Long Term Care Covid-19 Commission Mtg.

Dr. Bernard Leduc, President & CEO, Montfort Hospital
on Monday, October 19, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 19th day of October, 2020, 2:58 p.m. to 3:30 p.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTING:

Dr. Bernard Leduc,
President and CEO Montfort Hospital

PARTICIPANTS:

Jessica Franklin, Policy Lead, Ministry of Long-Term Care

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat

Derek Lett, Policy Director, Long-Term Care Commission Secretariat

John Callaghan, Lead Counsel, Long-Term Care Commission Secretariat

Dawn Palin Rokosh, Director Of Operations at Ontario's Long Term Care Commission Secretariat

ALSO PRESENT:

Pierre Flez, French Interpreter for Dr. Leduc

Judith M. Caputo, Stenographer/Transcriptionist

DOCUMENTS TO BE PRODUCED BY DR. LEDUC

-- Upon commencing at 2:58 p.m.

COMMISSIONER MARROCCO: Doctor, if you're ready, we are.

We're trying to understand the implications of something that's going on around us as we're trying to understand it. So it's a bit confusing on our end.

When I'm speaking to you, Doctor, I don't have to worry about the English, it's only the others that have to worry about my ability to understand en Francais. So I'll speak normally unless you tell me I should stop.

DR. LEDUC: (In English) No, we are good. Thank you.

COMMISSIONER MARROCCO: Okay.

THE INTERPRETER: Sorry, this is the interpreter.

Do I understand, therefore, I only interpret into English?

DR. LEDUC: (In English) yes.

THE INTERPRETER: Okay, thank you.

COMMISSIONER MARROCCO: So, Doctor, I think probably the best thing is to let you start.

Do you mind if we interrupt with

questions as we go along?

DR. LEDUC: (In English) let's do.

COMMISSIONER MARROCCO: Okay.

DR. LEDUC: I'd like to thank the Commission for allowing me to share my experience in long-term care facilities around COVID-19.

So my name is Dr. Bernard Leduc, I have over 20 years experience in family medicine as well as hospital settings.

When I arrived in Ottawa, I had the chance to work for two to three years in a retirement residence. And since 2010, I have the pleasure and privilege of working in the Montfort Hospital as CEO, that's a university hospital, since 2013.

I'm also, since August of this year, CEO of the Health Standards Association of Standards Canada -- (In English) Accreditation Canada.

THE INTERPRETER: Accreditation Canada -- I'm sorry.

DR. LEDUC: (In English) and policy CEO, and board chair.

So the Montfort Hospital is a university hospital of world class focused on the

best care for the people. In early 2000, we developed a partnership with long-term care partner in the private sector, which is now Revera, to open a long-term care facility of 128 beds on the grounds of the hospital. And this long-term care facility targets mainly Francophone residents.

So the Montfort Hospital is engaged in the fight against COVID-19, and it had 18 hospitalized patients during the first wave, and we were up to 15 last week. And we were asked to be involved in the outbreaks on the long-term care facility on the grounds of the hospital as well as for another long-term care facility.

We also opened the COVID-19 Assessment Centre in April, and I'm particularly proud to say that we opened, starting today, a new assessment centre in Orleans.

So for sure the pandemic has highlighted deficiencies in the systems, specifically for long-term care. So we often said that mental health came second when it comes to healthcare, but I think now we can agree that our elders are also second class citizens when it comes to healthcare.

The pandemic highlighted the age, and

derelict state of some of the residences, as well as the state of care for the residents. And those who were in rooms of three to four residents were particularly vulnerable.

And talking of equality, I'd like to draw your attention to the fact that availability to Francophone residents is much lower than the average for the province. And the White's Book published in September 2019 by the Assembly of the Francophone Language in Ontario does reveal this. And the recent report for the healthcare region of the east of Ontario for the Champlain region as well highlights the same fact; and it reveals there's a lack of about 405 beds for the Francophone population.

So if you believe it necessary, I'll be happy to transfer these documents to the Commissioners.

COMMISSIONER MARROCCO: That would be very helpful, Doctor, thank you very much.

DR. LEDUC: Thank you.

COMMISSIONER MARROCCO: Alison Drummond our executive director, and Dawn will be happy to receive them from you when you're in a position to send them.

DR. LEDUC: Thank you.

So I'll humbly share my experience that I see as a board chair of the first wave and now the second wave.

