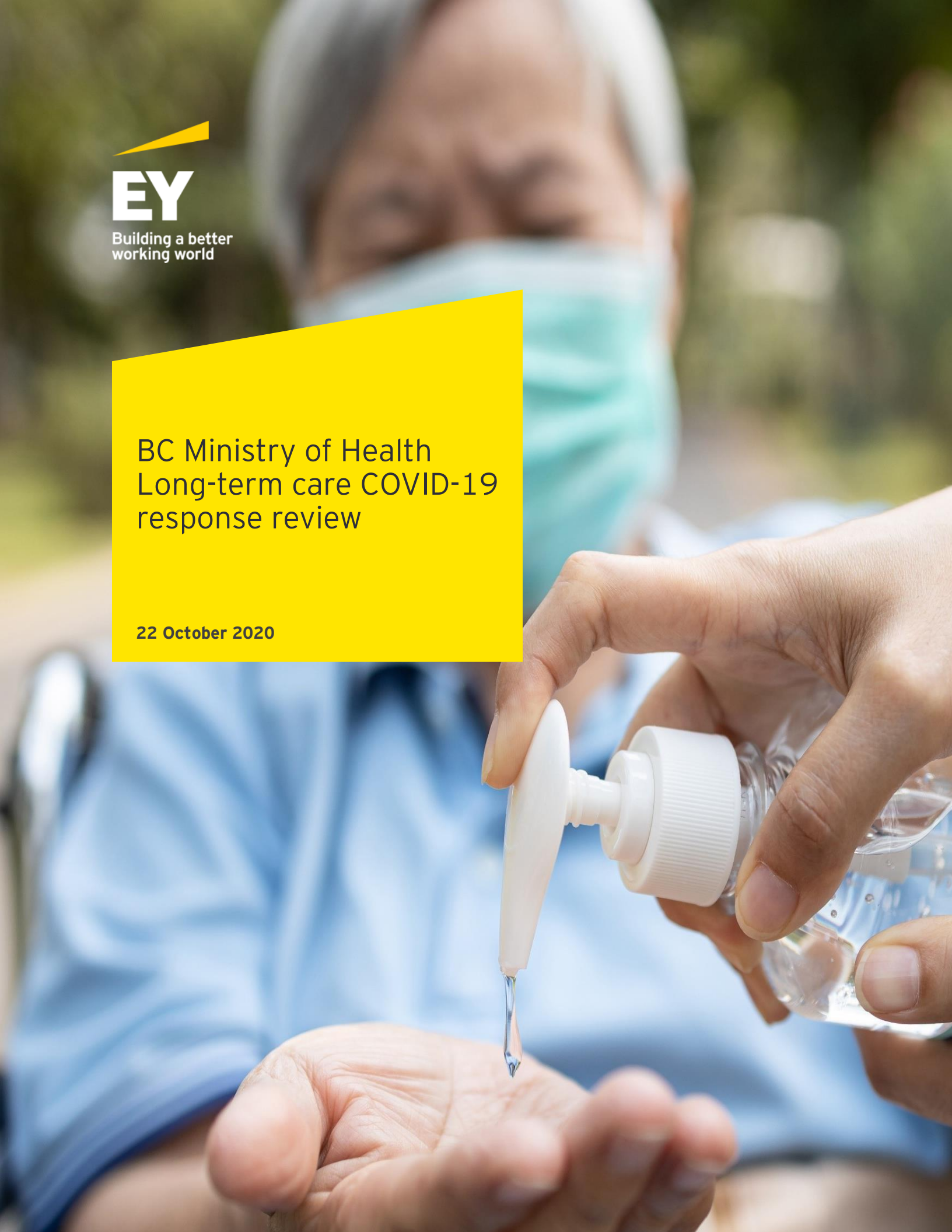


Building a better working world

BC Ministry of Health Long-term care COVID-19 response review

22 October 2020

Notice to reader

Ernst & Young LLP (EY) prepared this report for the British Columbia Ministry of Health pursuant to an agreement between EY and the BC Ministry of Health. EY did not perform its services on behalf of or to serve the needs of any other person or entity. Any use a third party may choose to make of this report is entirely at its own risk.

The considerations presented in this report were designed exclusively to assist the BC Ministry of Health in reaching their own conclusions, and to serve as one input into subsequent phases of planning.

Contents

1.0 Introduction

On December 31, 2019, the World Health Organization was notified of cases of pneumonia with unknown etiology detected in Wuhan, China. Shortly thereafter, officials confirmed a novel coronavirus had begun to spread across the world. As of March 11th, 2020, the World Health Organization (WHO) declared the 2019 novel corona virus as a global pandemic (WHO, 2020).

Health systems across Canada have rapidly mobilized to deal with the COVID-19 pandemic. The system's immediate response has focused on building-up testing capacity, ensuring hospitals have acute care capacity, maximizing safety in the community, as well as defining appropriate and safe use of personal protective equipment (PPE). At this time, there is no vaccine for COVID-19 however there is extraordinary research efforts underway across the globe to accelerate the development of a safe and effective vaccine to control the pandemic. Public health officials anticipate that even with a fast-tracked research and clinical trials, it could take upwards to 12-18 months before a vaccine is developed.

While Canada has responded relatively effectively to controlling the spread of infection within its greater population, analysis completed by the Canadian Institute for Health Information finds that the proportion of Canadian COVID-19 deaths that have occurred in long-term care (LTC) facilities is roughly twice the average rate of other developed nations. Case fatality rate among residents in Canadian long-term care homes is approximately 20%. This is roughly 5% higher than the global case fatality rate among people over the age of 80 (Canadian Institute of Health Information, 2020). Based on publicly available information, it is estimated that deaths of long-term care residents represent approximately 63% of all COVID-19 deaths in Canada (Amy T. Hsu, 2020)

Although LTC facilities across Canada have been hit hard by COVID-19 outbreaks, British Columbia has seen lower infection and mortality rates than other large provinces in Canada. From the outset, BC's Minister of Health put one consistent public health voice in place to manage the outbreaks and communicate to the public. The Provincial Health Officer was quick to respond to outbreaks in LTC and Assisted Living (AL) facilities through a Public Health Order under Public Health Act, ordering that staff work in only one facility instead of multiple locations. This mitigated the risk of cross-contamination by staff members, which was believed to be a common source of infection. Additionally, various other policies, such as wage leveling, essential visitor restrictions, and support for PPE procurement were implemented. BC has seen a notable difference in the number of COVID-19 deaths in BC LTC facilities when compared to other Canadian provinces (111 deaths in LTC facilities in BC, compared to more than 2,500 in Quebec and 1,500 in Ontario, as of June 2020) (Canadian Institute of Health Information, 2020)[1].

