in place, but discretely;
- Must be open to constructive dialogue with those responsible for the various missions.

57 Added to this is the difficulty of establishing best IPAC practices more solidly when staff are overworked and in short supply, even in ordinary times. When the first wave of COVID-19 hit, the disorganization and lack of local governance in some CHSLDs made it impossible to implement the flood of directives from MSSS. This is discussed later in the report.

58 From one living environment to another, there are sizable differences in access to IPAC training.[21] Only certain institutions have IPAC orientation and professional development modules. As a rule, the staff's academic training and on-the-job training alike are deficient. Moreover, constant staff turnover compromises the acquisition, integration and maintenance of IPAC knowledge. It goes without saying that these notions should already have been part of daily operations before COVID-19 struck According to experts interviewed during the Québec Ombudsman's investigation, laying a solid foundation for an IPAC culture in living environments requires action involving the role of nurses

[21] *Enquête épidémiologique sur les travailleurs de la santé atteints par la COVID-19 au printemps 2020,* Institut national de santé publique du Québec, 2020, p. 23, [Online] consulted on Sept. 9, 2021.

specialized in IPAC so that it becomes everyone's responsibility. Often tasked to make up for the IPAC knowledge gap by forming teams that are not very well versed in the basics, these nurses would be called on to do what they are meant to do: work upstream in tandem with CHSLD managers to shape a workplace and environment where modern IPAC practices are the standard.

59 According to experts interviewed during the Québec Ombudsman's investigation, laying a solid foundation for an IPAC culture in living environments requires action involving the role of nurses specialized in IPAC so that it becomes everyone's responsibility. Often tasked to make up for the IPAC knowledge gap by forming teams that are not very well versed in the basics, these nurses would be called on to do what they are meant to do: work upstream in tandem with CHSLD managers to shape a workplace and environment where modern IPAC practices are the standard.

60 The model which seems to be prevalent today is the opposite of this vision of things in that the responsibility for teaching and implementing new practices is squarely on the shoulders of IPAC- specialized nurses.

61 Lastly, measures could not be applied because of the lack of data and indicators about the general and local status of IPAC in CHSLDs.

The race to catch up

62 Seeing that several CHSLDs had lost control of the outbreaks in early April 2020, in the middle of the crisis the rush was on to correct the problems and rectify the situation.

63 Teams from different institutions or regional public health directorates were deployed to provide support. Members of the Canadian Armed Forces, the Red Cross and St. John Ambulance also assisted CHSLDs, as did infection-control specialists called "SWAT" teams. At the time, needs in private and public CHSLDs, as well as in private seniors' residences, vastly exceeded the resources ordinarily allocated for IPAC in institutions or within public health directorates. Large non-amalgamated hospitals and even external organizations were also enlisted.

64 In April and May 2020, the three-hour training program titled Prévention et contrôle des infections : formation de base en contexte de la COVID-19 was created and put online via the digital learning environment platform. It is intended for new staff or staff needing to refresh their knowledge of these notions.

65 During the same period, MSSS swung into action with more pivotal measures such as creating and rolling out the Plan d'action pour renforcer et assurer l'application des mesures de prévention et de contrôle des infections dans les milieux de vie, d'hébergement et de réadaptation.[22] The Québec Ombudsman notes that the plan's objectives acknowledge the failings identified in its progress report on the first wave.

[22] MSSS, *Plan d'action pour renforcer et assurer l'application des mesures de prévention et de contrôle des infections dans les milieux de vie, d'hébergement et de réadaptation*, August 18, 2020, [Online] consulted on Sept. 9, 2021.

66 MSSS also established Champions PCI training in living environments. At the same time, in June 2020, it created an IPAC directorate. Collaborative efforts between this directorate and MSSS's other general directorates such as DGAPA were undertaken, notably for establishing IPAC measures for the new houses for seniors. This collaboration should continue and become systematized.

67 Given the shortcomings observed, MSSS also introduced a data processing system that makes it possible to track outbreaks in living environments.

68 The ratio of IPAC-specialized nurses in CISSSs and CIUSSSs was increased, taking into account the institutions' populational responsibilities, as well as that of private residential facilities. In September 2020, the Treasury Board approved a request for funding to increase IPAC-nurse ratios for fiscal 2020-2021 and 2021-2022.

69 In the Québec Ombudsman's opinion, to ensure a sustainable and strong IPAC culture in CHSLDs and other living environments, these investments must be recurrent. A 20% increase had been recommended since 2017 by MSSS's assistant general director of public health protection and its nursing care directorate, as well as by the provincial panel on the prevention of healthcare-associated infections.[23]

70 Lastly, the Guide des éclosions pour les CHSLD et les résidences pour aînés[24] was distributed throughout the health and social services network in the fall of 2020.

IPAC: high-level governance put in place

71 In the wake of the first wave of the crisis, a new form of IPAC governance, now shared among MSSS, CISSSs and CIUSSSs, was established. The Québec Ombudsman has seen a genuine desire by MSSS to maintain clinical discussions between IPAC experts. Above and beyond these initiatives, the authorities assured the Québec Ombudsman that lack of IPAC governance and accountability would be a thing of the past.

72 The new avenues chosen and those being put in place by MSSS are:

- A genuine shift in organizational culture in matters of governance and accountability;
- Appropriation of the orientations by the institutions' senior authorities by designating a manager formally responsible for applying the culture under the best conditions within institutions;
- Creation of an IPAC directorate to ensure that the orientations are applied and to support institutions;
- An IPAC subcommittee within the network managing committee for coordination between MSSS and the CISSSs and CIUSSSs.

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[23] *Faire face aux défis actuels et futurs en prévention et contrôle des infections (PCI) dans les établissements de soins : proposition d'ajustement des ratios d'infirmières en PCI,* Ministère de la Santé et des Services sociaux, November 2017 (draft document).

[24] MSSS, *Guide de gestion des éclosions - Volet organisationnel, À l'intention des centres d'hébergement et de soins de longue durée et des résidences privées pour aînés,* 2020, [Online] consulted on Sept. 9, 2021.

Sustainable change underway

73 The Québec Ombudsman applauds the catch-up measures to better monitor and apply IPAC. Alongside MSSS actions, one of the remaining substantial issues is IPAC sustainability. Creating a ministerial directorate for IPAC in living environments is appropriate, but after having investigated, the Québec Ombudsman still has questions:

- Will this directorate be given the tools and resources it needs for it to carry out its mission?
- How will this directorate ensure that CHSLDs maintain best practices after the crisis is over? The Québec Ombudsman considers that this will require regular monitoring and follow-up with institutions;
- How can compartmentalizing be avoided despite the creation of a distinct directorate within DGAPA?

3.2.2 Recommendation

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-3 Produce and implement a detailed plan to strengthen CHSLDs' ability to apply rigorous infection prevention and control measures. The plan should include the following measures concerning:

- Making staff, residents and informal caregivers aware of the shared responsibility for seeing that IPAC best practices are followed;
- Professional development for healthcare teams;
- Compliance with adequate IPAC nursing staff ratios within CHSLDs;
- The role of the IPAC adviser in each CHSLD;
- Applying best practices;
- Performance and accountability indicators for the targets set;
- Reducing the adverse effects of IPAC measures on certain vulnerable residential client populations;
- Developing a data processing system that provides an accurate ongoing real-time portrait of outbreaks in CHSLDs;
- A review of the procedure for assessing the quality of living environments so as to emphasize IPAC;
- Strengthening of the IPAC directorate within MSSS in order for its influence and actions to be lasting.

3.3 Lack of personal protective equipment (PPE), locally and worldwide/Secure the network's PPE supply by revisiting our approaches

"We have to up our PPE supply and ability to react, even if it means losing some money. And we have to review things every two or three years to be ready for any eventuality. It doesn't get more basic than that."

"Our supply legislation must change to favour local supply."

3.3.1 The Québec Ombudsman's findings

Nothing on the horizon: no more PPE stocked than usual

74 Ordinarily, MSSS does not manage supply and distribution of the material that CISSSs and CIUSSSs need, nor does it have centralized data about the network's stock of equipment. The CISSSs and CIUSSSs use different information systems that do not communicate with each other.

75 In times of crisis, such a way of operating impedes coordinated and consistent decisions.

76 Moreover, usually purchases are not made with a view to hefty surpluses. Here, as globally, the "just-in-time" principle prevails. As a result, CISSSs and CIUSSSs do not stockpile equipment and therefore save on storage and inventory management.

77 Before the pandemic, there was no PPE manufacturer in Québec, which depended completely on foreign supply chains.

78 In January 2020, when MSSS's civil security units were being mobilized, one of the first concerns was to inventory the PPE available within the network. This had to be done manually because there were no centralized data. An official status report by MSSS's civil security dated January 29, 2020, indicated that the reserves distributed among the different CISSSs and CIUSSSs corresponded on average to two years' current use. According to the information available, massive purchases were not recommended at the time. Some CISSSs or CIUSSSs that had greater PPE expertise and purchasing power stockpiled equipment.