So the first wave revealed all the unknown about this new disease and all the difficulties linked to that; and anxiety, as well as fears about the stocks of PPEs. We focused a lot on intensive care at first, and the orders we received was to cease all other activities as much as possible and create capacity. And after news, this image we have now of a credit card with no max on it, and we have to do what was needed to be able to tackle this wave that was coming.

It's not necessarily clear in my mind that the same thing was done for long-term care. So at the hospital in the first wave, the fact of ceasing our activities meant we had a pool of resources that was available. That meant we were able to open up assessment centres and go and help in long-term care facilities.

The big concerns about the availability of PPEs, meant that we took maybe the wrong decisions or decisions that had detrimental impacts in long-term care. For example, excluding visitors

and caregivers from long-term care facilities and hospitals, and that limited greatly the capacity of caregiving.

And there was limiting one worker to a single site, that was also the timing of the pandemic with school holidays, where people had to self-isolate upon return from travel.

So we created an environment that was quite different from us in hospitals, where there was a full lack of resources. And whereas we could tackle more, they had difficulties having staffing at 50 percent of their usual capacity.

And we had a case where all the staff, and the cooking and nutrition staff for residents, had to be at home isolating because they tested positive, or for whatever reasons. And we saw it as a real difference in culture between long-term care and intensive care -- (in English) that was acute care.

(Through interpreter) because long-term care facilities is seen as a place where people live, and there was a lot of reluctance due to the fact that hospitals would come in and take control, and would change the place of residence for those people.

They had their limited possibility of stocking up on PPEs, and the practices for infection, prevention and control were not up to the standards that we were used to in a hospital setting, which brings me to the need of reintroducing inspections for long-term care. Not necessarily just to react or to punish, but truly to help the residences to improve the quality of care and safety of residents.

And the Accreditation of Canada is now reviewing its accreditation process, so they can have a continuous and collaborative approach with the organizations rather than just doing inspections every four years. That's important to have standards that the organizations can respect.

And maybe to conclude, what I see with the second wave is really the availability of human resources. Hospitals are now at capacity, not necessarily only because of COVID-19, we have increased our efforts for testing clinics, and we are another trying to catch up on the backlog of surgeries that were cancelled previously. But we see the level of patients for other levels of care increasing, and that's due to our incapacity to transfer those patients to long-term care

facilities.

In the Champlain region, there's about 900 long-term care beds that are vacant. So we need to find alternatives for these patients so that we can continue our activity. In other words, by opening up spaces in hotels or in new retirement residences, for example. But as we increase the number of beds, then comes the issue of recruitment of personnel.

So these are my humble thoughts about the situation.

COMMISSIONER MARROCCO: Doctor, who do you think should lead the effort to deal with the problems?

DR. LEDUC: I believe the efforts are done regionally, with the assistance of Health Ontario. And Jack can possibly attest to the good collaboration we have between colleagues, (In English) in Ottawa.

(Through interpreter) so we have regional tables that look at the activities reopening for long-term care facilities and the COVID testing.

COMMISSIONER KITTS: Bernard, can I ask a question? I didn't catch at the beginning, the

relationship between the Montfort Hospital and the long-term care home; it's beside your facilities, is that what you said?

DR. LEDUC: (In English) so we did strike a partnership with a private long-term care home operator. They have the licence, so they operate. But the building is on our site, we own the building.

COMMISSIONER KITTS: Was that one of the buildings that the hospital had to go in because of the COVID spread?

DR. LEDUC: (In English) yes, they had a bad outbreak in April.

COMMISSIONER KITTS: So the question then becomes, should Public Health long-term care homes and hospitals that triad, be a triad not just in response to an outbreak, but have that relationship that's fluid and smooth all the time?

DR. LEDUC: Having more formal relations with long-term care facilities would surely help, yes.

COMMISSIONER KITTS: Okay.

COMMISSIONER MARROCCO: Is there a reason why it didn't happen in the past, that these relationships were established?

DR. LEDUC: We have an excellent relationship with our partner, Revera. So we have quarterly meetings, and we look at a variety of indicators linked to the safety of patients, such as falls or wounds, etcetera.

We look at the satisfaction of residents and family boards. Where we didn't have that kind of relation with the second centre.

COMMISSIONER MARROCCO: Commissioner Coke?

COMMISSIONER COKE: Can you elaborate a bit more on some of the issues underlying the lack of support for Francophone population in long-term care?

DR. LEDUC: I think it's in the last report of the Health Services in French of 2019 with the French Health Services Commissioner 2019. So it was said at the time we had one designated bed for 3,400 Francophone people; compared to the average of one bed for 170 Ontarians.