Average new cases of COVID-19 are beginning to increase after a period of low infection rate across Canada. Now, with the implementation of phase 3 of BC's restart plan and the

[1] Based on the latest available analysis of the impact of COVID-19 on seniors in LTC/AL

beginning of influenza season setting in, BC's health system needs to assess and incorporate lessons learned as we prepare for additional pressure on health services over the fall and winter months. BC has been actively responding to COVID-19, but it is important to comprehensively evaluate how these lessons learned should be implemented in a consistent, equitable and timely manner.

To this end, the BC Ministry of Health (ministry) engaged EY to complete a review of the operational and policy response to COVID-19 in the province's LTC and AL facilities and identify recommendations to further mitigate COVID-19 risks moving into the fall and winter.

2.0 Approach

This review focuses on understanding the impact of BC's policy and operational response to COVID-19 in LTC and AL facilities and developing recommendations for how the response can be improved to continue to mitigate COVID-19 risks moving into the fall and winter. To gather information and formulate our observations and recommendations, EY:

- Conducted one-on-one or small group interviews with more than 40 stakeholders from the Ministry of Health, health authorities, BC Centre for Disease Control (CDC), seniors' associations, care home operators, providers and front-line staff.
- Reviewed Ministry of Health policy and operational documents related to COVID-19 outbreaks and response
- Considered data related to BC's outbreak rate, mortality rate, and demographics from BCCDC, Government of Canada, and the World Health Organization

Most interviews as well as documentation and literature review was conducted during the months of July and August 2020. Recommendations in this report reflect the considerations and input of information during that time.

The scope of our work was agreed with the British Columbia Ministry of Health. A more detailed or different scope of work may well reveal other material issues that this review has not.

The services provided do not constitute an audit, financial statement review or other form of attestation as those terms are defined by CPA Canada. EY did not independently verify the completeness or accuracy of the information and documents provided to us as part of this review.

This report does not constitute a legal opinion or legal advice of any kind.

No obligation is assumed by EY to revise this report to reflect any circumstances or information that become available subsequent to the date of this report.

3.0 Background

3.1 Long Term Care in BC

Long-term care facilities provide both medical and personal support to individuals who are no longer able to live independently. An aging population has resulted in residents entering LTC today having higher level-of-care needs than in the past, which has corresponded to higher demands on staff to support residents in their daily activities and provide more specialized care for complex health conditions and dementia (Canadian Institute for Health Information, 2017). The delivery of LTC in Canada is a mix of private-for-profit facilities, private non-profit facilities and public entities. Adding to the complexities and needs of this sector, LTC is not included in the Canada Health Act and therefore, systems, subsidies and policies vary significantly across provinces, as do the structures governing funding, ownership, and staffing as LTC is governed by provincial and territorial legislation.

In BC, long term care services are available through both publicly subsidized and private pay services. Publicly subsidized home and community care services are provided by the regional health authorities (HAs), who deliver them through a mix of HA owned and operated facilities and service delivery contracts with private and not-for-profit facility operators. Residents are assessed to determine if they are eligible for publicly subsidized services prior to being placed in a facility, and they pay a resident contribution based on their financial capacity. There are a wide range of needs that people require support for, including cognitive challenges and physical disabilities (Government of British Columbia , n.d.).

Currently in BC there are approximately 27,000 seniors living in publicly funded LTC homes. Services are provided by health authority owned and operated facilities (33% of beds), for-profit companies (35% of beds) and not-for-profit societies (32% beds). Many of the contracted care homes also have private-pay beds co-located alongside the publicly-subsidized beds.

The majority of LTC and AL health care workers in BC are represented by a union, the largest being The Hospital Employers Union (HEU). In addition, the Health Employer Association of BC (HEABC) manages the human resources and labour relation issues for BC' publicly funded health employers as an accredited bargaining agent. HEABC represents denominational, proprietary and affiliate health employers, as well as the province's six health authorities.

3.2 The timeline of COVID-19 in BC

The following timeline provides a high-level overview of the key events and the impact of COVID-19 in BC from January 2020 – August 2020.