79 It bears remembering that in late January 2020, the spread of coronavirus appeared to be limited to China. The chosen strategy consisted in negotiating open contracts with suppliers so that CISSSs and CIUSSSs and the megahospitals acted on their own to maintain sufficient stock. Certain Canadian provinces such as Alberta and Manitoba had access to information that enabled them to act strategically as of December 2019 and January 2020. Experts recommend the development of advanced supply expertise in Québec that would enable it to better anticipate supply chain disruptions by using predictors.[25]

[25] *Management of protective equipment in the Quebec health network: chronology of events, findings and recommendations*, Martin Beaulieu and Jacques Roy, collab. Sylvain Landry and Claudia Rebolledo, Centre for

The virus gains ground, PPE supply centralized

80 Clearly, the initial approach had to be reviewed in February 2020 when the WHO declared a worldwide shortage of PPE and an international situation that foreshadowed increased demand.

81 In Québec, as elsewhere, orders had been placed but there were difficulties with delivery. Hence, large quantities of PPE could no longer be sent to health network clients on schedule. Experts described the international PPE supply situation as something out of the "wild west." The application of any usual international trade rules or the reliability of any agreements with suppliers was fraught with uncertainty.

82 In the CISSSs and CIUSSSs, instructions began circulating on or around February 21, 2020, about efficient and judicious use of PPE. For many CHSLD workers, this meant that material was kept under lock and key, rationed, insufficient or misused. CISSSs and CIUSSSs witnessed overuse and theft.

83 Equipment supply quickly became a major challenge. As of March 20, 2020, MSSS had decided to centralize control so that supplies were distributed among institutions adequately. This was a new role for MSSS, without the advantage of any automated information system for tracking PPE inventory in the CISSSs and CIUSSSs. This flaw caused delays in data collection and strategic decision-making. Quite simply, these delays were incompatible with an urgent health crisis.

84 All of this brought into stark relief Québec's and Canada's PPE dependence on the United States, Europe and Asia.

85 During the first wave, Québec manufacturers, backed by the coordinated efforts of various government departments, changed their output to produce PPE. Later, the experts agreed that a hybrid solution was the right course of action: a reserve supply would be necessary going forward, combined with local production options.

86 In February 2020, MSSS quickly put together a supply strategy based on the information at its disposal. In the days and weeks that followed, the strategy evolved to keep pace with the global context. Despite this, supply chains could not be secured because of Québec's dependence on foreign manufacturers.

87 Nonetheless, supply centralization enabled better distribution of equipment based on new allocation priorities. Henceforth, all the distribution points for which the CISSSs and CIUSSSs were responsible (for example, private residential facilities) were taken into account. Once again, delays in matching increased needs and increased allocations occurred.

Productivity and Prosperity - Walter J. Somers Foundation, HEC Montréal, 2021 p. 16, [Online] consulted on Sept. 9, 2021.

88 In general, Québec's strategy, focused on supply centralization, was perceived by the experts as a sound practice in a time of pandemic.26 MSSS also saw the strategy as a good move. The Ontario strategy whereby each institution was left to its own devices made the competition for access to PPE even stiffer.[27]

89 Because the new logistics had to be put in place during a crisis, distribution problems were rampant. As said earlier, lack of an information system to provide reliable daily data on PPE inventory severely hampered MSSS's ability to ensure that institutions and their facilities had what they needed.

Lack of enough PPE: greater risk of transmission by staff

90 The feared shortage of PPE did in fact compromise authorities' ability to take all precautionary measures to protect CHSLD staff and residents at the right time. The directives sent to CISSSs and CIUSSSs starting the third week of February and in March 2020 about wise PPE use clearly reflect this. Inarguably, the watchword was to use the bare minimum, rather than take extra precautions. MSSS explained that the context for this choice was the unpredictability of the required amounts of PPE to deal with the pandemic's progression, about which little could be known, and difficulties with supply.

91 In a context of community spread of a virus this harmful, the safety of the care and services provided to CHSLD residents is closely tied to the health and safety of the staff who attend to them. The workers, whose health and safety were undermined28due to lack of appropriate PPE and lack of training in how to use, it were also at risk for contaminating the residents. This is where the extent of the importance of sufficient resources for adequately protecting those on the front line and informal caregivers assumes its full meaning, they being the cornerstone of the system's ability to ensure safe services to those most vulnerable.

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[26] Bohmer, R.M.J.; Pisano, G.P.; Tsai, T.C. *How Hospitals Can Manage Supply Shortages as Demand Surges,* Harvard Business Review, April 3, 2020, in *Management of protective* equipment *in the Quebec health network: chronology of events, findings and recommendations*, cited above, note 24.

[27] *Management of protective equipment in the Quebec health network: chronology of events, findings and recommendations*, cited above, note 25.

[28] Enquête épidémiologique sur les travailleurs de la santé atteints par la COVID-19 au printemps 2020, cited above, note 20.

3.3.2 Recommandation

Considering the preceding, the Québec Ombudsman recommend that MSSS:

R-4 Establish a PPE strategy aimed at securing supply chains, highlighting the following actions:

- Constitute, maintain and manage a provincial reserve that provides leeway should there be a sudden increase in needs or in the event of a sudden break in international supply chains;
- In collaboration with the Secrétariat du Conseil du Trésor, propose legislative and regulatory measures that make it possible to maintain local production and supply of certain products considered strategic.

3.4 Detect an unknown and pernicious virus in times of shortage/Rapidly deploy targeted screening strategies

"Our screening ability was limited. For a while, symptomatic people and travellers were the priority in terms of testing. It took us several weeks before opening up testing to other categories of people."

"NSA service users who were being taken out of hospitals and placed in CHSLDs were not tested, because at the time, the screening criteria were: returning from a trip, symptoms and close contact with a positive case."

3.4.1 The Québec Ombudsman's findings

A virus that outpaces the ability to detect it

92 Like PPE supply, as of January 2020, detection of the coronavirus quickly became a leading concern for Québec health authorities.

93 Various actions were taken as soon as the data from China made it possible to develop a test. At the start of the pandemic, the screening tests to identify COVID-19 carriers were analyzed at the Laboratoire de santé publique du Québec and had to be confirmed at the National Microbiology Laboratory in Winnipeg. As of March 9, 2020, the Québec laboratory stopped sending the results to Manitoba because the test developed in Québec was considered reliable enough to eliminate this extra step.

94 At the start of the pandemic, the screening tests to identify COVID-19 carriers were analyzed at the Laboratoire de santé publique du Québec and had to be confirmed at the National Microbiology Laboratory in Winnipeg. As of March 9, 2020, the Québec laboratory stopped sending the results to Manitoba because the test developed in Québec was considered reliable enough to eliminate this extra step.

95 In the weeks that followed, and with the virus spreading, the need to pick up the pace in testing and to transmit results as quickly as possible became priorities in attempting to control propagation. The first targets were symptomatic people and travellers who had returned to Québec.

96 However, the virus was quicker than the ability of Québec's health sector to trace it in order to have an accurate picture of the epidemiological situation.

- As we now know, COVID-19 can be transmitted from person to person by someone who has no symptoms whatsoever:
  - Pre-symptomatic (first three days of infection and signs only emerge later);
  - Asymptomatic (has the virus but no symptoms).

97 Either way, these people may be ground zero for an outbreak without knowing it.

98 Thus, in addition to the puzzle posed by an unknown, contagious and potentially lethal virus was this other factor which the scientific world did not immediately recognize and confirm, giving rise to transmission chains that could not be fully explained.

99 Increase in testing capacity inevitably hinged on decentralization of analysis towards several laboratories. But the fact remains that this decentralization had to be organized and coordinated, requiring time and equipment.

100 Problems with the availability of certain equipment (swabs, tubes, pipette tips, lab material) and resources were quick to emerge. Ordinarily, supplies were purchased in limited quantities, but all of a sudden, demand exploded. Alongside this, the industry, including China's, could not keep up.

101 In March 2020, Québec's health authorities had no information infrastructure for effective monitoring of the health situation—crucial in managing a pandemic. A first system had to be developed hastily, followed by a second. All of this created its share of confusion about how to declare cases and deaths, which may have affected data reliability.

102 Decisions that should have been based on how the epidemiological portrait was evolving, for example, confirmation of community transmission, were based instead on approximations. Adaptation of testing priorities to an ever-changing crisis and shifting parameters may have been slowed as a result.

103 On March 23, 2020, new outbreaks in CHSLDs prompted health authorities to prioritize testing in living environments for the elderly. However, the directive could not be applied simultaneously across the board. At the time, testing capacity was still limited, which explains why the virus made its way into many of these living environments. Many people criticized the delay of several days before test results were in, leaving vulnerable elderly residents and their families feeling uncertain and insecure.

104 Given the portrait of the situation, the Québec Ombudsman feels that MSSS's action to organize testing and speed it up was adequate. Making CHSLD residents the priority was announced quickly, and the required means followed apace. However, the implementation of decisions by CISSSs and CIUSSSs continued to be dependent on limited resources. Local organization of testing improved greatly in the summer of 2020 and when preparing for the second wave.

3.5 Confusion in recruiting and assigning back-up teams/Planning for the arrival of extra staff

"We got names from the Je contribue platform. But when we needed these people, we didn't have the structure to deal with the influx. People weren't called and were frustrated."

3.5.1 The Québec Ombudsman's findings

105 In March 2020, in the early days of the pandemic, CHSLDs had no leeway regarding human resources and the authorities had known about this problem for many years. Furthermore, sporadic periods in which there were not enough staff to cover a work shift occurred, especially at certain times of the year, for example, before and after spring break.

106 In preparing for the pandemic, MSSS had not put together any quantitative scenario that factored in absenteeism due to the virus. CISSSs and CIUSSSs had produced plans to discontinue certain hospital activities, but the amount of activity that could be suspended in CHSLDs was limited.