COMMISSIONER MARROCCO: We were told that there's a waiting list in Ontario of 38,000 people. Do you have any sense of what percentage would be Francophone?

DR. LEDUC: (In English), I don't think

I have this --

(Through interpreter) no, I don't think I have that number. So out of the 128 Francophone beds, we do have some Anglophone patients that they understand they are joining a Francophone environment. But it's no more than three out of five. And the waiting list for the centre at the back was 180 Francophone patients.

COMMISSIONER KITTS: Bernard, can I come back to the relationships with the long-term care homes. Your relationship with Revera sounds excellent, and I think that relationship will help things.

You said that you were called into a second long-term care home, but that wasn't so smooth. Can you let us know, compare and contrast, what worked in the first instance and what didn't in the second?

DR. LEDUC: Issues were different. The category of building in terms of long-term care facility was different. In both places, the clinical care was good, but the infection prevention control had to be improved.

And in the second residence, that's where we had an important lack of staff. There was

staffing issues in both, but in the second one it was more dramatic. And both residences had, at some point or another, due to isolation or testing, some leadership absence in the staffing on the spot.

COMMISSIONER MARROCCO: Do you have a sense, Doctor, what could be done to most quickly or promptly address the staffing problem or make it a little better than it is?

DR. LEDUC: I wish there was a silver bullet. And again, here is my personal perception that I feel that for a very long time now, long-term care has missed any kind of backup capability. And so we created a perfect storm here by removing the caregivers, the families and by increasing the workload.

You have to bear in mind the long-term care residents eat together, we're trying to foster social interactions. And from overnight, the residents were then confined to their rooms, which meant that the meals had to be brought to them into their rooms.

COMMISSIONER COKE: Bernard, the partnership with Revera, you say staffing, PPE, IPAC and sometimes leadership, those were four

important factors in these long-term care homes, and part of the differentiation between the two.

Does the hospital, because it's partnered with Revera, supply staff PPE, IPAC expertise, leadership to the Revera long-term care home?

DR. LEDUC: Not currently. Those we did for the first residence in the first wave, we had to supply PPEs and IPAC expertise and staff.

COMMISSIONER KITTS: Will that be the same for other long-term care homes in your area that you're not formally partnered with?

DR. LEDUC: We are occasionally approached by other residences. We had some residence that had an outbreak approach us for some help with residents. And I think we can help with infection, prevention and control.

COMMISSIONER KITTS: Does Public Health play a large role in these relationships?

DR. LEDUC: Yes. Public Health plays a role in maintaining the high standards of infection, prevention and control.

COMMISSIONER KITTS: Thank you.

COMMISSIONER MARROCCO: How do those relation -- how does the request occur? Who

originates, and once the request is made, who takes charge?

DR. LEDUC: So the beginning of the pandemic the request came through the regional table for the long-term care, and that's where it was culminated and there were representatives of the hospital, of Public Health and the region.

Does anybody have any further questions for Dr. Leduc?

COMMISSIONER KITTS: Just one. Do you feel that your area, Champlain, is better or much better prepared for Wave 2 than Wave 1?

DR. LEDUC: I believe we are better prepared. We understand the issues better. We're not as concerned about the supply of PPEs anymore. However, there's still a concern that it's a very vulnerable environment.

One of the things we did for the first wave that was a bit difficult at first was the principle of creating cohorts, so red zones, green zones. It's a bit different than a hospital where you can only assign a patient to a bed.

Over there, it's their place of residence, their apartments, so it was a bit of reluctance to us coming in and imposing that. But

I consider it wasn't one of the factors to best control the outbreak.

COMMISSIONER KITTS: Thank you.

COMMISSIONER MARROCCO: Well, Doctor, thank you for the presentation and thank you for answering our questions.

This fills in another portion of the story for us, and we want to thank you for your time. And if we have further questions, I hope you won't mind if we bother you again.

DR. LEDUC: Never a problem and thank you for the invitation, giving me the chance to chat with you.

COMMISSIONER MARROCCO: Thank you very much, Doctor. Thank you. Good afternoon.

COMMISSIONER COKE: Thank you.

DR. LEDUC: Goodbye, thank you.

-- Hearing concluded at 3:30 p.m.

REPORTER'S CERTIFICATE

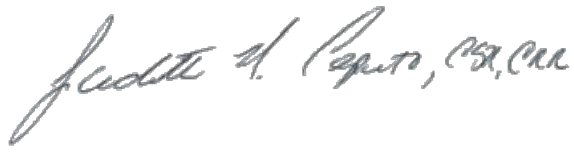
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 20th day of October, 2020.



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