Long Term Care Covid-19 Commission Mtg.

Meeting with Department of National Defence /Canadian Armed Forces
on Thursday, October 29, 2020

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7 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14 --- Held via Zoom, with all participants attending
15 remotely, on the 29th day of October, 2020,
16 1:00 p.m. to 3:00 p.m.
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19 BEFORE:
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21 The Honourable Frank N. Marrocco, Lead Commissioner
22 Angela Coke, Commissioner
23 Dr. Jack Kitts, Commissioner
24
25

1 PRESENTERS:
2
3 Colonel Scott Malcolm, Deputy Surgeon General,
4 Department of National Defence
5
6 Major Karoline Martin, Officer Commanding Standards
7 Company, Canadian Forces Health Services Training
8 Centre, Department of National Defence
9
10 PARTICIPANTS:
11 Alison Drummond, Assistant Deputy Minister,
12 Long-Term Care Commission Secretariat
13 Dawn Palin Rokosh, Director, Operations, Long-Term
14 Care Commission Secretariat
15 Jessica Franklin, Policy Lead, Long-Term
16 Care Commission Secretariat
17 Ani Mamikon, Legal Counsel, Department of Justice
18 Major Sonya Connick, Senior Public Affairs Officer,
19 Department of National Defence
20 Ida Bianchi, Counsel for the Commission
21
22 ALSO PRESENT:
23 Janet Belma, Stenographer/Transcriptionist
24
25

1 -- Upon commencing at 1:00 p.m.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Are we waiting for the brigadier?
4 COLONEL SCOTT MALCOLM: No, Sir. It's
5 Major Martin and I who will be presenting to you
6 this afternoon.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 All right. Well, I'm Frank Marrocco. I'm one of
9 the commissioners. There's Dr. Jack Kitts and
10 Commissioner Angela Coke. I assume you have some
11 idea of how we're functioning because the brigadier
12 was here the last time for a couple of hours, and
13 he made numerous promises on your behalf as he was
14 leaving.
15 And so I want to, you know, thank you
16 for coming back and, in a sense, completing the
17 presentation. So thank you very much for that.
18 And there's a transcript, tend to break
19 after an hour and 15 or so, so you just let me --
20 if you're still presenting, let me know when -- if
21 there's a time around the one hour, one hour and
22 ten minutes mark you want to break, that's fine, or
23 that you think it's appropriate, then we'll do
24 that. I just tend to do that, give everybody a
25 chance to collect their thoughts before they

1 conclude.
2 And the other thing is we -- as you
3 were probably told, we tend to ask questions as we
4 go along, so it's not that we're being rude. It's
5 just the most efficient way to ask the questions
6 rather than trying to go back. So with that, I
7 think we're ready when you are.
8 COLONEL SCOTT MALCOLM: Thank you very
9 much. So Commissioner Marrocco, Commissioner Coke,
10 Commissioner Kitts, on behalf of Major Martin and
11 I, I thank you for the opportunity to appear before
12 you this afternoon. We have presented a bit of a
13 deck, but before I get into it, because we've got
14 two presenters today, what we've tried to do is
15 I'll lead with the introductions for both
16 Major Martin; and I will walk us through the first
17 part of the deck, and then I'll hand over the floor
18 to Major Martin.
19 Certainly, understand that there will
20 be questions along the way, and really, the deck's
21 been built as a step-off point. In building this
22 deck, we've also reviewed a couple of other
23 documents including your early recommendations and
24 the transcripts that came from General Mialkowski's
25 presentation and have really tried to put into the

1 deck some responses to questions or themes that we
2 identified in it, again, as a step-off point.
3 So with that said, I will first
4 introduce Major Martin, currently working at our
5 Health Services Training Centre in Borden, but more
6 importantly for the purposes of today's appearance,
7 was the officer commanding our augmented civilian
8 care team, so can speak to the tactical level, what
9 was occurring within the long-term care facilities
10 and contributed greatly to the report that was
11 produced on the CAF observations in those long-term
12 care facilities.
13 And then myself, so Colonel Scott
14 Malcolm, family physician by training, currently in
15 the role as Deputy Surgeon General, but during the
16 period of time when we were deployed to the
17 long-term care facilities, I was within -- I was in
18 the position as the Director of Health Services
19 Operations. What that means in layman's terms is,
20 basically, I was the one helping to provide the
21 health planning and looking at how CAF Health
22 Services was going to respond to the pandemic and,
23 in this case, help to plot the teams that were
24 going to go into the long-term care facilities.
25 I'll just pause there if there's -- if

1 there's any questions before I have move on to the
2 next slide.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Just before you do, I'm having some difficulty
5 seeing the slide. So let's just stop for a second
6 and get that straightened out. Can the other two
7 commissioners see the slide? No.
8 COLONEL SCOTT MALCOLM: So I haven't
9 done a share screen. I wasn't under the impression
10 that we wanted to do a share screen, but I can get
11 that set up if you would like.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Well, I'll leave it up -- I'll leave it up to you,
14 whatever you think is the more efficient way to
15 present it. We can follow along, or you can -- I
16 just didn't want you to think that we were seeing
17 something on the screen that we weren't seeing.
18 COLONEL SCOTT MALCOLM: Okay. So if
19 you can, perhaps, bear with me for just one moment,
20 I'll go off video and pull that up. Would that be
21 all right?
22 COLONEL SCOTT MALCOLM: That's fine.
23 Thank you.
24
25 COURT REPORTER: Colonel Malcolm, if

1 you're having trouble, I can always share it on my
2 end here. Just let me know.
3 COLONEL SCOTT MALCOLM: I have it now,
4 but if you have it readily available, then feel
5 free to go ahead and do so, or I guess it's easier
6 because then I can control the slides. Just one
7 more moment, and I'll have it up. Sorry.
8
9 COURT REPORTER: Sure, if that's fine
10 with you. It's just easier if you can scroll, but
11 if I have to, that's fine.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 We can see it, Colonel, in case you're wondering.
14 COLONEL SCOTT MALCOLM: Okay. Perfect.
15 Sorry. Technology wasn't my friend today. I
16 sincerely apologize for the technological delay,
17 but are we okay now, Sir?
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Well, we are. There's just one thing. There's
20 someone here whose identified by a phone number.
21 Can you identify yourself, please?
22 HEATHER WALSH: Yes, sorry, Sir. It's
23 Heather Walsh. I'm with DND.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Oh, fine. Okay.