107 In addition, staff absenteeism worsened at lightning speed, so that MSSS had to react promptly to marshal back-up. Moreover, not only did care have to be provided in public network facilities, but MSSS also had to come to the rescue of residents of private facilities which were struggling as well.

Calls for help and rescue: ad libbing

108 Action was rapid. The Je contribue platform was activated on March 15, 2020. This digital app was not as effective as expected because it had not been designed based on hiring system parameters.

109 For its part, the directorate responsible for human resource planning, which ordinarily issues orientations, was given an operational mission overnight although it was short staffed and it did not have computer systems to back it up. How could it, in real time, identify the immediate staffing needs of the employers (health and social services institutions) without a centralized data system? For lack of anything better, MSSS public servants had to use the phone and email to update data extracted manually by CISSSs and CIUSSSs through their own means and with different systems.

110 Alongside this, health network players and political authorities sent out a call for volunteers many times. A wave of solidarity expressed itself through numerous local and regional initiatives. Some were particularly beneficial for the living environments under duress. Each contribution proved invaluable, whether that of education-system professionals, physicians, public servants from other government departments, or regular citizens. Teams from less heavily affected regions converged on the epicentre of the crisis. However, this movement was limited because of the uncertainty surrounding the evolution of the pandemic and staff and PPE shortages in all institutions.

111 Under a ministerial order,[29] some staff were forced to work in CHSLDs under imposed working conditions. While warranted by the context, over time this measure contributed to demotivation and detachment when employees were forced to work at a place they had not chosen and under difficult and risky conditions, in addition to being deprived of vacation time. Moreover, the suspension of services and the organization of back-up teams was such that professionals could not use their skills to ensure the best care for the elderly. Only the most pressing things were dealt with, and this prevented the authorities from optimizing the network's skills and resources.

Deploying exceptional back-up

112 In mid-April 2020, it was clear that the measures put in place were insufficient given that the outbreaks had veered out of control. Political authorities asked the Canadian Armed Forces to assist in the most beleaguered CHSLDs. MSSS's civil security operational cell was tasked to coordinate back-up. Administrative steps were also undertaken with Québec's Ministère de la Sécurité publique and the federal government.

113 The challenge was to match the military resources dispatched in pre-determined teams with the changing needs of living environments in disarray—coordination that did not always work well. Delays related to certain requirements by the Canadian Armed Forces, such as visiting the premises and training, could not be avoided, and this delayed the arrival of teams ready to intervene in CHSLDs. Similar issues arose with the people dispatched by the Red Cross.

114 It therefore proved complicated, in mid-crisis, to mobilize back-up while responding to CHSLD needs that fluctuated with the spread of the virus among residents and staff. To this was added the lack of local managers, which meant that new recruits were not given the guidance and supervision they needed.

115 In light of these considerations, the Québec Ombudsman has concluded that despite delays which slowed the arrival of operational back-up in crisis environments, and that therefore may have caused a lag between deployment and needs, action was prompt by the authorities, more specifically, DGAPA and the institutions which collaborated to make living environments that needed back-up a priority.

116 However, it is worth pointing out that there were no prior and standing agreements between MSSS and external organizations such as the Canadian Armed Forces or the Red Cross. The investigation showed that such arrangements would have made it possible to gain precious time. There are, in fact, agreements between Québec's Ministère de la Sécurité publique and the Red Cross for help to disaster victims.[30]

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[29] *Ministerial Order 2020-007 of the Minister of Health and Social Services dated 21 March 2020*, [Online] consulted on Sept. 9, 2021.
[30] https://www.croixrouge.ca/dans-votre-collectivite/quebec/services-en-cas-de-sinistre-et-d-urgence

117 Talks with labour unions and medical federations were also necessary concerning deployment of their members to CHSLDs. Conditions negotiated beforehand should apply in such emergency situations.

3.5.2 Recommendations

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-5 Put in place a provincial plan for deploying emergency workers within the health and social services network, including the private facilities which CISSSs and CIUSSSs must support. The plan would include, among other things:

- The determination of needs for maintaining essential services;
- A sequence of discontinued services and deployment of back-up resources from different organizations at the local, regional and provincial level;
- A resource deployment model aimed at optimizing the clinical skills of network professionals dispatched in small interdisciplinary intervention teams (SWAT teams) mandated to prevent the physical and psychological decline of people in living environments and care environments.

R-6 Establish with health and social services professional orders, federations and associations, labour unions and educational institutions protocols for deploying extra workers in exceptional situations.

R-7 Establish partnerships with a view to deploying last-resort back-up by civil-society organizations with such a mission.

3.6 Long-known labour shortages/Provide CHSLDs with sufficient numbers of qualified and competent staff

"Very quickly, instructions were issued to avoid staff mobility as much as possible, unless there were service interruptions. When you have no more names on the call-back list, what gets priority?"

"Understaffing is not the responsibility of CISSSs and CIUSSSs. It's the government's responsibility to have an international recruitment strategy."

"MSSS has a leadership role to plan, for example, planning with professional orders, institutions, the Ministère de l'Enseignement supérieur and Immigration. All of these are levers."

"It's old news that CHSLDs are understaffed and underpaid, especially in the private sector. We added resources in the past year, but I'm not proud of what's happening in our CHSLDs. We'll start by managing the current crisis, but when the dust settles, I want to review everything." (The Premier of Québec when 31 deaths at CHSLD Herron were announced on April 11, 2020).

3.6.1 The Québec Ombudsman's finding

118 Government and health authorities have known about acute understaffing for many years now. The alarm has been sounded many times, by the Québec Ombudsman as well as by numerous groups and stakeholders in a position to gauge the gap between human resources and day-to-day needs. As one person interviewed by the Québec Ombudsman said during the investigation in referring to the authorities and society as a whole, "We took our eye off the ball."

Chronic and desperate understaffing swept under the rug

119 CHSLDs were among the facilities that were particularly hard hit by staff shortages and labour instability. This proved even more alarming as soon as the first wave of the COVID-19 pandemic struck and this fact was quickly taken into account. However, as said earlier, in February and March upstream efforts were geared to increasing hospitals' intensive care capacity. At this stage, because of the lack of accurate and reliable data, the CHSLD client population was not associated with the highest risk of contamination, exacerbation and death due to COVID-19.

120 The health and social services network was doubly weakened by the pandemic—by chronic understaffing and absences due to the virus. Like many other directorates, MSSS's human resources branch lacked centralized data for agile daily management of any staff-related matters. Nor was it any better equipped to help government make decisions about the impact of certain measures on CHSLD services, such as prohibiting staff mobility, removing workers who had travelled during the spring break, or deploying emergency back-up.

Mobility that MSSS could not prevent

121 The Québec Ombudsman questioned MSSS authorities about the approach chosen and the strategy used to limit healthcare staff mobility between facilities in order to limit spread of the virus.

122 The reply concerned the circumstances described and gauged by MSSS, which explained that it could not formally prohibit mobility.

- First, MSSS maintained that because it had no quantitative data, any decision about mobility was made more complicated.
- It also feared that care would be interrupted.
- Word went out to MSSS from senior authorities not to hinder the individual freedom of workers by forcing them to work at one facility only, for fear of losing staff. This was surprising when we compare this position with ministerial order 2020-007[31], which suspended the application of collective agreements, and which, with hindsight, had the same impact on retention.
- When spring break was over, MSSS could not, it said, remove workers who had travelled, even if Public Health recommended it. Deprived of information about

[31] Ministerial order number 2020-007, cited above, note 28.

how many workers had travelled, MSSS could not foresee the impact of this kind of decision on the network's ability to maintain care. As a result, all it could do was to urge institutions to limit mobility as much as possible.[32] Note that in recent years, one way of countering understaffing within the health and social services network has been worker mobility.

- Use of private employment agencies, which became an unavoidable solution when work shifts were understaffed, added to the mobility problem in the context of the pandemic.

123 While in Québec, CHSLD visitors were identified as posing the greatest risk for contaminating CHSLDs and drastic measures for prohibiting non-essential visits were taken on March 14, 2020,[33] British Columbia adopted a different approach, where staff movement was pinpointed as being riskier for spreading the virus, and therefore was quickly and formally prohibited. As of March 25, 2020, the province's Health Officer, the equivalent of Québec's Public Health Director, issued a single-site order under which staff would have to work within only one environment from then on.[34] This made it possible to enhance working conditions across the board, whether in public or private facilities, as well as to collect the human resource management data needed to apply the order.[35]

124 Hence, it seems that the governments of British Columbia and Québec made different decisions based on the information at their disposal and according to their specific context. According to the information obtained by the Québec Ombudsman, the fact that there was less community transmission in British Columbia during the first wave may have contributed to limiting outbreaks in residential facilities.

125 Based on the results of epidemiological investigations and according to the stakeholders that the Québec Ombudsman consulted, we now know that movement of staff between facilities and units caused an increase in outbreaks in Québec. In fact, MSSS acknowledges this fact.[36] It argues that the risk posed by staff movement was weighed against that of not being able to ensure care and service continuity within the

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[32] In a directive to CHSLDs dated April 3, 2020, MSSS asked that, *insofar as possible,* that staff no longer work at more than one CHSLD in order to prevent cross-contamination (worker mobility).

