BRIEF

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Chronicle of a foreseeable tragedy

Investigation on the management of the COVID-19 crisis in CHSLDs

FIQ | SECTEUR PRIVÉ

Summary

Brought on by the political, budgetary and managerial decisions made over the last decades, the COVID-19 crisis in Quebec CHSLDs came as a brutal blow to the population. FIQ and FIQP healthcare professional members became increasingly alienated as the government severely misreported what was happening in care settings and then suspended their rights at a time when it should have been transparent and collaborative. They were on the front lines and not adequately informed, screened or protected. The contingency plans, lack of recognition of the complex care required in CHSLDs, and the poor working conditions causing a professional exodus cumulatively rendered staff incapable of offering all the required care to residents.

There are deficiencies at several levels of the health network, including the absence of a culture of prevention and the refusal to apply the precautionary principle. During this pandemic, confusion over roles among organizations responsible for health and safety led to contradictory opinions and contested decisions, including the one to limit access to N95 masks in CHSLDs. Over the years, these structures have been mangled by chronic under financing and successive reforms, and now the staff mobility managers love so much for its flexibility has become a factor of transmission, something authorities are now trying to limit. CHSLD residents and the healthcare professionals attempting to care for them were long neglected and consequently ended up the main victims of the COVID-19 crisis.

To help determine sustainable solutions, the Federations propose the following:

The impacts of the COVID-19 health crisis on care quality for CHSLD residents

- Gradually implement safe healthcare professional-to-patient ratios

The effectiveness of infection prevention and control measures taken

- Integrate the precautionary principle into OHS policies, regulations and legislation in the health sector
- Implement the AOHS's four prevention mechanisms in the health network
- Ensure CHSLDs have full infection prevention and control teams
- Broad, fast and regular CHSLD staff screening
- Set up a provincial PPE emergency fund and issue an annual public report
- Set up a PPE distribution mechanism
- Ensure information transparency and access to data

CHSLD organizational and funding problems highlighted by the health crisis

- Assess the decision to focus efforts on hospital centres at the beginning of the pandemic
- Restore true proximity management in CHSLDs
- Review the information transmission process
- Review the ARHSSS's legislative provisions to better define the Ministry's and the CISSS's and CIUSSS's responsibilities and obligations to private institutions
- Strengthen guidelines for using private agencies
- Improve healthcare professionals' working conditions
- Increase CHSLD funding

FOREWORD

The Fédération interprofessionnelle de la santé du Québec–FIQ and the Fédération interprofessionnelle de la santé du Québec | Secteur privé–FIQP represent 76,000 healthcare professionals in nursing and cardio-respiratory care, which constitutes the majority of nurses, licensed practical nurses, respiratory therapists and clinical perfusionists in Quebec health and social services institutions. The FIQ and FIQP's strong foundation in the health network enriches their expertise, one that is valued and recognized by decision-makers from all backgrounds. The FIQ and FIQP represent healthcare professionals with diverse work experience who provide care across all areas of the health and social services network.

As first-hand witnesses of the healthcare system's daily operations, healthcare professionals see the effects of socioeconomic inequality on health, as well as the impacts of the decisions made at all levels of the political and hierarchical structure. The Federations are labour organizations with a predominantly female membership, composed of healthcare professionals, public and private network employees, and citizens who use these services. Through their orientations and decisions, the FIQ and FIQP strive to protect social gains and to achieve greater equality and social justice.

They have a strong mission to defend the interests and concerns of their members and the population.

INTRODUCTION

The COVID-19 pandemic hit hardest where authorities were the least prepared. Quebec CHSLDs quickly became the epicentre of a crisis that shook the health and social services network, and the collective shock was brutal. FIQ and FIQP member healthcare professionals were on the front lines of this humanitarian crisis as care givers and first-hand witnesses. They gave care and support to the most vulnerable people; they tried to accompany all patients, some toward the end of their lives, in extremely difficult conditions. In addition to a constant work overload that was already hindering their ability to provide quality care, they had to face a pandemic without timely access to the required protective equipment in a healthcare system that has been run down by 20 years of poor political decisions and management.