1 Go ahead, Colonel.
2 COLONEL SCOTT MALCOLM: Thank you.
3 Thank you, Sir. So this is all that I've covered
4 thus far, so if it's okay with you, I'll proceed on
5 to the next slide.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 We're good.
8 COLONEL SCOTT MALCOLM: This just
9 covers a bit of an outline, so I'll provide just a
10 brief context with respect to how we came to be in
11 the facilities and some of the parameters around
12 what we were doing there and what shaped our
13 observations. I'll cover some systems
14 considerations, ones that certainly positively
15 impacted the CAF's approach to pandemic planning.
16 I will then delve into the chain of
17 command versus the professional technical chain
18 which I think will start to begin to respond to an
19 understanding around how our forces aligned in the
20 homes.
21 And at that point, I'll turn the floor
22 to Major Martin who will walk you through the
23 composition of the augmented civilian care teams,
24 their roles and responsibilities, and their
25 interface with the long-term care facilities and

1 the hospital networks.
2 She'll then look in and speak on the
3 CAF Ontario long-term care facility observations,
4 and we've put those alongside the recommendations
5 that your commission has put out as a bit of an
6 opportunity to perhaps explore areas that haven't
7 yet been covered in your recommendations but
8 certainly will provide the gamut of the
9 observations that we captured.
10 Finally, Major Martin will cover the
11 CAF lessons learned and certainly some valuable
12 lessons that we took away that will shape our
13 future activities of this nature, and then I will
14 take the floor back to conclude.
15 I will now move on to the -- to the
16 next slide, and I'll pause after each of the
17 statements just in the event that there's any
18 comments or questions.
19 So the CAF observations in Ontario
20 long-term care facilities represent a point in time
21 in those specific facilities and may not be
22 representative of the situation prior to the start
23 of the pandemic nor generalizable to other
24 locations.
25 CAF personnel deployed to Ontario

1 long-term care facilities in support of and in
2 partnership with the Province and the facilities
3 were there as a temporising measure and not as a
4 solution to this complex problem.
5 Canadian Forces Health Services
6 personnel are not experts in the delivery of care
7 to the elderly but represent a highly versatile
8 group of disciplined clinicians accustomed to
9 adapting to the needs of their care environment.
10 And finally, actions were taken
11 immediately to correct any observed patient safety
12 concerns that were formally captured in the report
13 later released to the Province.
14 Okay to proceed, Commissioner Marrocco?
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Yes, please.
17 COLONEL SCOTT MALCOLM: From a systems
18 consideration perspective and, again, looking at my
19 role as our health planner, the concept of
20 needs-based health workforce planning was pivotal
21 for us, and it was pivotal for a number of reasons.
22 We're a relatively small force spread across the
23 entire country, and it was going to be -- it was
24 clear to us that when demands may arise for our
25 services, that we're going to have to focus on use

1 of our least scarce human resources first. And for
2 us, that meant our cadre of nurses and our cadre of
3 medical technicians.
4 But beyond that, it was also we were
5 looking to optimise the scopes of practice of our
6 providers because if we had have been sought out
7 for just our number of physicians, our response
8 would have been much less than it was because
9 they're simply one of our more scarce resources.
10 And so in particular, in the response
11 to long-term care facilities, we were able to look
12 across our other providers who had clinical
13 experiences be they our physios, our pharmacists,
14 our dentist, our dental techs, and be able to
15 capitalize on those.
16 And further to that, the employment of
17 our general duty CAF troops in nonclinical roles
18 also allowed the freeing up of our clinicians to
19 focus on the patient care duties while allowing our
20 CAF duty troops to take care of other things like
21 portering, laundry, assisting with cleaning, all
22 very key and critical tasks to the functioning of
23 the facilities but ones which were better in the
24 hands of our nonclinical folks, allowing our
25 clinicians to carry on with the direct patient

1 care.
2 And just by way of a bit of a reference
3 and certainly one that I'd use as I became more
4 familiar with needs-based health workforce planning
5 over the years was this paper by Dr. Tomblin Murphy
6 which, again, formed the basis for some of my
7 planning considerations.
8 And finally, from another systems
9 consideration was our ability to rapidly mobilize
10 clinicians from within our single healthcare system
11 but one that is spread across the country.
12 So I'll just pause there if there's any
13 questions.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 No. I think -- I think we're fine.
16 COLONEL SCOTT MALCOLM: Okay. I bring
17 this slide back to your attention. It's one that
18 General Mialkowski had presented, and the reason I
19 bring it here again, it nicely shows the
20 co-operative, that partnership nature between the
21 chain of command on the left, the Province central
22 to all of this, and certainly the focus of our
23 support, and then the role of the Federal
24 Government in all of this as well. But I really
25 bring it just to highlight the chain of command

1 piece which sets me up for my next slide, so I'll
2 just move to that, if that's okay?
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Sure. Yes.
5 COLONEL SCOTT MALCOLM: And it's here
6 where I'd like to just provide a bit of explanation
7 around the difference between the chain of command
8 versus the professional technical chain.
9 So on the left, again, a carryover from
10 the previous slide, it starts, really, at the Chief
11 of the Defence Staff walking down through the
12 Canadian Joint Operations Command, Task Force
13 LASER, Joint Task Force Central, which you've
14 already spoken to the Commander, Brigadier General
15 Mialkowski. Then under him was the Territorial
16 Battle Group 1, and as part of that Territorial
17 Battle Group 1 was the augmented civilian care
18 teams.
19 So this is the chain of command as it
20 pertained to the response to the long-term care
21 facilities which has its own, sort of, reporting
22 mechanism.
23 But to the right is another very
24 important chain in -- particularly in the health
25 field which is our professional technical chain.

1 In this case, this chain is what provides the
2 clinical guidance and the professional oversight to
3 all of our healthcare providers that were working
4 in the long-term care facilities but also
5 represents another reporting chain for the findings
6 within the long-term care facilities.
7 So that chain starts with the
8 Surgeon General, and for the purposes of
9 operations, it flows next to my former position as
10 the Director of Health Services Operations. And in
11 that case, I was the Operation LASER which was the
12 name attributed to our pandemic response. I was
13 the Op LASER Senior Medical Authority, and I was
14 providing -- if you look to the left side, I was
15 providing medical advice to the commander of the
16 Canadian Joint Operations Command.
17 Next in line was the task force surgeon
18 who provided -- who I provided clinical guidance
19 and professional oversight on. Then you have the
20 Joint Task Force Central Surgeon, and that
21 individual was the adviser to General Mialkowski as
22 the commander of joint task force central. And
23 then we come to the position that Major Martin held
24 which was the officer commanding the augmented
25 civilian care teams.

1 So you can see the duality of her
2 reporting roles that she had there both on the
3 Professional technical chain and also within the
4 chain of command. And I provide that for a little
5 bit of context because I understand that you wish
6 to understand a little bit of how the interactions
7 occurred between the military and the facility
8 staff and the hospitals, and I think it's important
9 to understand that duality of function there.
10 And I'll just pause there if there's
11 any questions.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 None by me. No.
14 COLONEL SCOTT MALCOLM: Okay.
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 I think we're all okay.
17 COLONEL SCOTT MALCOLM: Okay. So with
18 that -- with that, Commissioner Marrocco, I'll turn
19 the floor over to Major Martin, and she will carry
20 on from there.
21 And for Major Martin, because I've got
22 control of the slides, please just feel free to let
23 me know, and I'll advance them on your behalf.
24 MAJOR KAROLINE MARTIN: Okay. Good
25 afternoon, Commissioners. So as Colonel Malcolm

1 had stated, I am Major Karoline Martin. I deployed
2 as the officer commanding the augmented civilian
3 care teams which really meant I was, sort of, the
4 medical director for all of the teams, the medical
5 teams that deployed into the various long-term care
6 facilities.
7 To provide some context to this slide,
8 it is a bit of an oversimplified representation of
9 what the ACC was. This is really just a snapshot
10 of one facility and, sort of, how that reporting
11 structure worked, but normally, you would have all
12 five of those teams all reporting to me as the
13 officer commanding the ACC team. So those -- each
14 facility -- so each of those teams in -- within the
15 long-term care facilities were composed of two
16 registered nurses and 12 CAF clinicians, the first
17 five being exclusively medical technicians.
18 When we originally went into visit the
19 long-term care facilities as part of our
20 reconnaissance, what we realized was that they were
21 in crisis and really required 24/7 support. So
22 what I did at that time is I broke that team into
23 two and really just put them into 12-hour shifts.
24 So when you look at Shift 1, registered
25 nurse and med techs, that is the day shift, the day