[33] Gouvernement du Québec, *Avis de suspension des visites dans tous les centres hospitaliers, CHSLD, RPA, RI-RTF*, cited in *Arrêté numéro 2020-009 de la ministre de la Santé et des Services sociaux en date du 23 mars 2020*, [Online] consulted on Sept. 9, 2021.

[34] Order announced on 25 March 2020: https://news.gov.bc.ca/files/1.25.2021_LTC_COVID-19_Response_Review.pdf, p. 12.
Order of 26 March 2020: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/archived-docs/pho_order_long_term_care_facility_movement_march_26_2020.pdf
Order of 27 March 2020: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/archived-docs/pho_order_long_term_care_facility_movement_march_27_2020.pdf

[35] BC Care providers association Review to the response to COVID-19 in seniors care and living, A dialogue with care providers, November 16, 2020, Wynona Giannasi, MPA, CE, Jennifer Hystad, MSc, CE Online

[36] MSSS, *COVID-19 : Plan d'action pour une deuxième vague,* issued Aug. 18, 2020, pp. 40 and 42, [Online] consulted on Sept. 9, 2021.

network. When these decisions were made, little was known about important factors such as how the virus is transmitted.

126 In December 2020, MSSS issued a directive[37] on stabilizing the labour force in the public living environments under the jurisdiction of CISSSs and CIUSSSs, as well as the private resources under contract with them. This directive came in the wake of MSSS's Plan d'action pour une deuxième vague[38] aimed at establishing the guiding principles of labour mobility in order to reduce the risk of COVID-19 cross-contamination from facility to facility. Staff mobility is now governed by standards regarding exceptions set out in the directive. These measures should continue to apply post-pandemic and long term.

The need for a ministerial order as the main way to secure room to manoeuvre

127 As stated before, on March 21, 2020, government adopted ministerial order 2020-00739 to amend the various provincial and local collective agreements in force within the health and social services network. The order concerned, among other things, the suspension of time off, including vacations and staff movement, work schedules and hiring of additional staff. The order declaring a health emergency across Québec allowed MSSS to do anything required in order to ensure that the health and social services network had the human resources it needed.

128 In the weeks that followed, certain categories of healthcare and assistance workers in public and private institutions were given a pay raise. The idea was to attract new workers and retain existing ones in the context of the health crisis.

The labour force as the cornerstone of the care network

129 In the Québec Ombudsman's opinion, during the first wave, not only was there the usual shortage of workers, but MSSS authorities and some health institutions responsible for distributing resources did not necessarily fully understand the kind of care needed in CHSLDs. It must be remembered that interventions in CHSLDs are often seen as support for activities of daily living. Inversely, some experts consider that the nursing care in CHSLDs can sometimes be similar to hospital care in terms of intensity, uncertainty and variability.[40] This complexity, brought into sharp relief by the situation experienced in CHSLDs during the first wave of the pandemic, must be recognized.

130 The Québec Ombudsman insists on the paramount importance of labour as the cornerstone of the network's capacity to offer quality care and services. As a result, MSSS must negotiate working conditions that enable human resource management

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[37] MSSS, *Directive sur la stabilisation de la main-d'œuvre des milieux de vie publics et privés conventionnés des établissements du réseau de la santé et des services sociaux* – Ministerial directive, issued Dec. 23, 2020, pp. 41-42 and 67, [Online] consulted on Sept. 9, 2021.
[38] MSSS, *COVID-19 : Plan d'action pour une deuxième vague,* cited above, note 35.
[39] *Ministerial order 2020-007*, cited above, note 28.
[40] INSPQ, *Reconciling the care environment and the living environment in long-term care facilities*, September 2020, pp. 28 and 41, [Online] consulted on Sept. 9, 2021.

which is safe, compassionate and efficient in an adequate work environment. Labour shortage is systemic and it is up to government to find solutions.

131 The Québec Ombudsman is aware of the initiatives for combatting the shortage of workers since the onset of the health crisis, including training of new cohorts of care attendants. This process must continue, be extended to every employment group, and quickly lead to resources that are more resilient.

132 Rapid action is needed to remediate and prevent the current and the future impact of labour shortages in the health and social services. We must also ensure that new hirees remain. Action is imperative, as is identifying leverage and powerful strategies for national and international attraction, retention and recruitment.

133 It is essential that a significant inflow of human resources provide the health and social services with real leeway in ordinary times and times of emergency. The measures must act as incentives and be persuasive, concrete and immediate.

134 It is crucial that staff be taken care of. Staff who have been the collateral damage of the pandemic must be given sustainable support. Maintaining the mental health support measures put in place for staff who experienced the COVID-19 crisis and developing new resources are important in recognizing the damaging impact (such as distress and burnout) the crisis has had on them. Such initiatives are essential in order to respond to the needs of employees and foster their retention.

3.6.2 Recommendations

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-8 Initiate a Québec strategy to combat labour shortages and to promote trades and professions in the field of health and social services. The goals of the strategy would be to:

- Gather data that would provide an exhaustive portrait of the need for employees, by means of a workforce planning exercise in public and private residential facilities;
- Reduce absenteeism within the network;
- Deploy strategies to attract and retain workers in collaboration with various partners;
- Establish strategies for the mass recruitment of workers nationally and internationally, including measures that provide incentives and that facilitate access to training;
- Reduce, with a view to eliminating, dependence on workers from private employment agencies;
- Examine the professional fields of practice concerned as well as reserved activities;
- Update existing strategies.[41]

R-9 Maintain current assistance and support measures and develop new ones. The purpose is to:

- Respond to the needs of health and social services workers who experienced the COVID-19 crisis;
- Recognize the damaging impact of the crisis (such as burnout and distress) on the workers concerned;
- Ensure the retention of the workers concerned.

3.7 CHSLD visits prohibited and dramatic consequences/Integrate informal caregivers and recognize their essential contribution

"At first the idea was to discontinue visits for a very short time to be able to take a step back and see what we were up against. But it dragged on and that's how we underestimated the extent of informal caregivers' contribution."

"They have to be seen as collaborators and partners, not as people who show up to see what's wrong."

[41] For example, the *Plan d'action pour l'attraction et la fidélisation des préposés aux bénéficiaires et des auxiliaires aux services de santé et sociaux*, MSSS, February 2020, [Online] consulted on Sept. 28, 2021.

3.7.1 The Québec Ombudsman's findings

135 On March 14, 2020, the Government of Québec announced that visits to residents would be suspended in order to protect them by reducing contact with the outside world. The measure applied not only to CHSLDs, but also to hospitals, private seniors' residences (RPAs), intermediate resources (RIs) and family-type resources (RTFs).

136 Senior authorities took their cue from data from China indicating that people 70 years old and over were particularly at risk for developing the serious form of the disease.

At first, a short ban on visits

137 Managers confided to the Québec Ombudsman that the decision to prohibit visits was made reluctantly because of the impact that could be seen looming on the horizon for residents.

138 At first, the measure was meant to be short-term, the thinking still being that the COVID-19 onslaught would be short-lived. However, the ban on visits persisted well beyond initial projections. The health network and, indeed society as a whole, witnessed the profound distress of residents for whom families were more than a source of comfort but, in fact, a vital link.

139 Two weeks after the formal ban on visits, the Deputy Health Minister issued a directive to the president-executive directors of CISSSs and CIUSSSs instructing them to restore contact between residents and their families. The aim was to alleviate the isolation-related stress of the confined residents.

140 The following orientations were to be implemented no later than April 1, 2020:

- Using means of communication, such as phones and technological tools, to maintain contact between families and residents;
- Identifying the employees, volunteers or other people who would contact families and friends to regularly inform them about the state of health and well-being of residents.

141 During those troubling weeks, CHSLD workers performed miracles of ingenuity to put technology at the service of distance reunions. However, this was not done equally in all living environments. Factoring in that workers were overloaded with basic care, it took some CHSLDs weeks to deploy such tools. As a result, more than anyone else, elderly people were cut off from all contact.

Visits resumed or postponed?

142 In mid-April 2020, the authorities sought to strike a balance between the pros and cons of suspending visits. On the one hand, the political authorities wanted to respond to public expectations by considering the risks. On the other hand, the administrative authorities and certain living environments did not feel comfortable with allowing informal caregivers back in a context of crisis, disorganization and a shortage of staff to enable this. As a result, mental health and senior-assistance issues had to be weighed against the imperatives of protecting their physical safety and health.

143 Discussions between Public Health and DGAPA led to the prudent and gradual resumption of visits by informal caregivers. Nonetheless, some living environments, fearing new outbreaks, continued to resist. MSSS had to maintain its position and instruct the CHSLDs to allow informal caregivers in under strict conditions such as a negative COVID-19 test. Because this condition was difficult to apply, it was quickly dropped.

144 The Québec Ombudsman concludes from this that given the rampant spread of COVID-19, the decision to prohibit visits in the short-term could be seen as legitimate. The automatic impulse to protect elderly people by temporarily keeping them at a distance from informal caregivers took account of the fact that the caregivers were potential carriers. Other provinces also faced these dilemmas, notably, Ontario and British Columbia, which, at a certain point, had to grudgingly ban visits.

145 With hindsight, the consequences of this measure showed that the invaluable contribution of these informal caregivers had been underestimated. In other words, at the height of the crisis, CHSLDs were deprived of the competent assistance of families who knew their respective relatives and the living environment. Luckily, the directives for informal caregivers and visitors were changed as the weeks went by. Gradually, as of mid-April, informal caregivers were better equipped to return to CHSLDs. In May and June 2020, with the gradual deconfinement, they were more present.