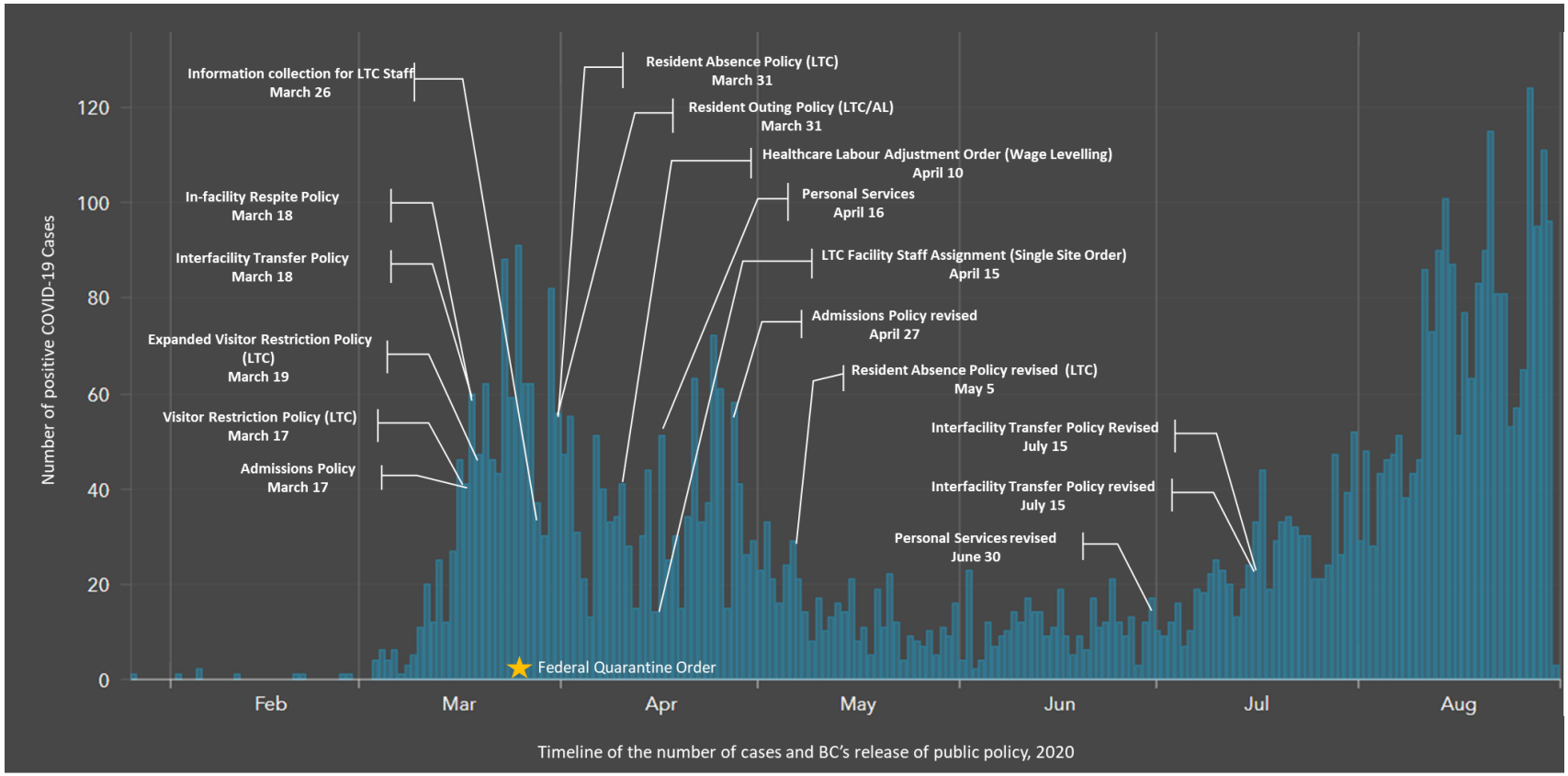
- **January 28, 2020** - Health officials in BC first reported that an individual is presumed to have COVID-19 after returning from his travels to China
- **February 4, 2020** – Second case of COVID-19 was reported in BC
- **February 19, 2020** – The first reported individual with COVID-19 fully recovered
- **February 2020** - BC saw a slow but steady rise in the number of reported cases
- **March 5, 2020** - The 21st COVID-19 case in BC was reported and officials stated that it was the first case of community transmission (patient had not recently travelled to COVID-19 affected countries or come into contact with known carriers of the virus). This woman was a health care worker at Lynn Valley Care Centre in North Vancouver
- **March 8, 2020** - An elderly man who lived at the Lynn Valley Care Centre was the first death reported in BC after contracting COVID-19
- **March 11, 2020** – World Health Organization ("WHO") officially declared the COVID-19 outbreak a global pandemic
- **March 17, 2020** – The Provincial Health Officer (PHO) declared an emergency under the Public Health Act which provided the ability to make orders to manage the pandemic
- **March 17-19, 2020** – Key LTC policy decisions, PHO and Medical Health Officers (MHO) orders were put in place, including restrictions on new LTC admissions, visitors to LTC facilities, inter-facility transfers, and in-facility respite
- **March 18, 2020** – BC declared a provincial state of emergency (initially for 14 days). Declaring a state of emergency allows the province, through the Minister, to implement any provincial emergency measures required regarding access to land and human resource assets that may be necessary to prevent, respond to or alleviate the effects of an emergency
- **March 21, 2020** – The PHO ordered personal service businesses to be shut down, including those who provide on-site services to residents of LTC facilities
- **March 31, 2020** – PHO confirmed additional outbreaks at 19 LTC and AL homes

- **April 4, 2020** – PHO announced that BC is starting to flatten the curve. BC health officials announced 29 new cases of COVID-19 and 3 additional deaths. The provincial total had now reached 1,203 confirmed cases and 38 deaths
- **April 17, 2020** – Dr. Henry presented statistical and epidemiological analysis that demonstrates that BC is 'flattening the curve'
- **April 28, 2020** – Outbreak declared at Langley Lodge. This would become BC's largest LTC outbreak
- **May 6, 2020** – As the number of cases continued to drop, BC starts to plan its reopening
- **May 19, 2020** – Phase 2 of BC's reopening plan begins, allowing many businesses to reopen with safety precautions in place
- **June 24, 2020** - Phase 3 of BC's reopening plan begins, allowing more businesses to reopen and British Columbians to begin travelling within the province. Over the next few weeks BC consistently saw very few new daily cases and many outbreaks in LTC were declared over
- **June 30, 2020** – Restrictions in LTC/AL homes were lifted and in-person visits were allowed again. Visits need to be scheduled in advanced and visitors must wear a mask
- **July 3, 2020** – Outbreak in BC's hardest hit care home (Langley Lodge) is declared to be over
- **July 10, 2020** – BC health officials reported 25 cases of COVID-19 in a 24-hour period. Daily new infections continue to grow at a slow but steady rate
- **August 2020** – BC confirms an increase of cases including record highs of active cases across the province

3.3 Policy measures

This section outlines the policies that were put in place to support the LTC/AL sector in responding to COVID-19. Multiple orders, policies, and guidance were released by the Provincial Health Officer and the ministry to help prevent the spread of the virus, including more than 16 policies and orders that directly impact the LTC/AL sector. Figure 3 provides a graphical representation of the BC COVID-19 cases over time (March – August 2020) with orders and policies overlaid.