1 12; and then Shift 2 is the night shift. So each
2 of those teams had one RN in charge of the military
3 medical team, and all of the medical technicians
4 fell under her for clinical and chain of command
5 oversight.
6 As part of that complement within those
7 long-term care facilities, we had the general duty
8 personnel, so those general duty personnel didn't
9 have a command relationship with the ACC, but they
10 were in a collaborative relationship where they
11 were the underpinning, like Colonel Malcolm had
12 stated, where they were doing portering, laundry,
13 cleaning, disinfection, et cetera. And that
14 provided the framework which allowed our clinicians
15 to provide high quality care.
16 When you look at the team composition,
17 we've put together a communication plan or a
18 reporting plan that was based on basically three
19 levels. The first level, and is depicted within
20 the slide, is really that frontline staff
21 communication. So the registered nurse on shift
22 was responsible to be the -- the clinical oversight
23 for the medical technicians, and she would have
24 daily and regular interactions with the long-term
25 care facility staff, both from a clinical

1 perspective and from an executive director
2 perspective. Any concerns, any critical incidents,
3 any even recommendations for improvement or
4 efficiency were funneled through the directors of
5 care or the executive directors on a daily basis.
6 Depending on if it was a night shift, it may have
7 been the senior registered nurse on site, but the
8 information always flowed to those two core
9 functions, so that was that first level of
10 communication in reporting.
11 The second level was focused on the
12 relationship between that registered nurse and
13 myself. So as part of that, we created two systems
14 of reporting. The first one was very chain of
15 command centric and very regimented in that the
16 nurses per shift were responsible to provide a
17 report which was called a daily medical situation
18 report, and that was done twice a day at the end of
19 each shift for each of the facilities.
20 And that daily medical sit rep
21 basically covered off any critical incidents of the
22 shift, any concerns that those nurses or those med
23 techs had, anything that was going on that I, as
24 chain of command, needed to be aware of; and then
25 additionally, they went into some of the drawdown

1 criteria that Brigadier General Mialkowski had
2 alluded to, and that was a daily check for us as a
3 headquarters to look at where those long-term care
4 facilities were in the spectrum of red, yellow,
5 green.
6 Once we had that second layer of
7 reporting to myself, I then had a dual reporting or
8 a triple reporting requirement. So I had one that
9 was from a chain of command perspective in
10 reporting any concerns to the commanding officer of
11 the Territorial Battle Group 1, and that was
12 Lieutenant-Colonel J.J. Stocker.
13 So for him, I was providing the daily
14 medical sit reps. I was providing any of the back
15 and forth that I was having with the nurses, and
16 then from the professional technical network, very
17 similar reporting but really focused on that
18 clinical oversight because, again, as the dual role
19 for chain of command and professional technical,
20 any time that nurses had concerns about standards
21 of practice, scope of practice, you know, when to
22 call a physician and what to do with the
23 disposition of the patient, they would call me for
24 mentorship or guidance, and so I would funnel that
25 information through the professional technical

1 chain to the regional surgeon. So from -- that was
2 the military side.
3 When I look at the civilian and, sort
4 of, the long-term care facility side, what we did
5 is we met with the corporate management, senior
6 management, and/or the hospital network as required
7 on a weekly basis or if any critical issues arose.
8 So there was constant interactions at
9 various levels within the facilities, and within
10 those weekly coordinations, we had a very collegial
11 discussion and really trying to unpack some of the
12 concerns being raised. And then at the local
13 level, it really was very patient-centred,
14 patient-focused based on the individual incidents.
15 I'll stop there and see if there's any
16 questions with that.
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Yes, there is.
19 Commissioner Kitts.
20 COMMISSIONER JACK KITTS: Just to
21 clarify, so you were entirely on the clinical side
22 in terms of your leadership; is that correct?
23 MAJOR KAROLINE MARTIN: No, Sir. So
24 what I was was the chain of command and the
25 clinical side for any of the health services

1 personnel that deployed under the umbrella of ACC.
2 COMMISSIONER JACK KITTS: But in the
3 home, so in the home, I think you said that there
4 was a senior administrator, either senior
5 management or -- of the hospital. There was an
6 administrator, not from the military, who was in
7 charge of the home; is that correct?
8 MAJOR KAROLINE MARTIN: From the
9 long-term care facility?
10 COMMISSIONER JACK KITTS: Yes.
11 MAJOR KAROLINE MARTIN: Yes, so all
12 of --
13 COMMISSIONER JACK KITTS: They were
14 still -- go ahead.
15 MAJOR KAROLINE MARTIN: Yeah, so they
16 were -- they were still there. So all of the
17 facilities had executive directors in location, and
18 that was actually a prerequisite to the deployment
19 is that the command structure within the long-term
20 care facility had to be in place. So the executive
21 director was really, sort of, that administrative
22 manager of the facilities, and then the directors
23 of care were, sort of, your charge nurses for the
24 various sectors of the facilities. And at times,
25 those were either acting executive directors or

1 acting directors of care, but that construct still
2 existed within the facility.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Right, so I'm just wondering what your relationship
5 was to the directors of care.
6 MAJOR KAROLINE MARTIN: It varied by
7 facility. In some facilities, I had close contact
8 with those directors of care to work through some
9 of those practice concerns or practice issues that
10 had come up or to provide additional information on
11 their policies and their procedures within the
12 facility itself.
13 And then there were other facilities
14 where if it was larger, I wouldn't necessarily have
15 direct contact with the directors of care.
16 COMMISSIONER JACK KITTS: Okay. So
17 your staff were working in a team with the civilian
18 care teams, and it says your team compositions were
19 45 to 55 members of the military.
20 Is that -- is that how short-staffed
21 the homes were when you arrived?
22 MAJOR KAROLINE MARTIN: So
23 the facilities themselves in the Recce reports
24 basically, when we went in, all but one -- most of
25 them were approximately 20% staffing, and I don't

1 mean that that's all that was left within the
2 facility.
3 I mean from a corporate -- the people
4 who actually worked at that facility, they were at
5 20% staffing. So they augmented with either agency
6 staff, temp help, new hires, and then the military
7 to augment. But in terms of the people who used to
8 work there and who were familiar with the
9 residents, they were at approximately 20%.
10 COMMISSIONER JACK KITTS: Thank you.
11 MAJOR KAROLINE MARTIN: Is there any
12 other questions?
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Actually, I do have a -- do you have any sense of
15 how long they were at 20% prior to your arrival?
16 MAJOR KAROLINE MARTIN: I'm -- I would
17 say probably a couple of weeks was the indications
18 from my Recce reports. Obviously, it varied based
19 on the facility, but there was a very clear rapid
20 decline in their staffing just prior to our
21 arrival.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Do you have any sense of what precipitated the
24 decline? I appreciate there's a pandemic, and I
25 appreciate we're dealing with, you know, a

1 contagious or infectious problem, but was there an
2 event that in -- from your impression, precipitated
3 the decline? Or was it just the circumstances?
4 MAJOR KAROLINE MARTIN: So from my
5 understanding and what was reported to us during
6 that initial Recce meeting was the staffing was
7 impacted, (1) partly because of positive staff
8 cases; (2) was childcare issues; (3) was, sort of,
9 fear of working in that environment.
10 So there was -- I think there was a
11 variety of factors that influenced those staffing
12 levels, but again, once they started to decline, it
13 became that people didn't want to come in to work
14 because of whatever was the precipitating event for
15 their personal circumstances.
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Thank you. Go -- carry on, Major.
18 MAJOR KAROLINE MARTIN: Okay. So my
19 next slide really is a snapshot to look at the key
20 observations and themes that we have had as a CAF
21 and then really, sort of, compare those to the
22 early commission recommendations. And as we can
23 see here, there's overlap in those key themes that
24 are starting to emerge.
25 And what I would like to do within this

