INFORMATION BULLETIN

© Seniors For Social Action Ontario

TESTIMONY BY CANADIAN MILITARY TO COVID-19 LONG TERM CARE COMMISSION

http://www.ltccommission-commissionsld.ca/transcripts/pdf/Government_of_Canada_Canadian_Armed_Forces_Final_Transcript_October_29_2020.pdf

October 29, 2020

- Military teams going in felt the LTCF's were in crisis and needed 24 hour support so worked on 12 hour shifts (Pg. 16);
- RN in charge each shift and critical incidents and recommendations funneled thorugh director of care or executive directors on a daily basis – daily medical situation report (Pg. 18/19);
- Met with corporate management and hospital oversight weekly (Pg.20);
- In larger facilities military medical director was not in contact with the directors of care (Pg. 22);
- **Most facilities were at only 20% staffing when the military went in and for approximately 2 weeks prior to military deployment (augmented with agency staff, temp help, new hires and the military (Pg. 22/23);**
- **Staff stopped working because they were COVID positive, had child care issues, or were afraid to come in (Pg.24);**
- Cohorting was a major problem because of short staffing and small, crowded rooms, and a 2-3 week testing delay (Pg. 25);
- Looked at establishing field hospital type settings to aid in cohorting but staffing and logistics were an issue (Pg. 30);
- **Double digit positive cases early on so entire wards were blocked off for COVID positive people (Pg. 31/32);**
- Military personnel that went in generally worked in emergency, medical-surgical and intensive care units, and medical technicians in trauma, as paramedics etc (Pg. 33);
- **Military clinicians were taken aback because of the "significant deviation from the way that they were used to practising medicine" – standards of practice, quality of care, ambiguity of local practice – 80% temporary or**

new hires created very challenging clinical practice environment – lack of knowledge of what an appropriate standard of care is (Pg. 33);

- **Poor access to supplies – RN holds key to locked supply cupboard – supplies were a scare resource – no one knew who was ordering until there was a shortage of supplies – supplies, especially for wound care were running low and problem existed before the military got there (Pg. 35);**
- **Inexperienced staff did not know how to access policies (Pg. 37);**
- **Communication a major problem because of a massive turnover of staff – new team every day – unable to identify difference in daily functioning of residents – so COVID, dehydration etc not identified but should trigger an assessment (**Pg. 38/39)
- **"Charting by exception" in long term care – it does not happen regularly. Only chart if there is an issue. Poor functioning thought to be "baseline" when in fact it represented a severe decline (Pg. 40);**
- Almost all the RN's had left so those left became directors of care (Pg. 41);
- **Military documented "inappropriate behavior"(individual, practice, lack of oversight re: clinically and ethically inappropriate care) - 1 RN for 200 staff, 1-2 RPNs per floor** – **PSW's had no one to report to** (Pg. 43, 45, 46);
- Barebones training occurring for new hires – very truncated training and education occurring – hospitals took that over once they came in (Pg. 43/44);
- Brought in dentists, housekeeping staff etc (Pg. 48/49);
- **Concern about trauma to own military clinicians having to work in these facilities and had to deploy a mental health support team (social worker and 5 padres for spiritual support) - described as "devastating" met regularly with teams to provide support as stress levels increased (Pg. 49/50)**
- **IPAC (infection prevention and control) guidance very different depending on facility depending on whether it was public health or in-house guidance – variation "that was causing angst" - military brought its own PPE(Pg. 52);**
- Many positive COVID tests were asymptomatic – needed frequent and broad testing to capture that – could not mandate testing for agency staff or anyone else coming into the facility - only tested monthly until province mandated every two weeks results took up to 10 days – very low infection rates in military personnel (Pg. 54/55, 56, 57);