Figure 3. BC Policy measures in response to COVID-19 in Long-term care (LTC) and seniors assisted living (AL) (As of August 31, 2020)



The specific policies, orders, and guidance issued by the PHO and the Ministry are described below:

Admissions

- March 17, 2020 – Prioritization rules established for the admission of acute care patients to LTC, over community. IPC procedures for transfers must be followed.
- April 27, 2020 – Resumed admission from community however priority continued for admission from acute care

Visitor Restrictions

- March 17, 2020 (LTC); March 20, 2020 (AL) - Visitor restrictions were put in place to only allow for essential visitors
- March 19, 2020 – The definition of essential visitor was expanded and it was indicated that HAs would determine if a visit was essential
- June 30, 2020 – Further amendment of the policy, stating that each facility must have a plan in place in accordance with BCCDC IPC (Infection Prevention and Control) guidance to indicate how social visits would be facilitated

Interfacility Transfers

- March 18, 2020 – Temporary suspension of interfacility transfers, except for cases of intolerable risk to the patient. Facilities were required to notify the receiving facility if an outbreak occurred within a 14-day period of the transfer. The outbreak protocol states that residents transferred to acute care for treatment of COVID-19 or its complications, can return to facility when medically stable
- July 15, 2020 – Notification that interfacility transfers may resume if precautions are taken. Services must follow regional MHO directions (including restricting transfers between facilities with active COVID-19 outbreaks). Precautions (e.g., 14-day isolation) for interfacility transfers will be at the direction of the MHO based on assessed regional risk

In-Facility Respite

- March 18, 2020 – In-facility respite was temporarily suspended with the exception of circumstances of intolerable risk to the patient. Facilities were asked to use respite, palliative and other beds/rooms as appropriate
- July 15, 2020 - In-facility respite could resume according to the following guidelines:
    - Services must follow regional MHO directions (including restricting respite within facilities with active COVID-19 outbreaks)
    - All clients being admitted for in-facility respite must adhere to a 14-day isolation requirement (with appropriate precautions)
    - Where clients cannot or will not adhere to isolation and physical distancing requirements, sites should refer to COVID-19 Ethics Analysis: Intervening When

Patients or Residents Pose a Risk of COVID-19 Transmission to Others to inform any decision regarding admission to in-facility respite

Single site order (announcement)

- March 25, 2020 - Workers in British Columbia's long-term care and assisted-living facilities were limited to working in a single facility

Emergency Prioritization in a Pandemic Equipment (PPE) Allocation Framework

- March 25, 2020 - The BC Emergency Prioritization in a Pandemic: Personal Protective Equipment (PPE) Allocation Framework guided health care providers in determining what type of PPE individuals working or visiting in health care settings will receive in the event of a pandemic when demand for PPE overwhelms supply

Information Collection from Long-Term Care Facility Staff

- March 26, 2020 - LTC operators directed to provide personal and employment information, including name, contact information, Social Insurance Number for all staff to the ministry to support decisions about the allocation of staff among facilities

Ethical Decision-Making Framework

- March 28, 2020 - The Ethical Decision-Making Framework Interim Guidance was issued, with a stated intention to foster transparent and sound ethical decision-making, helping to balance respecting individual rights and freedoms while attempting to satisfy the needs of and protecting the broader public

COVID-19 Ethics Analysis: What is the Ethical Duty of Health Care Workers to Provide Care During COVID-19 Pandemic

- March 28, 2020 - This guidance focuses on health care worker's ethical duty of care in circumstances where there is a risk of harm to their own person

Resident Outings

- March 31, 2020 – It was requested that all outside appointments be limited to those considered medically necessary

Resident Absences

- March 31, 2020 - Extended leave (beyond the standard 30 day per calendar year policy) for LTC residents would be considered upon request on a case by case basis. Beds would not be held for the absent clients and timing of the return would be impacted by bed availability, outbreak, staffing and community exposure
- May 5, 2020 (LTC) – The resident absences policy was amended after feedback from the Senior's Advocate and the health authorities to allow absences for up to 90 days and to allow residents to maintain their bed while they were absent

Health Care Labour Adjustment (COVID-19)

- April 10, 2020 - All employees within the scope of the Single Site Order would receive a common hourly wage regardless of their facility and employer. The common hourly wage is equivalent to the applicable HEABC collective agreement. HEABC and the bargaining associations (NBA, HSPBA, FBA, CBA) agreed to facilitate implementation of the PHO's orders

Long-Term Care Facility Staff Assignment

- April 15, 2020 - Regional Health Boards were ordered to establish a working group to make recommendations to their Medical Health Officer about the assignment of staff

Personal Services Order

- April 16, 2020 - Operators of 'personal service establishments' and 'persons who provide personal services' had to close all personal service establishments, including in-home establishments and mobile establishments, and could not provide personal services to clients or customers in any location, including the residence of a client or customers, which includes long-term care facilities

Personal Protective Equipment (PPE) Supply, Assessment, Testing and Distribution Protocol

- May 1, 2020 - Information provided regarding PPE including: 1) Supply: How is B.C. sourcing PPE? 2) Assessment and Testing: How is B.C. determining the safety and efficacy of PPE prior to decisions about use? 3) Distribution: How is B.C. ensuring that appropriate PPE is being delivered to health-care settings in a safe and efficient manner?

Cancelling Personal Services Order

- May 14, 2020 - Personal Services Order (established on April 16, 2020) was cancelled

Policy Communique – COVID-19 Infection Prevention and Control

- May 19, 2020 - This outlines the Ministry of Health requirements for preventing and controlling novel coronavirus (COVID-19) in health authorities. Updated guidance for Long-Term Care and Seniors Assisted Living settings, as well as updated family and visitor guidance

4.0 Key Observations

4.1 Summary of Observations

Given the nature of an after-the-fact the review, there is a tendency to focus on what did not work during the initial stages of responding to COVID-19. It is important to acknowledge the tremendous effort of individuals and organizations across the health system that came together to respond to this unprecedented global pandemic. Although this report identifies ongoing challenges and areas for improvement, BC's response to COVID-19 as outlined above was widely seen as the key contributor to BC's lower outbreak and mortality rates.

The observations and recommendations are organized into four areas:

- Governance and decision-making
- Policy
- Operations
- Workforce

Governance and decision-making

There was widespread acknowledgement and praise for the rapid mobilization of emergency response governance structures across the ministry and HAs. The structures that were created during the onset of the pandemic brought key leaders and representation from across the sector together to share information, provide support, and engage in rapid and coordinated decision-making. Despite the recognized effectiveness of this approach, now that BC's response has stabilized and matured there are opportunities to apply lessons learned to refine accountability and decision-making frameworks and ensure that the ongoing response is consistently coordinated irrespective of HA, contracted or private services across the entire sector. The importance of data availability was also highlighted as a key challenge in the sector and over the course of the pandemic there has been ongoing effort in collecting human health data for LTC/AL health care workers.