1 slide is to really go through the CAF observations
2 and themes and really provide a little bit more
3 granularity to what our experiences were and what
4 our observations have been.
5 So I'll start off with infection
6 prevention and control. Certainly, IPAC has been a
7 central theme to the spread of the virus within
8 long-term care facilities, so I won't belabour the
9 point.
10 But from our perspective, one of the
11 main challenges that was really challenging for the
12 long-term care facilities was the cohorting. So
13 cohorting, the ability to cohort and cohort
14 effectively was severely impacted through all
15 phases of this operation and finally started to
16 gain momentum near the tail end.
17 But when we look at testing regimes,
18 how often we were testing, really having that
19 situational awareness or that site picture of where
20 were the positive outbreaks, where were the
21 clusters internal to the facility had a
22 two-to-three-week delay between testing.
23 But once the facilities had that site
24 picture, there was then the planning to be able to
25 cohort effectively. And when you look at the

1 long-term care facilities, that's a challenge.
2 They're smaller rooms. They're multi-resident
3 rooms, and really just the scope of being able to
4 plan that out is a project within a crisis.
5 So it was very challenging for everyone
6 to even have come up with a really good plan on
7 cohorting, but really, the part where we saw the
8 most challenges was the actual execution of the
9 cohorting because you needed a significant amount
10 of personnel to be physically able to move
11 residents and their personal belongings from one
12 wing to another, one room to another.
13 And so when you're looking at being
14 short-staffed and still having those clinical
15 responsibilities, those activities of daily living,
16 be it feeding, wound care, et cetera, you needed to
17 have an additional team juxtaposed on top to be
18 able to do that. And that's where some of those
19 military personnel, the general duties, came in
20 very handy, but, again, that was one of our core
21 takeaways was good cohorting did have better impact
22 long-term.
23 Any questions on that?
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Is there any way to quickly construct not a

1 facility, but to quickly construct a space so that
2 you could -- you know, rather than trying to cohort
3 or coordinate place to people within the structure
4 that's not really built for that purpose especially
5 if it's older, a way of quickly creating some kind
6 of -- something beside it that you -- that you
7 could move people into for a temporary period of
8 time until this, sort of, crisis at least abated?
9 MAJOR KAROLINE MARTIN: So,
10 Commissioner, not being a logistics expert, I would
11 say I'm sure there was some, sort of, solution out
12 there on the civilian sector, but again, it would
13 be facility specific on what is their parking lot
14 situation, heating and cooling, et cetera. I think
15 that there's a lot of factors that would go into
16 even creating temporary structures that are on site
17 with that facility.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 But I appreciate that, but the notion of creating a
20 temporary facility is not -- it didn't seem to me
21 it was -- this would be unusual or difficult. It
22 may be challenging to do, but not impossible to do.
23 And I was just curious if, given your
24 background, your experience, when the military
25 construct a temporary facility, and it can be

1 done --
2 MAJOR KAROLINE MARTIN: I mean,
3 there's --
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 -- relatively quickly if you -- in an emergency.
6 MAJOR KAROLINE MARTIN: Right. And
7 again, looking at, you know, Red Cross has
8 deployable hospitals, et cetera. The CAF has the
9 same type of concept. What that would look like
10 from a long-term care perspective and from the
11 logistics sense, I wouldn't know, but I maybe turn
12 it over to Colonel Malcolm to speak more on the
13 capability side.
14 COLONEL SCOTT MALCOLM: Thanks,
15 Major Martin.
16 So, Commissioner Marrocco, to -- again,
17 to echo some of the comments that Major Martin
18 said, I mean, there are a lot of factors. And as
19 you've said, you appreciate those.
20 The military had looked at the
21 possibility of constructing, I guess, these hasty
22 infrastructures, but, really, they were looked at
23 from the perspective of something that the Canadian
24 Armed Forces may use for their own populace.
25 Obviously, we're a hardened force who

1 are used to living with less amenities, if you
2 will, and the idea of having such facilities
3 available for particularly this vulnerable
4 population really wasn't going to be feasible, and
5 if you start to look at the more robust
6 infrastructures when they're talking field
7 hospitals from the Canadian Armed Forces'
8 perspectives or the Red Cross's perspective, you
9 start to get into the limitations of the
10 availability of these structures.
11 So, I mean, we've put a fair bit of
12 thought into it, and I know there's some Federal
13 Government planning around looking at increasing
14 availability of such structures.
15 But I think as the Federal Government
16 is learning on that front, there's a lot of
17 considerations that go into it and then becomes the
18 staffing challenge after that because not only are
19 you then staffing your primary facility, but then
20 you're looking to also staff that as well, so many
21 human resource and other resource challenges with
22 it.
23 So it's definitely a good
24 consideration, but I think one to move from concept
25 implementation which is more challenging than one

1 may initially believe.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 I was thinking of it more in terms of going
4 forward, you know, Wave 2, Wave 3. And I -- I was
5 imagining that a facility that was limited in
6 Wave 1 would be -- would be similarly limited in
7 Wave 2 in terms of its space and how it's
8 constructed.
9 And so that made me think, well, then,
10 you'd have to create some makeshift facility so
11 that you could -- you could separate people, and
12 then I was just curious as to how realistic it
13 would be to be able to do that for a short period
14 of time, and that's what prompted the question, so
15 I --
16 COLONEL SCOTT MALCOLM: And, Sir,
17 that's -- yeah, it's certainly -- it's certainly a
18 great thought. I think the other potential
19 disadvantage that we're faced with now is the
20 Canadian fall environment at this particular time
21 of year making the feasibility of that a bit more
22 challenging as well, but I'm starting to delve
23 outside my area of expertise on that front but
24 certainly a good thought, and, like I said, one
25 that I know that the Federal Government had been

1 approaching from increasing availability of a field
2 hospital or a respiratory type of facility for down
3 the road, but I think there's still in the early --
4 well, they're advanced along to some degree, but I
5 still think they've identified other challenges,
6 most notably the staffing piece.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 All right.
9 Yes, Commissioner Kitts.
10 COMMISSIONER JACK KITTS: Major Martin,
11 I think in your comments around the difficulty with
12 cohorting in these homes, you added, in addition to
13 the infrastructure challenges, that there was
14 insufficient staffing to actually physically move
15 the patients and their belongings to a place; did
16 you say that?
17 MAJOR KAROLINE MARTIN: Yeah, and I
18 would -- I would say that's accurate, Commissioner.
19 So the way that the movement of cohorting happened
20 is once there was a batch of positive results, they
21 then had to reseparate. And so it wasn't moving
22 one or two individuals. Early on in that pandemic,
23 they were getting dozens of new positives or, let's
24 say, double-digit positives early on, and so there
25 was a massive movement of personnel.