146 The first wave proved beyond a doubt that informal caregivers in CHSLDs must be welcomed within the healthcare team and have the tools they need to play their role.

3.7.2 Recommendations

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-10 Recognize the contribution of informal caregivers in CHSLDs and include them as partners within living environments. Do this by giving them adequate guidance and supervision and effective support through continuing education and consolidating their collaboration with the care and assistance team.

R-11 Ensure that informal caregivers are never denied access to CHSLDs barring exceptional and short-lived circumstances, but are supervised, supported and involved as invaluable partners, while respecting their wishes and capacity for involvementent.

R-12 Encourage distance contact between residents, their informal caregivers and family members by means of technology.

3.8 Lack of fluidity in applying instructions and negative impact on service organization/Better communication so that authorities know what is happening in CHSLDs and vice-versa, and establish strong local management within every CHSLD

"Directives didn't have time to trickle down to every CHSLD level before they were already changed."

"If was hard to have instructions passed down in real time and to reorganize quickly when changes were made. So many moving parts and a moving target."

"We have to get our act together to be able to react faster. It must become part of institutions' and living environments' DNA."

"It's not for nothing that every CHSLD has to have a local manager—so that directives are applied correctly on the ground."

3.8.1 The Québec Ombudsman's finding

147 In the opinion of many, the disorganization in CHSLDs during the first wave of the pandemic is related to the structural and decisional distance between these facilities and health and social services network authorities. Reform of the healthcare system in 2015 created bigger structures without providing them with enough managers.[42]

148 This may be part of the reason why senior authorities were unaware of the reality of the crisis happening on the ground, since concrete indicators as to the consequences of the events and information about daily needs were not conveyed on a day-to-day basis. Alongside this, health instructions and MSSS directives did not reach CHSLDs with the effectiveness and speed called for by the urgency of the situation.

149 The ground was constantly shifting regarding:

- Knowledge about the virus;
- Taking new data about COVID-19 into account;
- Decisions made in emergency situations;
- The availability of human and material resources;
- Adaptation of resources and services to the priorities dictated by the increase in positive cases, outbreaks and deaths.

Bungled application of the directives coming from the top of the decisional pyramid

150 In the great rush that occurred and in the opinion of many witnesses, the transmission of information and instructions about best practices was well and truly bungled. Vertical information (from MSSS, CISSS and CIUSSS authorities and experts down to the living environments) should have better equipped and reassured CHSLD staff, as well as the

[42] See Appendix 3 for a view of a CIUSSS's organizational structure.

residents and their families. In such circumstances, the primary goal must be to convey a clear, consistent and adapted message in order to prevent any confusion or the impression of contradiction.

151 This absence of local guidance often led to a loss of clarity about task-sharing and caused staff to be demotivated and disheartened by the lack of leadership and accountability within battered CHSLDs. This feeling of detachment was just as common among regular workers, who were powerless witnesses to the dramatic degradation of their work environment, as well as replacement staff, who felt neither supervised nor supported.

152 This absence of local guidance often led to a loss of clarity about task-sharing and caused staff to be demotivated and disheartened by the lack of leadership and accountability within battered CHSLDs. This feeling of detachment was just as common among regular workers, who were powerless witnesses to the dramatic degradation of their work environment, as well as replacement staff, who felt neither supervised nor supported.

153 A gulf was also seen between MSSS and CISSSs/CIUSSSs. On the one hand, MSSS's mission is to issue broad orientations rather than to intervene on an operational level. On the other, institutions demand autonomy for defining their means of action. The gap between the two may have weighed down decision-making and hindered the agility of operations. The result was that the health crisis exacerbated top-down management, a concept that emerged at the start of the 2015 reform, and the centralization of powers. This generated a kind of paralysis in living environments constantly bombarded by revised and modified orientations.

154 The Québec Ombudsman considers that CHSLDs did not have a local governance structure enabling them to optimally apply the directives sent to them and to make informed and adapted organizational decisions quickly enough. Hence the importance of establishing local management that is operational at all times in order to correctly identify the realities and issues proper to each living environment.

155 Each CHSLD must have managerial autonomy by means of strong separate governance in order to make residents and their families the centrepiece of the decisions that concern them.

156 In the fall of 2020, MSSS instructed CISSSs and CIUSSSs that every CHSLD under their governance have one person mandated to act as the manager in charge within the facility. Unit heads were also added when the clinical-administrative staff ratios were increased. The Québec Ombudsman sees this as a step in the right direction in bolstering local management. That said, once in place, the manager must have a real ability to act and the authority to do so.

157 Tools must therefore de developed to:

- Allow local management;
- Strengthen accountability;

- Maintain service quality within CHSLDs;
- Ensure reporting.

158 Furthermore, a local management plan must be produced for unforeseeable situations.

159 The specificities and complexity of CHSLDs' mission must also be better known and recognized. Therefore, careful thought must be given to the suitability of decentralizing, to some extent, the long-term care mission within CISSSs and CIUSSSs, which would make it possible to recognize its unique character.

3.8.2 Recommendations

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-13 Recognize the mission and unique character of CHSLDs within CISSSs and CIUSSSs by means of distinct governance so that these living environments are more autonomous and able to adapt to their particular issues. Give the managers a mandate and supervisory conditions empowering them to exercise strong leadership based on the specific features of the living environment.

R-14 Review the management approaches in CHSLDs in order to foster proximity and a team approach between the manager, the workers, the residents and their families.

R-15 Monitor the commitments[43] by CISSS and CIUSSS authorities to CHSLDs stemming from the two editions of the forum on best CHSLD practices held in 2016 and 2018, and demand accountability.

R-16 Require CISSSs and CIUSSSs to work with the managers concerned to develop local crisis plans and plans for back-up management staff in CHSLDs in case of emergencies or exceptional events, and to update the plans regularly.

R-17 Do what is required to convey clear, consistent and adapted messages through well-identified communication channels locally, regionally and Québec-wide so as to facilitate a common understanding of the messages and prevent any confusion.

3.9 Lack of timely data: obsolete computer systems/Have reliable and quality information at all times

"Information from the field didn't make its way up the ladder like it should have to provide input for government decision-making. Unfortunately, in a time of pandemic, when the quality of information isn't there, it means delayed decisions, and that can be fatal. It's a matter of hours."

[43] https://www.msss.gouv.qc.ca/professionnels/soins-et-services/forum-sur-les-meilleures-pratiques-usagers-chsld-et-soutien-a-domicile/engagements-du-forum-sur-les-meilleures-pratiques-en-chsld/, [Online] consulted on Sept. 9, 2021.

"MSSS management systems have gaps. If the right question isn't asked, the right information doesn't come out."

"We're going from faxes to Excel spreadsheets, and from that to computer systems that hold up."

"What we want is information in real time. That's what we need. We can't afford to wait three weeks for an answer when we have to make management decisions. It's as simple as that."

3.9.1 The Québec Ombudsman's findings

160 Computer systems did not keep pace with the reconfiguration of the health and social services network in 2015, a phenomenon that has often been criticized. Afterwards, attempts to computerize the network were slowed by the promise of comprehensive programs that performed better. Real reform lagged and is still lagging.

Handwritten requisitions, delays

161 Because there was no centralized information system, MSSS was reduced to relying on CISSSs and CIUSSSs to fill out requisitions manually and obtain information that did not reach them fast enough. For example, this was the case for information about human resources, outbreaks, management of material, equipment inventories and epidemiological data.

162 In the full throes of a health crisis, the disastrous consequences of the lack of means of communication were palpable:

- Difficulty obtaining an accurate portrait of events to enable a correct assessment, notably regarding epidemiological data;
- Lack of data about preparing for the pandemic;
- Lack of data for assisting crisis management, notably regarding human resource and supply management.

163 In light of the experience during the first wave—even though it was common knowledge well before the crisis that means of communication were obsolete—the importance of obtaining real-time data for guiding day-to-day management hit home even harder. Whether in ordinary times or in times of crisis, relevant data must be available and up-to-date so that solutions adapted to needs can be introduced rapidly. Efficient systems could also strengthen accountability mechanisms for managers and public decision-makers alike.

164 During its investigation, the Québec Ombudsman noted that MSSS civil security teams had put together factual daily status reports. The Ombudsman also learned that documenting the making of decisions or orientations was not common practice. People who were supposed to act decisively were reduced to relying on their own memory, intuition or impressions, without any other support.

3.9.2 Recommendations

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-18 Procure integrated computer systems that provide centralized data at all times and in real time to direct day-to-day management, notably regarding human resources, public health surveillance, and supply.

R-19 With a view to transparency and accountability, use high-performance and up-to-date computer systems to document important actions and decisions, as well as the opinions of the authorities in times of crisis to assist decision-making, justification of these decisions, and their follow-up.

3.10 CHSLDs: a model that needs reviewing/Humanize care for residents and the work environment for staff

"When the dust settles, we will have to rethink the residential-resource network and emphasize human respect and dignity."

3.10.1 The Québec Ombudsman's findings

165 The acute crisis that struck CHSLDs during the first wave of the pandemic showed, through an oppressive portrait of the situation, the pressing need to humanize care to residents and staff working conditions alike.

166 This is a priority if we are to ensure that living environments satisfy quality criteria based on convincing data[44] and to enable an agile and ongoing balance between the requirements of a living environment and a care environment. It is precisely the problems with this two-pronged function that prevented CHSLDs from adapting to the pandemic, whether in terms of IPAC or the ability of CHSLDs to provide essential care, including end-of-life comfort care.