Policy

In response to the increasing number of cases across BC, policies, PHO orders and other pieces of guidance were rapidly developed in the early days of the pandemic based on the best information and evidence available at the time. Critical policies such as the single site order, wage leveling, visitor restrictions, and interfacility transfer guidelines are recognized as having had substantial impact on reducing the spread of the virus in LTC/AL homes and in the community. While these policies were foundational to BC's response and comparative success, there are now opportunities to be more coordinated to reduce the operational impact to LTC/AL providers and residents.

Operations

While BC put in place a comprehensive response to reduce the transmission of the virus in LTC and AL homes, a number of existing operational challenges across the sector impacted

the effectiveness of that response. There was general acceptance that there were gaps in Infection Prevention and Control (IPC) and emergency preparedness, including inconsistent application of clinical standards and use of PPE, as well as the availability of PPE supplies. Health authorities also varied in their interpretation and implementation of operational orders and policies, which led to differences in practice in areas such as the process for decanting and/or isolating residents that tested positive.

The operational response to facilities with outbreaks developed by Vancouver Coastal Health was acknowledged to be effective: VCH assigned a rapid response team of medical and operational leaders to supplement expertise and aid facilities during the outbreak period to ensure an effective response and enable rapid decision-making. The approach was quickly adopted by Fraser Health as well and is being implemented across the rest of the province as cases emerge in other health authorities.

Workforce

Early implementation of workforce-related policies, including the single site order and wage leveling policy had a significant and positive impact on reducing the overall spread of infection. However, the strain placed on the long-term care system by COVID-19 highlighted pre-existing human health resource shortages. Operational staff and front-line workers also felt the psychosocial burden of working across the sector responding to the emergency, expressing concerns about their personal safety and their ability to effectively care for residents.

The remainder of this section outlines our observations and recommendations across each category in detail.

4.2 Detailed Observations

Governance and decision-making

1. BC (Dr. Henry and Minister Dix) had a united and consistent presence in providing key messages to the public which may have led to greater adherence and compliance to public health recommendations.
2. There was an immediate ramp up and mobilization of governance structures to respond to the pandemic which enabled effective information sharing and the development of clinical policy and guidelines.
    - The ministry set up a Health Emergency Command Centre (HECC) structure to respond to the pandemic. This structure served the purpose of bringing people together and assisted with communication at a time when unknown circumstances where changing very quickly
    - After the first COVID-19 case was identified in Vancouver Coastal Health, each health authority rapidly mobilized an Emergency Operations Centre (EOC), which included the medical health officer (MHO). The MHO has authority under the Public Health Act to manage the public health response and the outbreak in their region.

3. While the HECC structure ramped up quickly and enabled rapid decision-making early on, it wasn't well integrated into provincial decision-making and accountability frameworks.
    - Decisions were reportedly sometimes made in silos within the HECC structure. I.e. planning and operations workstreams were not coordinated in supporting the planning, sourcing, purchasing and distribution of PPE
    - The decision-making powers of the HECC were not explicitly defined and the accountabilities and responsibilities were sometimes unclear, which lead to confusion around who was authorized to make key decisions, including direction to HAs to enter into commitments to use funds specifically around additional PPE
4. The EOC structure within the HAs effectively brought key leaders across the sector together to discuss issues and mobilize resources as needed.
    - Multiple weekly meetings allowed HA's to provide real-time information and influence decision-making and policy (i.e. Single site order)
    - EOCs were effective in coordinating and responding to HA owned and operated LTC facilities, however there was variation in the messaging and support provided to affiliate and private LTC providers
5. There was a consistent perception that the oversight, management, and support available to long term care providers varied depending on if a facility was HA owned and operated versus operated by a private or not for profit provider.
    - Facilities that were HA owned and operated were supported in procuring PPE, managing staffing availability, and IPC education and training, whereas private and affiliate sites felt that they were left to manage independently unless an outbreak occurred. For example, one Health Authority provided PPE to private providers with 3 days notice, where others only provided supplies to Health Authority owned and operated facilities. This discrepancy was later resolved through coordinated central supply chain access
    - Messaging and communication was sometimes inconsistent across HA owned and operated versus private and affiliates, which caused confusion and led to inconsistent practices from staff and providers
6. There were initially gaps in the ability to manage and oversee PPE supplies at a provincial level, which made it challenging to direct supplies across health authority boundaries.
    - Lack of centralized supply coordination resulted in challenges with distributing and directing PPE supplies to where they were needed in a timely manner
7. There was a lack of clarity on oversight and access to supplies in unique circumstances, such as a pandemic, which often lead to private and affiliate care operators left to source their own PPE supplies through non-traditional methods outside of the provincial supply chain, unless they were experiencing an outbreak.
    - Private and affiliate LTC providers as well as home and community care organizations were sourcing PPE through local initiatives (Operation Protect,

CAPES initiatives, CARES initiative) as well as unauthorized IPC distributers (I.e. goggles from hardware stores, counterfeit supplies, purchases from private individuals, and private manufacturers)

- Procured supplies sometimes did not meet clinical safety standards due to gaps infection prevention and control knowledge

8. Existing limitations with accessing basic LTC and AL sector data, including health human resources and expense data, created challenges with implementing COVID-19 policy and operational support initiatives.
    - For example, the ministry was asked to cover the incremental provider costs associated with staffing policies, additional PPE needs, and increased cleaning requirements, but did not have the base cost information to determine the spending amount that was in excess of regular operations
    - The ministry's governance and oversight of LTC is limited and largely centred on a funding relationship that flows through the health authorities. The ministry has limited visibility into operator cost and quality performance and there's no provincial view of LTC staffing to enable coordination of the single-site policy

Policy

1. BC's policy responses to COVID-19 were seen as being largely effective given the information available at the time and have been updated by the ministry based on lessons learned throughout the course of the pandemic.
    - Several policies have been updated since initial implementation to align and adapt to new information as it became available, including guidelines on visitor restrictions, admissions policy, and resident absences
2. Specific policy directives could sometimes be confusing, inconsistent, or lacking in detail, which led to operational variation, specifically related to PPE, IPC practices, single site order policy and essential visitor policy and guidelines.
    - PHO orders would sometimes be interpreted differently by HA MHOs), which lead to operational variation across the province. For example, for the essential visitor's policy, HAs each developed their own visitor eligibility guidelines based on their specific interpretation of the provincial order
    - In order to develop policy on a rapid timeline, the ministry focused on establishing minimum standards to be implemented. HA's noted that only establishing minimum standards sometimes led to confusion, requiring HAs to frequently request clarification of specific details
3. The clinical operational policy made by the HECC structure had some initial implementation challenges.
    - HAs and operators had to rapidly operationalize evolving policy directives from the HECC that didn't always consider operational constraints (i.e., changing directives

on PPE usage from using 1 mask per day to 4 masks per day, without any operational lead time for facilities to procure)