1 Some facilities decided to block off an
2 entire ward or entire floor, and that was the
3 COVID-positive floor. That seemed to be a little
4 bit more efficient because you would simply move
5 individuals into those floors, but other facilities
6 simply didn't have the infrastructure, so they
7 would have to move -- like, Ward A suddenly had a
8 cluster, and they would collect half the
9 individuals, move them into Ward B, and so you have
10 this double movement of one person coming out, one
11 person coming in and having to disinfect in between
12 along with trying to keep track of all of their
13 personal belongings. But from a staffing
14 perspective, it was very, very challenging.
15 COMMISSIONER JACK KITTS: No. That's
16 interesting. Thank you. It's another way that
17 shortage of staff was a problem in this. So thank
18 you.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 So I don't think there are any other questions, so
21 carry on if you like, Major.
22 MAJOR KAROLINE MARTIN: Okay. So my
23 next point is regarding standards of practice and
24 quality of care, and I will preface this with, sort
25 of, an understanding of the clinical background of

1 military clinicians. So when you look at the
2 nursing cadre, our military nurses primarily work
3 in emergency departments, medical-surgical units,
4 and intensive care units. And then our medical
5 technicians are primarily field, trauma, paramedic,
6 et cetera. And they all are working within a
7 military construct which is a very regimented, very
8 organized system. And so the culture of military
9 medicine is what it is. So those clinicians, when
10 they went into these facilities in crisis, were
11 taken aback. They were taken aback because there
12 was a significant deviation from the way that they
13 were used to practicing medicine.
14 But throughout their -- and so
15 standards of practice, quality of care, plus
16 ambiguity of local practice, sort of, tie into one
17 another. When you have 80% of the workforce being
18 either temporary health agency staff or new hires,
19 the understanding of what the culture within that
20 long-term care facility is, what their policies and
21 procedures are for clinical care is very, very
22 challenging; and so there was deviation sometimes
23 based on the individual practitioner and sometimes
24 based on a lack of knowledge of what was actually
25 the standard of appropriate care.

1 Any questions on that point?
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 So it's a training issue? So you have a staffing
4 problem, and then layered on top of that, you have
5 untrained -- well, relatively speaking, untrained
6 people to work with.
7 MAJOR KAROLINE MARTIN: Right.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Thank you.
10 MAJOR KAROLINE MARTIN: So the next
11 point is really tied into supplies, and again, this
12 goes back to a difference in the culture between a
13 hospital and a long-term care or a military setting
14 and long-term care.
15 Our clinicians are used to having ready
16 access to any supplies that they require be it
17 wound care supplies, be it -- whatever the
18 clinician required, they would have ready access to
19 it. It would really be the clinician's personal
20 judgment on what that resident or what that patient
21 required.
22 Within long-term care, there's a little
23 bit more layers to that supply management chain
24 where the RN holds the keys to the locked supply
25 cupboards for, be it wound-care supplies,

1 et cetera.
2 And so again, that ties back to the
3 training and the ambiguity of local practice
4 because when you have several new clinicians that
5 are coming in, they: (1) do not know where to find
6 those supplies; (2) how to access those supplies;
7 who to go to; and then sometimes, you know, being
8 asked, well, why do you require this? Have they
9 had a dressing change, et cetera?
10 So again that supply became a scarce
11 resource that impacted clinicians' ability to
12 effectively or efficiently care for their -- for
13 their residents.
14 The other thing to note on the supply
15 chain is, again, when you have staffing levels at
16 20% or even 30%, the normal individuals that are
17 responsible to restock those shelves, restock and
18 reorder the supplies becomes problematic because
19 nobody knows who is actually ordering until there
20 is a shortage of supplies.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Did you have a sense -- are you able to say whether
23 in the homes you were in whether there was a
24 shortage of supplies to start with, or did the
25 shortage develop as you described it because of the

1 staffing, and I won't repeat what you just said,
2 but as you've described it?
3 MAJOR KAROLINE MARTIN: So by the time
4 we went in, there was very clear supply management
5 concerns, and so supplies were running low,
6 particularly when you're looking at wound-care
7 supplies which again, those, you go through a lot
8 more readily, same with pads, et cetera.
9 And again, not all the facilities were
10 the same, but there was impacts to the supply chain
11 within the facilities.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 So there's a shortage when you get there, but
14 you're going in when you're going. The problem has
15 persisted for a while before you get there?
16 MAJOR KAROLINE MARTIN: Correct. And
17 I'm not sure, you know, to what extent
18 the shortages or the supply issues existed prior to
19 the pandemic, but it certainly was one of the areas
20 that were affected when we were there.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Okay.
23 COMMISSIONER ANGELA COKE: So, sorry.
24 I just wanted to clarify: You're not just talking
25 about PPE supplies. This is supplies generally?

1 MAJOR KAROLINE MARTIN: Yes, Ma'am.
2 COMMISSIONER ANGELA COKE: Okay. Thank
3 you.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Go ahead, Major.
6 MAJOR KAROLINE MARTIN: Is there any
7 other questions on supplies?
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 No. I think we're good. Carry on.
10 MAJOR KAROLINE MARTIN: So the next
11 major theme that we saw was the ambiguity on local
12 practice. And again, this ties back into that
13 training and onboarding in staffing, so they're all
14 themes that juxtapose themselves into each other.
15 When staff do not have a policy to
16 follow, by their very nature, they will find
17 solutions that at times are appropriate based on
18 their experience or their work in another facility;
19 and at times, they're inappropriate and maybe
20 aren't in accordance with best practice guidelines.
21 So even being able to access those
22 policies at times was problematic, and not because
23 they didn't exist, but simply people knowing where
24 to go to get that information.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.
2 MAJOR KAROLINE MARTIN: Then my next
3 point is on communication. And again, this is a
4 theme that you will see throughout is, as there was
5 a massive turnover of staff and there was several
6 key players, communication was extremely
7 problematic internal to the facility partly because
8 you had one individual from an agency or two
9 individuals from an agency, but they were not
10 coming in as a cohesive unit.
11 And so it was very hard to do that
12 communication transfer between the various shifts
13 or the various teams. And, again, because that
14 communication wasn't great, the handover of
15 patients or really starting to see patients decline
16 from baseline was problematic because it was
17 just -- it was a new team, a new individual every
18 single day, and so you didn't have that
19 communication stream.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Can you help me a bit with that? You said a
22 decline from baseline that causes -- I'm just
23 trying to get a bit more granular sense of that.
24 MAJOR KAROLINE MARTIN: So in a
25 clinical setting, basically what baseline means is

1 what is that patient's normal condition. So if
2 they are up and walking, if they're -- if they're
3 able to eat their food, they eat three meals a day
4 with a snack, what is their regular vital signs,
5 et cetera, that is their baseline.
6 So when you have a patient, you expect
7 them to be at baseline, and if there is a deviation
8 from that, it means something's going on, either
9 that patient potentially has COVID, potentially
10 they're dehydrated, potentially there was something
11 else going on in a clinical perspective. And it's
12 those early indicators when patients move away from
13 baseline that trigger an assessment or trigger
14 actions by the clinician.
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay. And this is made worse by the fact that
17 there's no continuity of staff from day-to-day.
18 Well, because there's --
19 MAJOR KAROLINE MARTIN: Yes.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 -- there's no sense of what the baseline is; is
22 that right?
23 MAJOR KAROLINE MARTIN: Yes, Sir.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Okay.