Rethink living environments, fully and immediately

167 Battered by the crisis, these environments displayed a flagrant lack of robustness that must be corrected by, among other things, adding human, material and financial resources. Care and service quality and their monitoring must also be enhanced by means of effective control mechanisms. Solid foundations must be ensured.

[44] Institut national d'excellence en santé et en services sociaux (INESSS), *Qualité du milieu de vie en centre d'hébergement et de soins de longue durée pour les personnes âgées en perte d'autonomie-États des connaissances*, Coup d'œil, , 9-10-2018; INESSS, *Reconciling the care environment and the living environment in long-term care facilities*, Repères, 22-09-2020, [Online] consulted on Sept. 10, 2021.

168 Various measures are called for in a future vision of CHSLDs, and this report enumerates several. Add to these, required initiatives and adjustments such as:

- Forging strong ties between CISSSs and CIUSSSs and the public and private living environments within their respective territories. This would entail formalizing or strengthening communication and mutual support processes among them;
- Establish quality indicators and an accountability mechanism;
- Involve the local community and encourage citizen participation in every CHSLD;
- Increase the dissemination of best gerontology and geriatric practices in CHSLDs;
- Ensure that residents and their families are supported by system navigators in the long-term care and service continuum;
- Plan to retrofit and transform certain living environments to ensure that they are physically safe and adapted to elderly people's needs.

169 Plus spécifiquement, pour les CHSLD privés :

- Ensure similar service quality standards in public and private CHSLDs to counter the disparity in residents' living conditions;
- Ensure care quality supervision and levers for action in private resources.

170 During the investigation, MSSS informed the Québec Ombudsman about the initiatives underway concerning private uncontracted CHSLDs, and its intention to better support and supervise them, with a view to greater equity in how residents are treated. MSSS also wants to enhance care and service quality in living environments across the board.

171 The Québec Ombudsman encourages any action to counter disparities in CHSLD residents' living conditions. Access to comparable quality care and services should be an imperative, no matter which living environment.

The resources needed to effect change

172 Implementing concrete, structural and sustainable measures to improve the future of CHSLDs is urgent. MSSS must allocate the required resources, propose a suitable timeline, and ascribe genuine importance to the changes so that they actually materialize. Remedial action must be effective, sustainable, people-centred and adaptable in exceptional circumstances.

A policy whose benefits must be measured

173 The Québec Ombudsman applauds the very first policy on residential and long-term care resources, (Politique d'hébergement et de soins et services de longue durée – Des milieux de vie qui nous ressemblent),[45] released on April 15, 2021. The document was produced in collaboration with the ministerial committee of long-term residential

[45] Gouvernement du Québec, *Des milieux de vie qui nous ressemblent - Politique d'hébergement et de soins et services de longue durée*, 2021, consulted on Sept. 10, 2021.

resource experts, including DGAPA ensuring leadership. It lays out a vision and the guiding principles that underpin an action plan for implementing this essential and long-awaited policy.

174 While the Québec Ombudsman fully endorses the new policy, it would nonetheless point out that its real value will only emerge if the principles it champions lead to concrete actions. Ministerial long-term care orientations remain to be fully implemented in certain living environments. The policy will only achieve its goals if, in the very near future, it becomes the lever and guide it is expected to be.

3.10.2 Recommendations

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-20 Produce a Québec action plan that includes concrete, structural and sustainable measures aimed at recognizing the complexity of care and service provision in CHSLDs and at improving living environments and their quality based on solid evidence. The action plan should cover:

- The slate of compassionate care and services delivered under adequate working conditions, whether long-term, basic, intensive, or palliative care;
- A stable work force based on a single-site format that prioritizes full-time jobs and that limits the use of workers from employment agencies;
- Sufficient staff-resident ratios for a personalized approach that responds to residents' needs and enables manageable work loads;
- The interdisciplinary composition of teams;
- Staff professional development;
- Living conditions in public and private CHSLDs;
- The IPAC program;
- Local and participatory management practices that foster decisional autonomy, staff involvement and recognition of worker skills;
- Accountability and designation of the people in charge;
- Physical environment.

R-21 Adopt legislative measures that define the guiding principles that must be followed regarding living environment quality and organization, and establish the procedure for applying them by regulatory means.

R-22 Reinforce the mechanisms for controlling and monitoring the quality of living environments in order to detect shortcomings and take the corrective action required in a timely fashion by establishing measures such as:

- Increasing the frequency of quality assessment spot checks in CHSLDs;
- Making it a priority to directly observe living environments as part of quality assessment;
- Review accountability mechanisms to ensure effective monitoring.

- Add the resources needed to strengthen these quality control and monitoring mechanisms.

R-23 Establish a standing advisory and watchdog committee composed of long-term care players and experts who:

- Advise MSSS on the concrete, structural and sustainable measures in the short, medium and long term to improve care and service quality in CHSLDs;
- Follow the implementation of Québec action plan measures to recognize the complexity of care and service provision in CHSLDs and to improve the quality of care and services;
- Assess whether studies on the ways of funding the care and service continuum for people with age-related reduced autonomy are warranted

R-24 Ensure that CISSSs and CIUSSSs increase the number of system navigators in CHSLDs to support the teams and help implement a harmonious and safe trajectory for the residents, from their admission until end-of-life.

R-25 Enhance the dissemination of best gerontology and geriatric practices; promote sharing and transfer of knowledge between CISSSs and CIUSSSs and research centres that specialize in aging.

Considering the preceding, the Québec Ombudsman recommends that the Minister of Health and Social Services:

R-26 Keep track of the outcomes of any investigative report concerning the COVID-19 crisis sent to MSSS or to the Government of Québec, and over the next five years, report annually and publicly on the progress made in implementing the recommendations.

3.11 Remembering

3.11.1 The Québec Ombudsman's findings

A yearly day of remembrance

175 In March 2020, COVID-19 laid siege to numerous CHSLDs and caused casualties under revolting conditions. Residents, their families and workers were plunged headlong into a general service meltdown, in a system whose shortcomings were known long before the crisis.

176 It is not time to look back, but instead to move towards a future that recalls the suffering of fragile seniors caught in the cyclone of an exhausted and depleted system.

177 Loving and respecting our elders requires that, together, we remember this tragic time in CHSLDs and, more broadly, our collective powerlessness to save lives when everything was going up in flames.

3.11.2 Recommendation

Considering the preceding, the Québec Ombudsman recommends that the Minister of Health and Social Services :

R-27 Propose that there be an annual day of commemoration for the COVID-19 victims and those who worked with them directly or indirectly, in order to remember what they went through during the first wave of the pandemic and the suffering and loss experienced by these sorely affected people.

Follow-up to recommendations:

The Québec Ombudsman is asking the Ministère de la Santé et des Services sociaux, no later than January 14, 2022, to provide it with a work plan indicating the actions chosen and the timeline proposed for implementing each of the recommendations of this report.

The Québec Ombudsman is also asking the Ministère de la Santé et des Services sociaux to provide it with a progress report about implementation of the recommendations as at March 1, 2022, and then, according to a follow-up schedule to be agreed upon.

The Québec Ombudsman intends to discuss this follow-up in its Annual Report until the recommendations have been implemented to its satisfaction

CONCLUSION

THE STATUS QUO IS NOT AN OPTION

178 In the comments and analysis of the pandemic, a common theme was that CHSLDs were the blind spot in bracing for COVID-19. The truth is that, above and beyond CHSLDs, it was the residents who were cast aside when the attack against the virus was being mounted. Whatever the future holds and whatever the possibility of another global upheaval, this must never happen again. Decision-makers must commit to this and keep their word.

179 Long-term care environment workers unfairly and disproportionally bore the brunt of public authorities' inaction regarding the flaws seen in CHSLDs well before COVID-19 and exacerbated during the first wave. CHSLDs, like their residents, were the victims of a conception of living environments that disregarded the complexity of their mission.

180 For the women and men who attend to elderly people's health and well-being to be better recognized and valued, CHSLD working environments must be held in greater esteem. Caregivers were heroes at the height of an unprecedented crisis. For them, and for the residents and their families, the status quo is unthinkable.

181 This report and its witness statements brought back painful memories of the times when efforts to combat the virus spun out of control despite best intentions. However, the fact of being able to contribute to ensuring better days for those who have earned the right to grow old peacefully and with dignity, in living environments that reflect who we are and that respect us, has brought us together. Let us hope that it will also rally us around the challenges that must be addressed.

APPENDIX 1: LIST OF RECOMMENDATIONS

Considering the preceding, the Québec Ombudsman recommends that MSSS:

R-1 Establish a risk assessment and management policy for residential and long-term care centres that must have the following goals:

- Equip MSSS's general directorates with the medical, clinical and scientific expertise needed for managing risks adequately and comprehensively, so as to anticipate the impact on the client populations concerned;
- Plan safe transitions for users who have to be relocated in emergency and crisis situations in order to respond to their needs adequately and rapidly;
- Formally make the precautionary principle the centrepiece of risk assessment and management.

R-2 Formalize joint action and communication mechanisms in MSSS's general directorates in times of crisis or in any other situation requiring the pooling of expertise in order to prevent compartmentalization and to foster the understanding and overall consistency of actions.