The government's strategy and actions should have been designed to mobilize them and give them the energy and cohesion necessary to get through the COVID-19 crisis. Unfortunately, that's not what happened: the government racked up missed opportunities, while healthcare professionals felt increasingly disrespected each time they heard the government's official statements misreporting the reality in the field. The government said there wasn't a shortage of personal protective equipment (PPE) and, on March 21, 2020, the MSSS issued Ministerial Order 007, suspending their rights and giving managers exceptional powers that were only to be used based on "specific parameters." FIQ and FIQP members will remember what came next for a long time—as expected, these powers were poorly used and, according to the Federations, abused. The measures in the ministerial order imposed 12-hour schedules and full-time positions on healthcare professionals, making it nearly impossible for them to balance their family and work lives. Some of them resigned.

Relaying and transmitting the situation on the ground, which was not reflected in the government's statements, took up a significant amount of energy during the pandemic. Some healthcare professionals broke the health and social services network's code of silence and spoke up. The Federations quickly developed tools to enable members to fearlessly sound the alarm, i.e., the web page "Je dénonce." The personal accounts collected have been sent to the ombudsperson.

We thought it was important to add our organizations' voices to that of healthcare professionals by analyzing the issues that led to this crisis and this investigation on the management of the COVID-19 crisis in CHSLDs. We will outline the main points of the FIQ and FIQP's analysis with a focus on the solutions needed, as members are still exhausted and the COVID-19 crisis is far from over.

IMPACTS OF THE COVID-19 HEALTH CRISIS ON CARE QUALITY FOR CHSLD RESIDENTS

Out of the 5,953 deaths in Quebec since the beginning of the crisis, 4,961 (83.3%) were residents in either a CHSLD (3,725, i.e., 62.6%), an intermediary resource (232 or 3.9%) or a private seniors' residence (1,004 or 16.9%).[1] The Federations believe that all of these vulnerable people in care/living environments died because the government neglected them for years, and because of the disastrous management of human resources in healthcare institutions.

Before the pandemic

In recent years, the FIQ and FIQP, along with many other organizations, including the Ombudsman, Coroner's Office, Committee on Health and Social Services, Conseil pour la protection des malades, and the FADOQ spoke up about the unacceptable problems in CHSLD care. There is a clear diagnosis and known solutions and yet nothing is changing. Instead, the situation is continually getting worse. The health network's CHSLDs have the highest number of adverse events with 224,817 reported events, i.e., 44.92% of all events in the health and social services network.[2]

The staffing shortage in CHSLDs cannot be boiled down to a lack of beneficiary attendants. CHSLDs are mini hospitals and residents' needs are not limited to hygiene care and help with eating. In CHSLDs, healthcare professionals provide complex care and assess the health conditions of vulnerable patients to determine a therapeutic nursing plan. They administer treatments and perform acts such as administering a significant quantity of medication, conducting diagnostic tests, giving end-of-life care and accompanying families. There is a serious shortage of nurses, licensed practical nurses and respiratory therapists to provide all required care to patients with complex health problems.

The Federations see the shortage as artificial, primarily because they believe it is caused in large part by terrible practice conditions, a significant work overload and mandatory overtime hours. As a result, many healthcare professionals are currently on disability, taking early retirement, quitting, choosing to move to a private agency or changing careers. They suffer from significant ongoing moral distress. They know they have to provide care in accordance with the law and their professional obligations but they don't have the means to do so.

Even before the pandemic, they couldn't complete a lot of care assistance and nursing care. For years now, healthcare professionals have had to continuously make distressing decisions about which care to prioritize due to the staffing shortage, underfunding, and employers' failure to take corrective action. Their decisions were dictated and amplified by care priority lists drawn up and approved by managers. There was also increased substitution of professionals in other job titles. All of this contributed to legitimizing not

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[1] « Répartition des décès selon la région sociosanitaire et le milieu de vie », data from October 10, [Online], [https://www.inspq.qc.ca/covid-19/donnees/regions].

[2] MSSS, « Rapport 2018-2019 sur les incidents et les accidents survenus lors de la prestation de soins de santé et de services sociaux au Québec ».

providing full care to seniors who have every right to receive safe, dignified and attentive care.