1 MAJOR KAROLINE MARTIN: That's correct.
2 And so it was interesting for us going in is in a
3 hospital setting, there is a very regular, very
4 frequent charting on patients. Within long-term
5 care, that's not part of the culture because you
6 expect that most residents within long-term care
7 are relatively stable, and they have, you know,
8 maybe charting by exception where they'll only
9 chart if there's a -- there's an issue.
10 Because of the crisis and the pandemic,
11 their ability to chart was severely impacted, and
12 so when you had the majority of the workforce not
13 there, and you had all brand-new staff, we had
14 many, many incidents where we had patients who were
15 immobile or very poor appetite, were not able to
16 feed themselves, and because we'd only seen the
17 first snapshot of one or two weeks or the agency
18 nurses had only seen them for one or two weeks,
19 that was deemed baseline only to come to find out
20 once regular staff started to return, that actually
21 that had been a pretty severe decline from baseline
22 that we weren't able to identify simply because of
23 either communication or documentation.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Right.

1 Commissioner Coke.
2 COMMISSIONER ANGELA COKE: Was there a
3 continuity in terms of the leadership folks in the
4 home?
5 MAJOR KAROLINE MARTIN: It varied by
6 home. They certainly tried to keep the continuity
7 as much they could. Obviously, some of those core
8 pieces -- so in some of the facilities, almost all
9 of their RNs had gone for a variety of reasons, and
10 there was only one or two left which means that
11 those RNs become the directors of care.
12 And then what the corporate management
13 had done is because the corporation still has that
14 same culture, so very similar policies, they would
15 move directors of care from other facilities into
16 there to take over some of that management piece.
17 So they tried as much as possible, but
18 in the -- in the reality, sometimes it did change.
19 COMMISSIONER ANGELA COKE: And my other
20 question was just in terms of the management's role
21 in terms of communications with staff and others,
22 how did that happen?
23 MAJOR KAROLINE MARTIN: So that works,
24 more or less, really well, but again, it was
25 finding a method that was effective.

1 So normally, in any setting, you have
2 your work email that that's where you have
3 information promulgated or there's a -- there's a
4 message board that people read.
5 In that current situation, people were
6 so busy that they didn't have time to either read
7 newsletters, communiqués, et cetera, or there was
8 such an evolution of updated policies that people
9 just would get lost in the minutiae changes.
10 When we first came in, the
11 communication was very challenging because there
12 was a lot of moving pieces, a lot of changes, and a
13 lot of change in staff.
14 As they started to stabilize, many of
15 the facilities started to do, basically, team
16 debriefs. And so the managers, the executive
17 directors, the directors of care, and their
18 clinical team would meet, you know, every morning,
19 at every shift change, and they would go through
20 any of the updates within the last 24 hours, and
21 that communication started to really positively
22 impact the facility and the communications group.
23 COMMISSIONER ANGELA COKE: Thank you.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Carry on, Major, when you're ready.

1 MAJOR KAROLINE MARTIN: So staffing, I
2 think I've hit it on pretty much every single one
3 of my points, and as you have heard from many of
4 your other witnesses, staffing was a major concern
5 within these facilities, so I won't belabour that
6 point.
7 In terms of inappropriate behaviour,
8 certainly that was well-documented within the
9 report, and any inappropriate behaviour that was
10 witnessed was reported immediately in accordance
11 with our duty to report.
12 And then I will move on to onboarding,
13 and onboarding within a long-term care facility is
14 basically the word that is used for orientation or
15 training.
16 Again, because of the crisis, the
17 training that was happening for new hires or new
18 individuals coming into the facility was very
19 barebones. They hit on, sort of, Federally
20 mandated or provincially mandated requirements, be
21 it WHMIS, et cetera. They did an orientation to
22 PointClickCare which is their electronic medical
23 record and maybe like a, this is -- this is our
24 facility, but not the typical orientation that is
25 expected within onboarding that takes several days,

1 and then somebody comes in with a mentor on the
2 floor and is shown where to find all supplies.
3 And that onboarding actually was a
4 critical missing link within the response because
5 what you were having is either new hires, brand-new
6 grads, or individuals who had been retired for a
7 long time coming in, getting very, very truncated
8 training or orientation and then immediately coming
9 onto the floor and trying to work through that
10 environment.
11 Once it started to stabilize and they
12 started to build a more robust training package,
13 that seemed to help quite a bit, and once the
14 hospitals networks came in, that was one of the
15 core initiatives that hospital networks did is they
16 started to try and build that onboarding package so
17 that it didn't require the same human resources to
18 have that director of care or that clinical nurse
19 educator to brief every single staff member that
20 was coming in. So that is certainly a lesson
21 learned and something that is being implemented
22 within long-term care.
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Yes, Commissioner Kitts.
25 COMMISSIONER JACK KITTS: Can I go

1 back, Major Martin, to inappropriate behaviour.
2 I'm intrigued by -- you listed that as an
3 observation. Can you expand a little bit more on
4 what that was?
5 MAJOR KAROLINE MARTIN: So the
6 inappropriate behaviours as outlined within the
7 report really had a variety of concerns. Some were
8 individual; some were, sort of, practice, and some
9 of them really spoke to the lack of oversight of
10 individuals when you do not have that command
11 relationship or within a medical, clinical
12 oversight then you're -- you were opening up the
13 risk for inappropriate behaviour, and they range
14 everything from clinically inappropriate care to
15 ethically inappropriate care, et cetera.
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Oh, go ahead, Commissioner Kitts. You're on mute,
18 Jack.
19 COMMISSIONER JACK KITTS: Sorry. Yeah.
20 Did it appear that that was kind of a cultural
21 thing or a one-off infrequent concern?
22 MAJOR KAROLINE MARTIN: They -- I
23 would -- I wouldn't say it was cultural because I
24 don't know the background of or the very minutiae
25 details of who and what location, so I can't say

1 it's necessarily a cultural issue.
2 What I would say that the theme was
3 there was no oversight to make sure that people
4 weren't conducting themselves in an unethical
5 manner.
6 COMMISSIONER JACK KITTS: Okay. So
7 was -- it was not condoned. It just wasn't acted
8 upon prior to you arriving?
9 MAJOR KAROLINE MARTIN: Right. And
10 because, again, when you look at the staffing
11 ratios, there's -- there was often only one RN in
12 the entire building for 200 staff, or there was one
13 RPN per floor, sometimes one RPN for two floors.
14 So, again, from that -- from that
15 clinical perspective, it was simply sometimes as
16 little as a few -- like, PSWs on a floor, and so
17 they had nobody to report to or nobody was going to
18 hold them to account to make sure that their
19 behaviour was ethical.
20 COMMISSIONER JACK KITTS: Okay. Thank
21 you very much.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 So, Major, if I understand it, then, there's a lack
24 of staff, a lack of training, and -- of the staff
25 that are there, and a lack of oversight?