- Given the rapid pace of change during the initial days of the pandemic, the health authorities would often have their own policy operationalized prior to provincial directive. (e.g., single site order, cancelling adult day programs)

4. There were gaps in some provider's understanding of which governing bodies in the province were responsible for which policies and who ultimately makes final decisions.
    - Providers that had care homes across multiple health authorities were sometimes unclear on who was leading the response (i.e. PHO or HA's MHO). They were given policy that was different in each HA they operated in, which was also different to the PHO order While the MHO has the authority under the PHA to create local orders, the expectation is that they should use provincial orders as a minimum baseline.
    - Additional clarity is required in understanding who develops clinical policy for the province in unique circumstances, such as a pandemic, where issue may sit outside of regular ministry direction. In this case, the ministry established a clinical reference group as part of the HECC to develop clinical policy responses to COVID-19, however this function could be duplicative of the Provincial Health Services Authority's (PHSA) role in setting provincial clinical policy
    - Accountabilities of the public health officer and MHOs in emergency situations were reported to sometimes be unclear, creating confusion about when the ministry should be consulting with public health versus the needs for Public Health Orders (i.e., when to seek input from public health versus seeking approval)
5. Guidance from public health and ministry could be more coordinated with HAs and operators to consider the operational impact of policies.
    - In some cases, public health orders and ministry policies did not fully consider the associated operational impact (i.e., N95 masks as standard use when supply was critically low)
6. Based on the epidemiological information regarding infection sources, experts indicated that the single site order played a critical role in reducing the spread of infection across LTC facilities.
    - In many cases it was determined that initial infections in LTC facilities were introduced via staff members, so limiting movement of staff helped control the spread and enabled improved contact tracing and containment of the infection
    - Those interviewed at BCCDC felt that the limiting single site order to just LTC facilities achieved an appropriate balance between reducing infection risk and adding additional operational burden to the provincial health system

7. Given the early information regarding the impact of COVID-19 internationally, the interfacility transfer guidelines aimed at limiting the transfer of vulnerable populations and reducing the burden on acute care centres was widely regarded as appropriate.
8. Guidelines around restricting visitors and resident outings were seen as effective in reducing the spread of infection. As a result, however, these precautions were consistently noted to have a significant impact on resident autonomy, mental health and wellbeing.

Operations

1. On-site support and the physical presence of HA leaders at LTC facilities that were experiencing outbreaks was seen as a crucial and effective element of outbreak responses, however the level of support provided varied across health authorities.
    - Operators felt that there was significant variation in the timeliness and quality of support across HAs for facilities that experienced outbreaks. VCH was the first to deploy an on-site Rapid Response Team to support facilities during outbreaks, which included a Medical Health Officer Lead and Operational Lead. Other HAs quickly adopted this model, but initially lacked inclusion of medical leadership support, which was considered essential by operators
    - Facilities that received on-site support from HA representatives to manage increased media interest during an outbreak found this support to be very helpful
2. High degree of practice and process variation across HAs led to confusion and inconsistent practices by LTC operators with facilities in multiple health authorities.
    - Communication and messaging from each HA varied in content and timing, which left providers trying to implement consistent guidelines across their facilities based on inconsistent messaging and guidance
    - Examples include support for supplemental funding, PPE distribution strategy and support, implementation of ministry policies (e.g. single site order, essential visitor policy), and protocols for handling COVID positive residents (e.g. off-site COVID isolation facility vs. on-site isolation)
    - This contributed to a sense that facilities were receiving unequal levels of support and resources based on location and ownership structure
3. COVID-19 outbreaks highlighted major gaps in IPC and emergency preparedness knowledge and training in the LTC and community care sectors
    - In facilities that experienced major outbreaks (e.g. Langley Lodge), management did not feel adequately educated on IPC and emergency management practices and felt unaware of emergency support resources that could be leveraged such as IPC specialists and staffing support

- Providers had not received regular, ongoing training and education on IPC and emergency management to help understand how to properly respond in emergency situations and were required to learn in real time during the outbreak. For example, audits of LTC facilities in FHA revealed that more education and coaching for proper use of PPE for pandemic situations was required, specifically around donning and doffing gowns and hand hygiene
- Many staff in LTC and AL homes were not expected to don full PPE (masks, goggles, and gowns) for patient care prior to COVID, and therefore did not have adequate training or experience in such IPC protocols during the initial outbreaks

4. There was a lack of clear and consistent guidelines on the proper use and standards for PPE in pandemic situations.
    - Operators in LTC and community care settings felt that they needed more consistent and specific direction on proper use of PPE from the HAs and ministry, and in a timelier manner
    - Some facilities stressed that providing clear rationale for protocols that differed from existing IPC practices would have created better understanding, buy-in and compliance to changing PPE directives
    - Contracted and private LTC and community care organizations felt as if there was no guidance from the ministry or HAs on proper gown requirements. E.g., Langley Lodge cites the misuse of gowns for several weeks after the onset of a COVID outbreak in their facility (May 4th) as an example of unclear guidance around PPE standards
5. Contracted providers felt that the personal health information and other data they were required to collect and provide was time consuming and were not clear on why the data was needed. However, despite the operational burden, this data was necessary for the ministry to make effective pandemic response decisions (particularly related to PPE requirements and staffing).
    - The rationale for the collection of information was not widely understood and is perceived by some operators as resulting from the ministry's lack of trust in operators' ability to report outbreaks. E.g. mandatory daily report on COVID tracking from all LTC and AL facilities
    - Operators felt that the implementation of policy did not reflect the information collected and questioned where the information was being stored
    - There was a lack of real time data of the LTC / AL sector in general (prior to the data collection) which created challenges in modelling PPE requirements the system needed
6. Real time supply chain data was not readily available due to the manual nature of inventory tracking which led to reduced oversight and inefficient management of supplies. PHSA did not have line of sight into utilization of PPE supplies and was unaware of additional procurement by HAs outside of the existing provincial supply chain processes.