R-3 Produce and implement a detailed plan to strengthen CHSLDs' ability to apply rigorous infection prevention and control measures. The plan should include the following measures concerning:

- Making staff, residents and informal caregivers aware of the shared responsibility for seeing that IPAC best practices are followed;
- Professional development for healthcare teams;
- Compliance with adequate IPAC nursing staff ratios within CHSLDs;
- The role of the IPAC adviser in each CHSLD;
- Applying best practices;
- Performance and accountability indicators for the targets set;
- Reducing the adverse effects of IPAC measures on certain vulnerable residential client populations;
- Developing a data processing system that provides an accurate ongoing real-time portrait of outbreaks in CHSLDs;
- A review of the procedure for assessing the quality of living environments so as to emphasize IPAC;
- Strengthening of the IPAC directorate within MSSS in order for its influence and actions to be lasting.

R-4 Establish a PPE strategy aimed at securing supply chains, highlighting the following actions:

- Constitute, maintain and manage a provincial reserve that provides leeway should there be a sudden increase in needs or in the event of a sudden break in international supply chains;

- In collaboration with the Secrétariat du Conseil du Trésor, propose legislative and regulatory measures that make it possible to maintain local production and supply of certain products considered strategic.

R-5 Put in place a provincial plan for deploying emergency workers within the health and social services network, including the private facilities which CISSSs and CIUSSSs must support. The plan would include, among other things:

- The determination of needs for maintaining essential services;
- A sequence of discontinued services and deployment of back-up resources from different organizations at the local, regional and provincial level;
- A resource deployment model aimed at optimizing the clinical skills of network professionals dispatched in small interdisciplinary intervention teams (SWAT teams) mandated to prevent the physical and psychological decline of people in living environments and care environments.

R-6 Establish with health and social services professional orders, federations and associations, labour unions and educational institutions protocols for deploying extra workers in exceptional situations.

R-7 Establish partnerships with a view to deploying last-resort back-up by civil-society organizations with such a mission.

R-8 Initiate a Québec strategy to combat labour shortages and to promote trades and professions in the field of health and social services. The goals of the strategy would be to:

- Gather data that would provide an exhaustive portrait of the need for employees, by means of a workforce planning exercise in public and private residential facilities;
- Reduce absenteeism within the network;
- Deploy strategies to attract and retain workers in collaboration with various partners;
- Establish strategies for the mass recruitment of workers nationally and internationally, including measures that provide incentives and that facilitate access to training;
- Reduce, with a view to eliminating, dependence on workers from private employment agencies;
- Examine the professional fields of practice concerned as well as reserved activities;
- Update existing strategies.

R-9 Maintain current assistance and support measures and develop new ones. The purpose is to:

- Respond to the needs of health and social services workers who experienced the COVID-19 crisis;
- Recognize the damaging impact of the crisis (such as burnout and distress) on the workers concerned;
- Ensure the retention of the workers concerned.

R-10 Recognize the contribution of informal caregivers in CHSLDs and include them as partners within living environments. Do this by giving them adequate guidance and supervision and effective support through continuing education and consolidating their collaboration with the care and assistance team.

R-11 Ensure that informal caregivers are never denied access to CHSLDs barring exceptional and short-lived circumstances, but are supervised, supported and involved as invaluable partners, while respecting their wishes and capacity for involvementent.

R-12 Encourage distance contact between residents, their informal caregivers and family members by means of technology.

R-13 Recognize the mission and unique character of CHSLDs within CISSSs and CIUSSSs by means of distinct governance so that these living environments are more autonomous and able to adapt to their particular issues. Give the managers a mandate and supervisory conditions empowering them to exercise strong leadership based on the specific features of the living environment.

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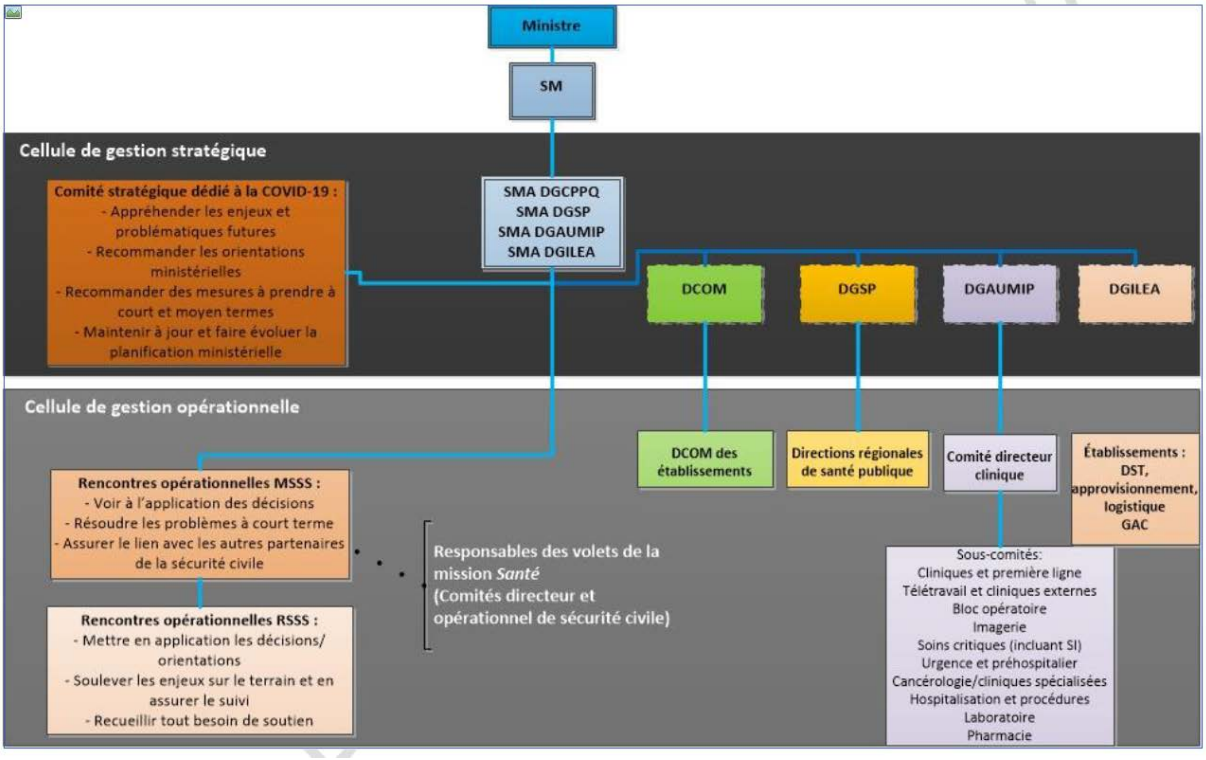
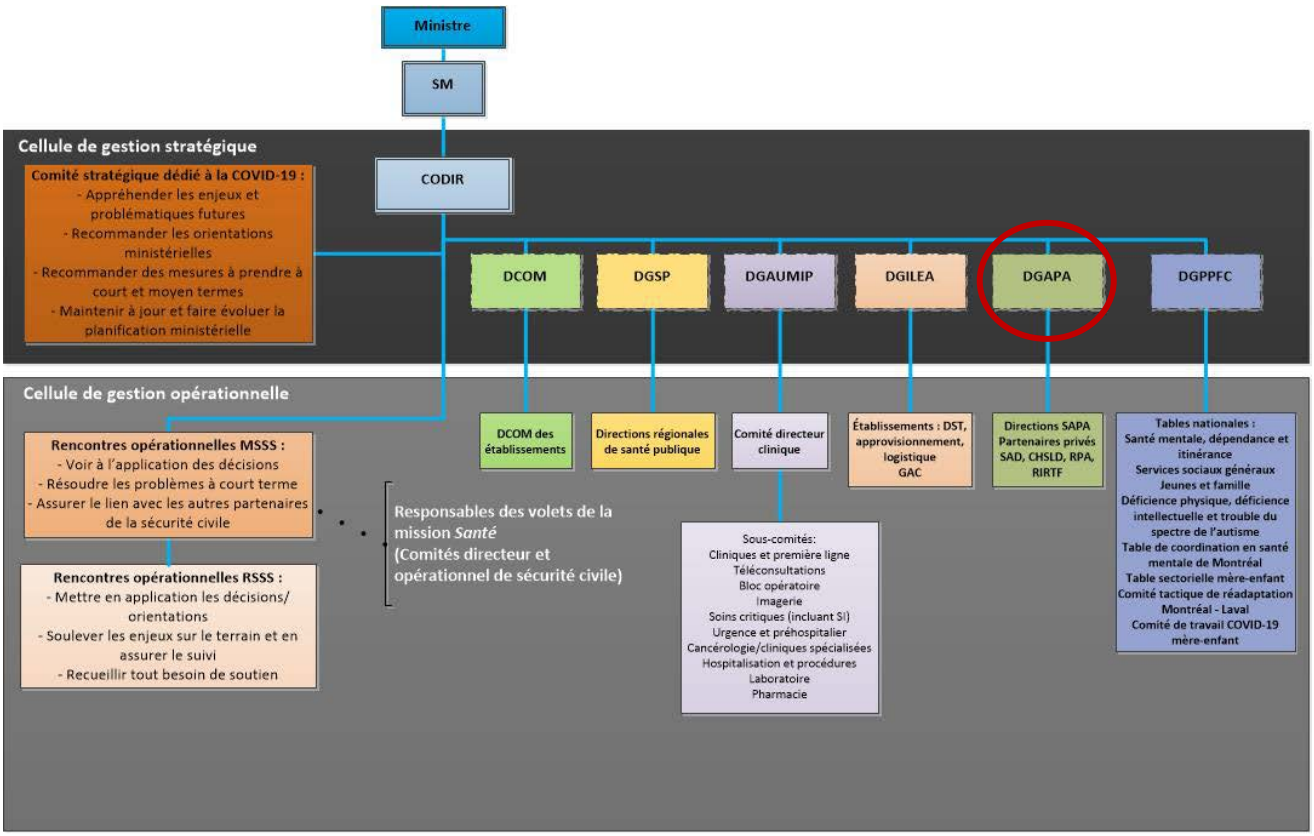
APPENDIX 2: PANDEMIC GOVERNANCE STRUCTURE EVOLUTION (MSSS)