1 MAJOR KAROLINE MARTIN: That is
2 correct, Commissioner.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Thank you.
5 MAJOR KAROLINE MARTIN: And that's from
6 our perspective. Certainly, you know, as things
7 stabilized, those mechanisms started to fall back
8 into place, but those were, sort of, the core --
9 core pieces that affected residents.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Did it appear to you that these problems -- are you
12 able to say whether the problems that we -- those
13 three problems were pandemic related or pandemic --
14 did the pandemic exaggerate problems that were
15 already there? Or can you say?
16 MAJOR KAROLINE MARTIN: Having not
17 worked within that sector outside of, you know, my
18 short time during nursing school, not having worked
19 in long-term care, I can't say what the baseline
20 was for long-term care.
21 But I would expect that it would be
22 significantly more robust than it was during the
23 pandemic, but I think, like any sector, there is
24 always room for improvement.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Very tactful. Thank you. Carry on, Major. I
2 don't think there are any further questions.
3 MAJOR KAROLINE MARTIN: Okay. So I
4 will move on to our lessons learned. So these are
5 the CAF lessons learned and really coming to an ACC
6 perspective.
7 So I'll start off with creative
8 staffing solutions. As Colonel Malcolm had alluded
9 to, we really went outside of the box of
10 traditional medical teams and really started to
11 look at who else could we use from the allied
12 healthcare provider team to support that, and that
13 worked extremely well for us.
14 Although the original group of
15 individuals who deployed were all medical
16 technicians and registered nurses, the second wave
17 were physician assistants. They were dentists,
18 dental technicians, and they were trained to be
19 able to do those functions, and they worked
20 extremely well. They had enough background
21 knowledge and enough training through the
22 military-mission-specific-training package that
23 they were able to safely and effectively care for
24 those -- for those residents.
25 Additionally, coming outside of that

1 medical framework, we used infanteers to provide
2 the underpinning logistic support that included the
3 laundry, the housekeeping, et cetera; and so,
4 again, looking at -- at the global construct, I
5 think that there is an opportunity to look at
6 creative solutions, be it families, volunteers,
7 et cetera, to do some of those peripheral tasks
8 that really were key enablers to the clinicians to
9 be able to do their job effectively.
10 Any questions on that?
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 No, I don't think so. I don't think so.
13 MAJOR KAROLINE MARTIN: Okay. I will
14 move on to mental health support. So as we were
15 walking through and going into the Reckies
16 (phonetic) and starting our work within the
17 long-term care facility, we very, very quickly
18 recognized that this had a high risk for either
19 mental health struggles or long-term impacts on our
20 clinicians.
21 It was -- it was very traumatic. It
22 was very devastating to the clinicians to see
23 residents passing away, so we very quickly deployed
24 a mental health support team to the ACC, and they
25 also supported the Territorial Battle Group 1.

1 But we deployed a social worker, and
2 then we deployed five padres and embedded a padre
3 into each of the teams. And what a padre does is
4 they're spiritual support. They are some
5 psychosocial support. They are, sort of, the link
6 into social work.
7 But, again, it provided the clinicians
8 and/or the staff an opportunity to seek mental
9 health whichever route they chose, the traditional
10 mental health route or, sort of, the peripheral
11 supports. And that proved to be very, very useful
12 to have particularly as stress levels increased.
13 The other thing that we did was,
14 although it wasn't, in the traditional sense, a
15 critical-incident debrief, we did meet with staff
16 and decompress and have almost a town-hall with
17 each of the teams on a weekly basis.
18 So day shift team had our own pow wow
19 with myself and my Sergeant Major at night shift,
20 et cetera, and just providing the clinicians an
21 opportunity to speak about their experience was
22 very helpful for us as a chain of command to
23 understand where they were coming from and what was
24 happening to them but also for them to feel like
25 they were heard. So mental health was a really,

1 really positive lesson learned for ACC.
2 The other piece that I'll --
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Excuse me. Sorry to interrupt. But you made that
5 support available to both the military staff and
6 the staff that were working there? Right or wrong?
7 MAJOR KAROLINE MARTIN: No. No. My
8 apologies. So our deployed forces from a clinical
9 perspective are responsible to care for military
10 personnel, so our mental health teams were
11 exclusive to the military deployed personnel.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 And that would be part of your obligation in terms
14 of your people?
15 MAJOR KAROLINE MARTIN: Yes.
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Okay. I think you can carry on. I don't think
18 there's any questions at this point.
19 MAJOR KAROLINE MARTIN: So moving on,
20 one of the other pieces in terms of IPAC that we
21 found to be a really good lesson learned is each of
22 the facilities had -- and I had to be -- the
23 privilege of being able to see multiple facilities.
24 We started to see very early on they were all very
25 different in terms of the guidance that they were

1 receiving for IPAC. Sometimes they had an IPAC
2 specialist embedded in-house. Sometimes it was the
3 public health agency or the public health network
4 that was providing the guidance, and sometimes it
5 was just internal to the long-term care facility.
6 But there is a variation that was causing quite a
7 bit of angst.
8 For the military, when we deployed to
9 reduce the supply burden on the facilities, we
10 deployed with our own PPE into each of the
11 facilities. The other thing that we did is we
12 centralized our IPAC guidance so we have a
13 Directorate of Force Health Protection within the
14 military, and they provide overarching policies and
15 procedures.
16 But we also have an IPAC specialist
17 within the Canadian Forces who he was my central
18 point of contact to resolve any tactical level
19 questions or concerns that were based on the actual
20 facility. And what it provided was a continuous
21 message and a central point or a central authority
22 for that IPAC.
23 Any questions on that?
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 No. I think we're good.

1 MAJOR KAROLINE MARTIN: And then for
2 mission-specific training, so the Canadian Forces
3 Health Services Training Centre in concert with
4 1 Canadian Field Hospital actually developed an Op
5 LASER training package for all of our clinicians,
6 nonclinicians, et cetera. And it became the primer
7 of them walking into that -- into that environment.
8 And, really, the focus was on,
9 obviously, IPAC. It was, obviously, you know,
10 elder care, but also making sure that their
11 assessment skills were up to -- up to speed. And
12 what we did is we actually pulled in the -- one of
13 the very few long-term care specialists within the
14 military.
15 So we brought her in to do the debriefs
16 and the discussions. She's a military physician
17 regular, and then she works part time in long-term
18 care.
19 So having that primer was very helpful
20 for our clinicians. What we found lacking within
21 our -- within our planning and something a little
22 bit out of our control was that onboarding because,
23 again, our clinicians, although they knew what they
24 were going into -- they knew the mission set --
25 once they got into the facility, the granularity

1 and the details of practice suddenly were not
2 there.
3 So a lesson learned to us was maybe
4 prior to deploying, put together a bit of an
5 onboarding package to provide to our clinicians.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Okay. I think we're fine.
8 MAJOR KAROLINE MARTIN: Yes. And then
9 the lesson learned, obviously, across this entire
10 pandemic, the province, the country is frequent and
11 broad testing of personnel. What we actually saw
12 was that many of our positives were asymptomatic.
13 And so had we not been very, very
14 frequent, very broad testing, we would have not
15 caught those in time, and that was a very
16 collaborative effort with both the long-term care
17 facilities, Toronto Public Health, and our military
18 health authorities, and that worked extremely well.
19 And then lastly was the frequent
20 coordination between the ACC teams. So as you saw
21 in the early diagram, each of the teams were
22 completely segregated in their long-term care
23 facilities, and that was partly to minimize any
24 risk of cross-contamination between teams.
25 But what ended up happening is we

1 weren't getting the lessons learned. I would have
2 all of the various teams, but there was no central
3 point.
4 So what we started to do very early on
5 is have meetings with all of the teams together,
6 and we would start to see themes and start to see
7 the same concerns coming up for multiple facilities
8 which actually allowed us to action those themes
9 and action those concerns very early on because it
10 was no longer an individual facility problem.
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Can I go back to the testing for a minute? When
13 you first went in, what testing were they doing in
14 terms of testing the employees and that, sort of,
15 thing? Can you just tell me what that was?
16 MAJOR KAROLINE MARTIN: So it varied by
17 facility. Most of the facilities, when we went in,
18 had tested within a two-week period of us going in,
19 so they had somewhat of a site picture.
20 The variance was the frequency of
21 testing. So when they were doing testing, they did
22 100% of all of the residents, and then any of the
23 staff that they -- that worked for that long-term
24 care facility. But unfortunately, they were unable
25 to mandate testing for any of the agency staff or