- PPE data was disjointed (based on order patterns vs. actual stock, HA owned and operated vs. private providers) and messaging out to LTC operators regarding PPE availability and distribution was initially absent, as the primary focus was on acute care facilities
- HAs can currently order directly from PHSA supply chain or procure supplies on their own. This creates challenges for PHSA to understand what the comprehensive needs are across the province

7. Despite funding for HAs to create PPE stockpiles for use during a pandemic, much of the inventory was badly depleted at the onset of COVID.
    - There was a lack of oversight into how the funding for pandemic stockpiles was being used, as well as how those stockpiles were managed and maintained across health authorities
8. The physical design characteristics of LTC and AL facilities likely contributed to the vulnerability of these settings to the spread of infection.
    - Characteristics such as congregate living and eating, cohorting of vulnerable populations, frequent touchpoints between staff and residents, and presence of furniture or belongings that may be more difficult to clean may have contributed to the spread of infections in facilities
9. There was no consistent provincial policy on how HAs and operator sites handled COVID-19 positive residents, either through decanting to other facilities or cohorting within facilities leading to regional variation.
    - Some sites had to isolate the COVID-19 positive resident in their room or a specific wing of the facility. Other sites had the support of an acute care facility to decant COVID-19 positive residents
    - Some sites started to cohort staff to facility 'neighbourhoods' to create social bubbles between staff and residents
10. Spread of infection was magnified in cohorted populations of residents with advanced dementia or behaviour and aggression challenges.
    - Residents with dementia, aggression, and/or behavioural issues generally do not understand or comply with social distancing requirements and other IPC standards, leading to greater widespread infection on those particular units
    - There was a lack of clinical guidance on COVID-19 precautions with this population

Workforce

1. The single site staffing order had a positive impact on reducing the overall spread, however there were issues in implementation which led to loss of staff for contracted and private facilities.

- Due to pre-existing disparity in the attractiveness of employers, primarily driven by salary and benefit structures, staff chose to work for HA owned and operated facilities, leaving contracted facilities short staffed and more reliant on overtime
- Contracted facilities rely more heavily on their casual pool of staff than HA owned and operated facilities. In many cases this led to increased overtime hours and higher staffing costs (i.e. staff working double shifts), as the single-site order made casual pools untenable
- While operators were allocated supplemental funding to a total of 1.3 FTE per full-time staff person in order to fully cover staffing demands during the pandemic, in practice due to illness and concerns regarding workplace safety, a significant portion of staff worked 1.0 FTE or less, creating more staffing pressure. Additionally, operators stated it was difficult to staff the 0.3 FTE using part-time or casual staff

2. The single site staffing order did not restrict staff from working in acute care or other occupational settings (i.e. other care homes or non-care related organizations).
    - This sometimes caused discomfort for staff and operators, who were concerned that staff working in other settings could be a source of infection
3. Some staff from LTC and AL facilities expressed concern about the safety of themselves, their families, and the residents under their care, which reportedly led to increased psychological stress, anxiety and burn out. Critical staff shortages further added pressure on the workforce.
    - Several staff turned down work stating fear of bringing home COVID-19 to loved ones at home.
    - A recent survey sent out from Safe Care BC showed that many LTC staff had increased psychological fears and anxiety as well as an intention to leave, further impacting the availability of human health resources
4. While wage leveling was broadly seen as a necessary incentive to help operators who were struggling with appropriate levels of staffing, operators (particularly contracted and private facilities) felt that communication around the associated funding support was lacking and inconsistent
    - Operators had to cover the upfront cost of additional wages for employees and it was not made clear when or if additional funding would be made available
    - In cases where funding has been distributed, operators stated that the method to determine the amount of funding for each site was not understood, resulting in questions about why some facilities received more funding than others
5. COVID-19 exacerbated pre-existing staffing shortages in the LTC and the continuing care system.
    - Facilities that were already short-staffed faced increased pressure from the need to respond to COVID-19

- There has been a long-standing struggle recruiting and retaining staff. Changes to staffing models, recruitment strategies, and training approaches will be required to address these longer-term issues

5.0 Recommendations

5.1 Overview

This section outlines a set of specific recommendations that the ministry and health authorities can consider in response to the observations outlined above. Short-term recommendations have been identified across each of the four categories, as well as a number of more general longer-term recommendations.

5.2 Short Term Recommendations

Governance

1. As the new ministry Pandemic and Health Emergency Response division replaces the HECC, this updated governance structure should aim to find a balance between the ability to make quick decisions and ensuring appropriate decision-making accountability.
    - The governance structure should clarify decision-making accountabilities and ensure that all decisions are escalated to the relevant ADM, Associate DM, Deputy Minister or the Minister for input and approval, as appropriate
    - The new division should play an enabling role to coordinate and support rapid decision-making and policy development within the existing ministry, health authority, and BCCDC framework
    - The new division should coordinate with the ministry Finance and Corporate Services division to ensure that the financial implications of policies are appropriately understood and considered

2. The ministry should consider establishing policies for financial support to operators during the pandemic that clearly outlines which providers will be eligible for financial support and the principles underlying how funding will be allocated.
    - The framework should identify which types of providers (HA owned/operated, contracted, fully private, etc.) are eligible for financial and other support in a pandemic emergency and the conditions in which support can be requested/received
    - While the ministry and health authorities should not be expected to 'negotiate' the amount of support provided, giving greater clarity into the approach to allocating support will enable providers to better plan how they will use it

3. The ministry should continue to collect health human resource and financial data needed to support informed decision making in emergency situations, while putting in place more standardized reporting expectations and processes in the longer term
    - While some providers identified the need to provide data as an operational burden, it is critical that the ministry and health authorities have the information needed to make operational decisions. The ministry should develop a formal reporting framework for the collection of data in a streamlined and efficient manner
    - Much of the data being collected to support pandemic response decision-making is critical for ongoing oversight of the sector, and so more formal policies and tools regarding data collection should be implemented in the longer-term, in alignment with any changes to the funding and contract model that may occur

4. The approach to pandemic response communications and governance should more formally consider contracted and private providers to ensure that messaging and policy is consistently understood and applied.
    - To improve the ability of the ministry to design policy that considers implications for contracted and private LTC facilities, the ministry should continue to set up touchpoints with LTC operator's associations to strengthen lines of communication and engage in information sharing