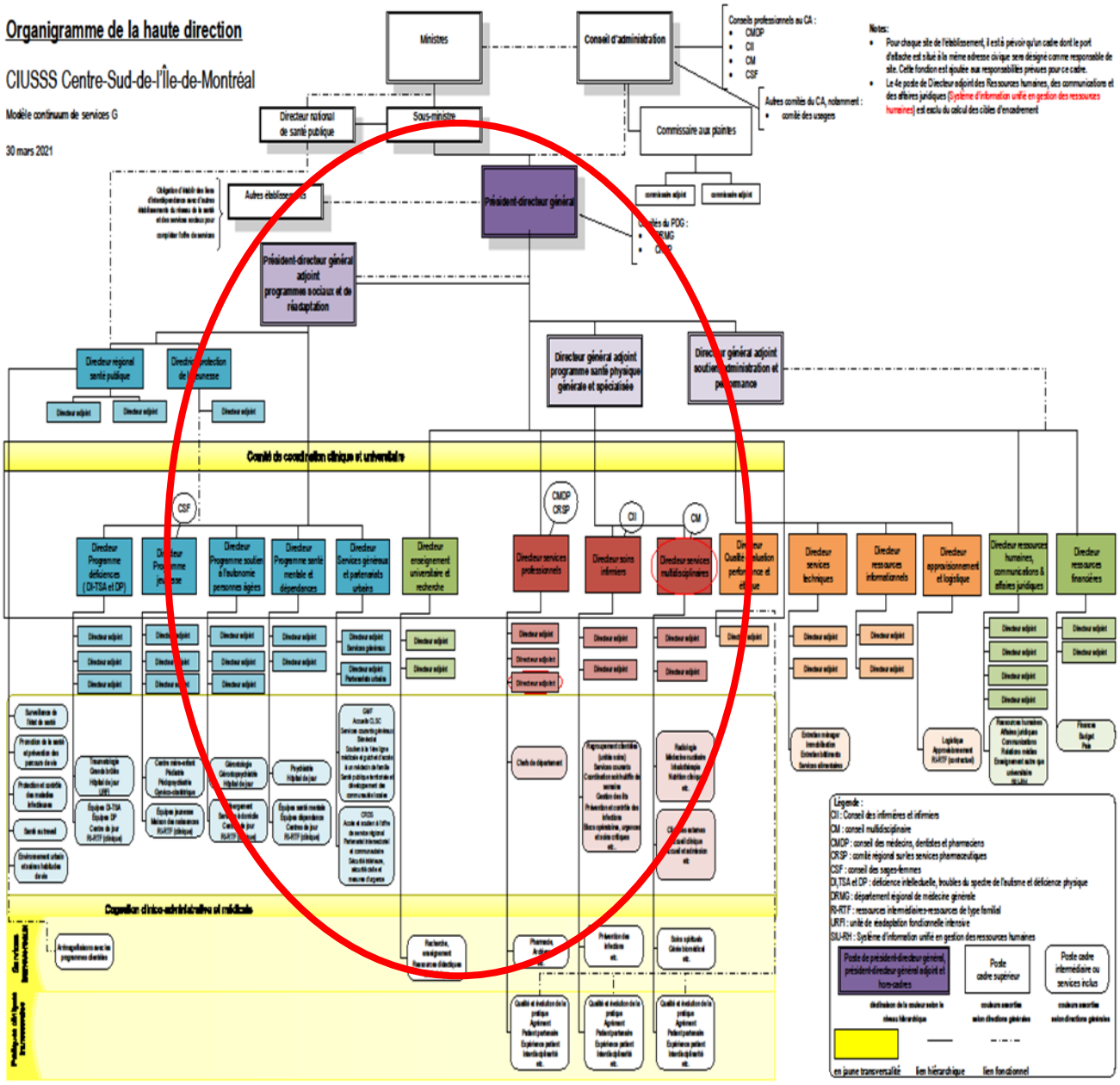
March 2020 version: Without the general management team responsible of the CHSLDs (DGAPA).



July 2020 version: Addition of the general management team responsible of the CHSLDs (DGAPA).

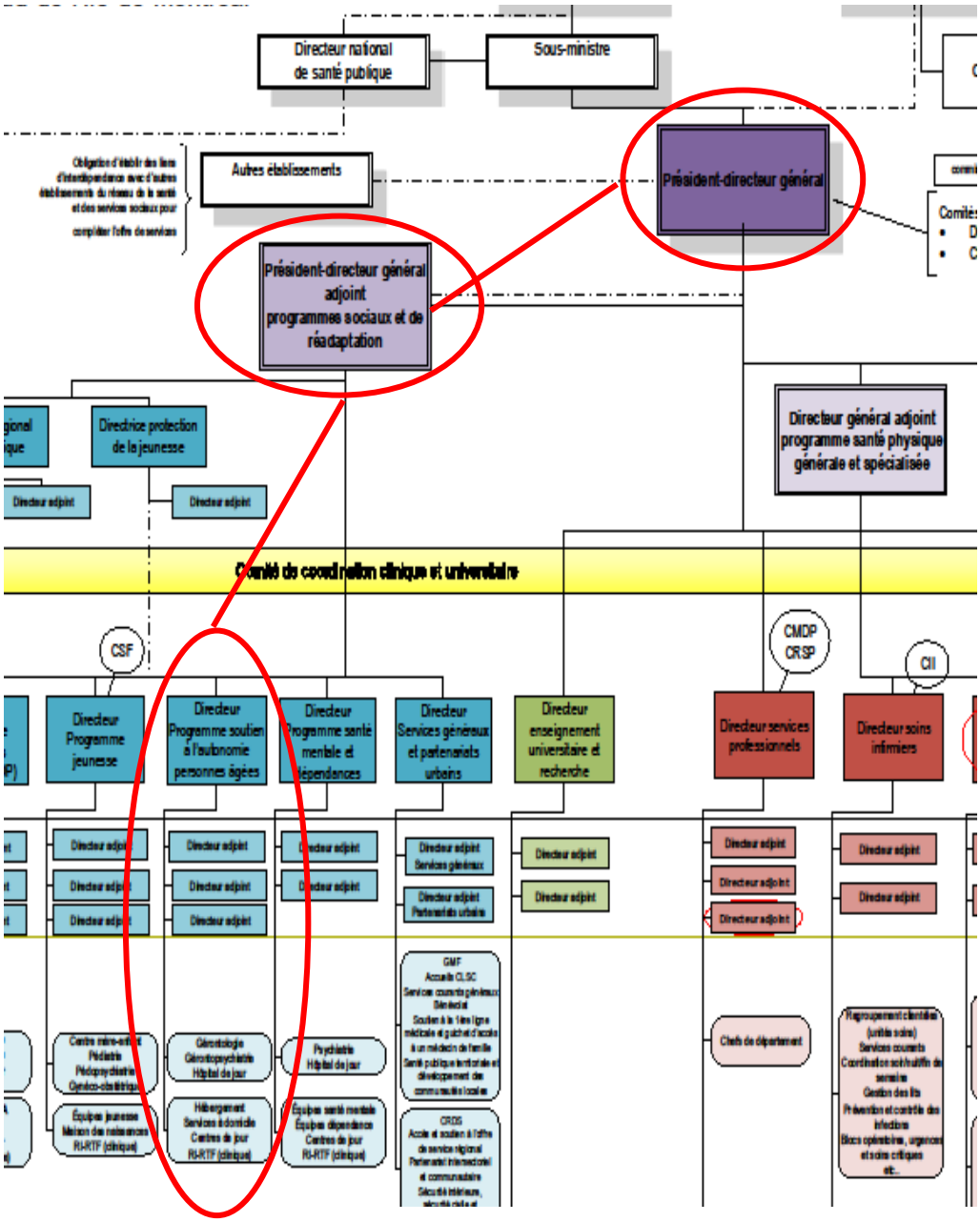
APPENDIX 3: ORGANIZATIONAL CHART OF A CIUSSS

Organigramme d'un CIUSSS[46]



See enlargement on next page.

[46] For example, we copied the organizational chart of the CIUSSS Centre-Sud-de-l'Île-de-Montréal, March 30, 2021 [Online], consulted on September 10, 2021.



Hierarchical levels

1. Président-directeur général (PDG)
2. Président-directeur général adjoint (PDGA)
3. Directeur du programme Soutien à l'autonomie des personnes âgées (SAPA)
4. Directeur adjoint à l'hébergement
5. Coordonnateurs de sites (1 pour 2 CHSLD ou plus)

PROTECTEUR DU CITOYEN

Listening • Rigour • Respect

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