1 anybody else coming into the facility, be it temp
2 help, et cetera.
3 So although it was a hundred percent
4 staff testing -- and most staff actually did agree
5 to testing because they wanted to know if they were
6 positive or negative.
7 But the issue, sort of, came down to
8 the frequency of testing. When you have a testing
9 regime, let's say, on the 1st of the month, that's
10 a snapshot in time. And so two weeks, three weeks
11 can go by in many of these facilities before they
12 even do another round of swabbing. And as you know
13 from the virus, within a three-week period, you can
14 actually have pretty significant outbreaks in that
15 time.
16 So by the end, I believe the Province
17 began to mandate testing every two weeks within all
18 long-term care facilities, and that is -- when we
19 left, that was still in place.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 So the issue or the circumstance when you arrived
22 there, among other things, is that temporary agency
23 personnel could decline to be tested.
24 MAJOR KAROLINE MARTIN: That was my
25 understanding, Sir.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 All right. So if you had an asymptomatic temporary
3 person who declined to be tested, that's a problem.
4 MAJOR KAROLINE MARTIN: Yes, sir.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 How long did it take to get the results back from
7 the testing? Do you have any sense of that?
8 MAJOR KAROLINE MARTIN: It varied. It
9 certainly got much better by the tail end of the
10 operation. But when we were first going in, the
11 first batch was taking up to ten days.
12 So when you look at if you're testing
13 every three weeks and then it takes an additional
14 ten days for results to come back on individuals,
15 it no longer is an accurate situational picture.
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 And in ten days, a person who, let's say, you --
18 what was it -- just infected on Day 1, would --
19 most of the -- most of the damage in terms of
20 shredding the virus would have been -- would be
21 done within ten days? Am I -- is that correct?
22 MAJOR KAROLINE MARTIN: Right. But
23 then -- but because you're going off of that
24 positive result, you are now moving him in -- or
25 that individual into the positive zone, and,

1 therefore, you never really know who is positive,
2 who is not, who is still -- who is still infection,
3 who is not.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Right. Okay.
6 Commissioner Kitts.
7 COMMISSIONER JACK KITTS: Did you
8 identify any commonality of cause and effect of
9 those who did become positive and those who didn't?
10 MAJOR KAROLINE MARTIN: From a staff or
11 from a --
12 COMMISSIONER JACK KITTS: From military
13 staff that -- like, was it PPE, or were they in a
14 COVID ward, or was there any cause and effect? Or
15 was it just random positive tests?
16 MAJOR KAROLINE MARTIN: I haven't seen
17 the contact tracing report for that.
18 Maybe, Colonel Malcolm, if you could
19 speak to that.
20 COLONEL SCOTT MALCOLM: So,
21 Commissioner Kitts, we actually in -- had very low
22 rates of infectivity relative to the number of
23 troops deployed to the tune of 3 to 4% of all
24 deployed somewhere in the early -- somewhere in the
25 early phases, but there didn't seem to be any --

1 there was no -- there was no outbreak, if you will,
2 amongst a cohort of folks.
3 We did see -- we did see in homes where
4 the rates of infection were higher that there
5 seemed to be a bit of a connection there, but,
6 again, no big outbreak, relatively small numbers
7 by facilities, so no -- I guess the end, if you
8 will, was so small that it became difficult to see
9 any link between the cases.
10 COMMISSIONER JACK KITTS: Thank you.
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Major.
13 MAJOR KAROLINE MARTIN: And with that,
14 I will turn the floor over to Colonel Malcolm for
15 the conclusion.
16 COLONEL SCOTT MALCOLM: So,
17 Commissioner Marrocco, Commissioner Coke,
18 Commissioner Kitts, once again, thank you for the
19 opportunity to appear before you today.
20 Just a few concluding statements. So
21 premised on the needs-based health workforce
22 planning, the CAF deployed a highly versatile and
23 disciplined team in support of provincial partners
24 to stabilize COVID-19 outbreaks in a number of
25 Ontario long-term care facilities.

1 At that difficult point in time, these
2 CAF members worked collaboratively with facility
3 staff and immediately addressed any patient
4 concerns they observed. Documentation of these
5 concerns has provided a snapshot in time of the
6 challenges faced by these facilities and an
7 opportunity to address them going forward.
8 And with that, that concludes our
9 presentation for today depending on if you have any
10 additional questions.
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 I don't. Do the other Commissioners have any
13 questions? Additional --
14 COMMISSIONER JACK KITTS: No. Just a
15 comment that the Brigadier told us you would be a
16 wealth of information, and I think you've more --
17 you've over-delivered, so thank you.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Yeah, I think that's --
20 Commissioner Coke, would you agree?
21 COMMISSIONER ANGELA COKE: I just
22 wanted to echo the thank you. It was very
23 informative, very helpful.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Yes, and me too, you know, and thanks. Please --

1 it's, sort of, not enough to say -- to extend the
2 Commission's thanks to the men and women who did
3 this. But it's very clear that this situation
4 would have -- at least in respect of the homes
5 where you were, would have spun out of control if
6 it hadn't been for your arrival, so thank you.
7 That concludes. We'd please -- and
8 thank -- thank the Brigadier for carrying out his
9 undertaking that he would fire both of you in here
10 to answer any and all questions that he couldn't
11 answer, and thanks again for doing that.
12 And with that, we're concluded.
13 Bye-bye.
14 COLONEL SCOTT MALCOLM: Thank you very
15 much. Have a good afternoon.
16 COMMISSIONER JACK KITTS: You too.
17 Bye-Bye.
18 COMMISSIONER ANGELA COKE: Bye.
19 -- Adjourned at 2:12 p.m.
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1 REPORTER'S CERTIFICATE
2
3 I, JANET BELMA, CSR, Certified
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1 Feedback / Comments -
2 Transcript of the Commission on LTCF meeting
3 29-Oct-20
4
5 Para #
6
7 Original Text:
8
9 Recommended Text:
10
11 Comments:
12
13
14 P.1 para#17
15 Robert Abramowitz, Legal Counsel, Department of
16 Justice
17 Ani Mamikon, Legal Counsel, Department of Justice
18 Ms. Mamikon replaced Mr. Abramowitz as an observer
19 at the committee appearance
20
21

22 P.4 para # 24
23 Mialkowski
24 Mialkowski
25

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2
3 P.5 para # 15
4 As a deputy Surgeon General
5 As Deputy Surgeon General
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9 P. 5 para # 21
10 Health services
11 CAF Health Services
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15 P. 7 para #23
16 D and D
17 DND
18 Department of National Defence
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21 P.11 para #2
22 Cadre of nurses and our cadre
23 Cadre of nurses and our cadre
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2 P.11 para #17
3 CAF troops and nonclinical
4 CAF troops in nonclinical
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8 P.12 para #18
9 Mialkowski
10 Mialkowski
11 Throughout the transcript
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14 P.13 para #10-11
15 Chief of the Defence Staff
16 Chief of the Defence Staff
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20 P.13 para #12-13
21 Task force laser, joint task force central
22 Task Force LASER, Joint Task Force Central
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1 P.13 para #14-15
2 Commander and brigadier general Mialkowski
3 Commander, Brigadier General Mialkowski
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7 P.13 para #16
8 Territorial Battle Group 1
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13 P.13 para #17
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