Policy

1. Messaging of key provincial policies and expectations should be communicated more consistently across regions.
    - The ministry and/or the PHO should provide clear and concise expectations around the implementation of provincial orders and policy to help improve consistent application by the regional MHOs

2. The ministry should consider coordinating or sending key policy changes/messaging to HA's and operators, if there is an operational impact, before releasing to the public (for example, the family visitation policy was released to the public before care providers had the time to implement a proper safety plan for their staff and residents).
    - When practical, consider a framework where operators or representatives from seniors' associations have the ability to provide timely feedback based on the interpretation of the policy before it is released to the public (for example, a 24 hour hold for review before public release)

3. Clearer and more consistent IPC guidance, including PPE policy standards and proper use during a pandemic response should be provided to LTC and continuing care operators, including rationale when guidance varies from regular IPC practices or conflicts with standards used by neighbouring jurisdictions (e.g., the reusability of masks, limits to the number of masks per employee per day, minimum medical grade requirements for gowns, and proper donning and doffing procedures).

4. There was clear consensus that the single site order was effective and should remain in place for the remainder of the pandemic, as it is an effective policy to limit a major contributing factor in the spread of infection in LTC facilities.
    - If there is a growth in spread of cases from staff working in facilities outside of LTC, consider strengthening the policy to limit the movement of health care workers between acute care sites and LTC/AL as well as other medical and non-medical sites

5. Guidelines around inter-facility transfer and in-facility respite was deemed effective, but should continue to evolve as the context of the broader pandemic changes in BC.
    - In the longer term, considerations should be provided for appropriate clinical procedures that can be accommodated within LTC to minimize transfer to hospital. There should be a balance between supporting procedures to be done in the LTC facility and accommodating the transfer.

6. Continue to assess guidelines limiting resident outings and essential visits based on learnings from the first wave of COVID to better balance infection risk with the resident's autonomy and mental health and well-being.
    - The ministry has relaxed these guidelines as the pandemic has evolved, and should continue to monitor if any additional changes are required to manage a second wave of infections

Operations

1. A standardized continuing care pandemic response plan that clearly outlines how to respond to outbreaks based on lessons learned from the first wave of COVID-19 should be adopted in all HAs. Standardization is particularly important due to the number of operators in the continuing care sector that work across multiple HAs.
    - The pandemic response plan should include guidance on key policies, such as the timing and make up of on-site support teams, handling and/or isolation of COVID-19 positive residents or staff and IPC guidance that includes PPE guidelines and usage
    - PHO/MHO order and associated guidance for the proper precautions for handling and/or isolating COVID positive residents should be standardized across HAs, with considerations for residents with specialty needs such as advanced dementia or behaviour and aggression challenges
    - A province-wide standardized approach to on-site support for continuing care facilities experiencing outbreaks should be established, including the inclusion of medical, operational and IPC specialists
2. The ministry and HAs should review their approach to audits and inspections of LTC facilities to put greater focus and oversight on IPC protocols and outbreak preparedness.

- Tabletop exercises and scenario planning could also better prepare LTC facilities to respond to a potential future outbreak
- Audits of IPC standards and protocols could be considered to ensure they are being implemented and followed appropriately.

3. The province should continue to support centralized PPE procurement through PHSA for both health authority owned and operated and contracted facilities.
   - Provincial oversight of the entire supply chain, from procurement to utilization, including oversight of demand management, should be considered in response to pandemic planning to enable greater management of HA supplies and stockpiles
   - Consider developing guidelines for HA procurement of supplies outside of PHSA during emergencies. These guidelines should include an approach for reporting purchases back to PHSA for tracking purposes. This will allow for greater transparency and oversight into the availability of supplies as well as enabling better PPE supply and demand modelling
   - Fully private service providers should have the option to purchase PPE from health authorities/PHSA during emergencies, and regional health authorities should formally consider the needs of private providers in their PPE distribution planning

Workforce

1. Single site order has been an important factor in mitigating spread. While it remains in place, the ministry should consider increasing FTE allocation above the budgeted baseline to help operators manage absences such as sick time and vacation without having to use overtime or causal staff.
   - Principles to determine how much above baseline operators should be allocated will need to be established, as well as a mechanism to reconcile unused funding

2. If the wage leveling policy remains in place in the longer term, the provincial LTC funding model should be updated to reflecting the actual incremental cost of the increased wages
   - This will require assessing the actual staffing costs incurred by operators to ensure that any subsidies are necessary and appropriate

3. The ministry and/or HAs should continue to provide access to psychological health, wellness and safety supports to staff in the LTC sector
   - MOH and HA's should assess the supports currently in place and ensure they are sufficient and that there are no unnecessary barriers to access

5.3 Long Term Recommendations

1. Consider leveraging IPC practitioner positions, making them a resource available to care homes to support consistency across all provider types and standardized IPC practice

across the sector. This should be considered as part of an HR strategy that includes other necessary positions as well.

    - The IPC practitioners should be well-trained and available during the emergency/pandemic and leverage existing public health resources during influenza season in LTC/AL homes to reduce the spread of infection

2. Moving forward, as new facilities are designed and built, the ministry and operators should consider leading practices in terms of pandemic response that may reduce vulnerabilities and susceptibilities to infection.

    - Examples of leading practice consideration include but not limited to, single beds, reduced shared spaces, updated ventilation systems, room layout and medical access (to isolation rooms) as well as designs to support residents with dementia or complex cognitive and physical needs

3. Consider having PHSA create a centralized repository of emergency stock for pandemic supply of PPE which would allow for full oversight across the system to mitigate any challenges for HA or operators to obtain supply in an emergency or pandemic response
4. Evaluate opportunities to improve access to the availability of real time supply chain data across the system to improve oversight, tracking and management of supplies
5. Address critical staff (care aids, PSWs) shortages by redesigning employment pathways that attract, train and retain staff to enable the professionalization of the workforce. Support staff within the sector to gain new skills and develop specialized expertise so that they see it as a career role (rather than a stepping stone) which may reduce high turnover rates currently experienced in the sector

Completion of this review depended on input from front-line workers, LTC facility operators, Ministry of Health, health authorities, and other stakeholders. They were generous with their time during a very challenging period, and we appreciate their contributions. We hope that this review has highlighted the key lessons learned from the first wave of COVID-19 and that the recommendations will support BC's health system in continuing to effectively manage this ongoing pandemic.

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