Living and care environments

Since 2014, the FIQ has observed that CHSLDs remain first and foremost care environments and that it is important that they be humane.[3] Ministerial orientations concerning the "living environment" approach were not truly applied there. This living environment philosophy would therefore remain theoretical without the necessary financial, human and material resources. While initiatives to improve food services and the physical environment can certainly improve the quality of life for elderly residents, humane care remains absolutely crucial.

Over the years, authorities have exploited the notion of living environment in order to reduce the percentage of healthcare professional staff and substantially increase the percentage of unprofessional staff, without taking into account patients' health conditions. Less professionals means less monitoring, less direct professional care, less safe care, and therefore a reduced ability to react in serious situations.

In the INESSS's recent report on practices in living/care environments, it says that "Having a sufficient number of staff on site remains a prerequisite for the success of several other proposed potential means. Various staff attraction, retention, promotional and recognition strategies can be implemented to ensure there are enough employees.[4]" (unofficial translation) The INESSS favours the notion of conciliation over the notion of balance.

The spread of COVID-19

COVID-19 infiltrated this weakened system and killed nearly 5,000 vulnerable people. In the end, the decisions to massively free up hospital beds, cease transferring residents to hospitals and completely prohibit the presence of caregivers didn't achieve the expected outcome. CHSLD residents and staff faced horrible situations: severe dehydration and malnutrition, incontinence briefs soiled for extended periods, people who died in solitude and were left in their rooms.

Initially, many healthcare professionals were sharing personal stories about PPE (sometimes kept under lock and key), the lack of precautions taken while awaiting a screening test result or the lack of guidance and training for those called in as back-up in CHSLDs who ended up feeling left totally on their own. What should have been done was regular, swift, broad screening to both identify infected people and reduce staff fear. In reality, the announced screening was done late and irregularly. As healthcare professionals became infected, the cycle of exhaustion that they were experiencing was exacerbated. Then, the fact that residents had to maintain social distancing and were socially isolated made things even more difficult for healthcare professionals.

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[3] FIQ, « Hébergement des personnes adultes en CHSLD : Passer de la parole aux actes », a brief submitted to the Commission de la santé et des services sociaux regarding the consultation on the living conditions of adults staying in residential and long-term care centres, January 2014.

[4] INESSS, « Conciliation du milieu de soins et du milieu de vie en centre d'hébergement et de soins de longue durée (CHSLD) », September 2020.

In the MSSS's recent investigative reports about the Herron and Ste-Dorothée CHSLDs, the investigators recognized that the care staff was working under highly difficult circumstances and observed a true desire to offer patients quality care throughout this period. The pandemic exacerbated existing problems, making it important to look at the system in which the staff has to work, which extends far beyond individual professional responsibility.

According to the FIQ and FIQP, the fact that authorities deliberately decided not to ensure sufficient nursing staff to meet patients' needs over several years unfortunately demonstrates very little consideration for their well-being and complex needs. The HR management model is based on the Lean method and its Just-in-time process. This model created job insecurity for care staff (part-time positions, float team positions, call-back lists, private employment agency staff upon request, unreplaced absences, substitution of professionals by non-professionals). Consequently, the health network is no longer able to quickly react to increase the level of care, including during a pandemic.

Ratios for safe, humane, quality care

The FIQ and FIQP have been recommending a promising solution for years. They have been exploring, testing, documenting, proposing and demanding the gradual implementation of safe healthcare professional-to-patient ratios. That said, they aren't the only ones recommending safe ratios. In 2016, the Committee on Health and Social Services recommended "That the Ministry of Health and Social Services update the standards regarding staff ratios to ensure adequate provision of care and services to residents based on their individual needs."[5] Very recently, in the report on the Ste-Dorothée CHSLD, the investigator concluded that "[…] given the increase in the clientele in CHSLDs, staff ratios should be updated, and there should be an increased presence of all healthcare professional types."[6] (unofficial translation)

This solution has proved effective internationally and is supported by conclusive evidence. Implementing safe ratios would establish, once and for all, a truly safe standard of care that wouldn't be subject to changing management practices or politics. In Quebec, safe ratios were put to the test in a series of pilot projects (which happened to catch the ombudsperson's attention in 2019), and five of which took place in residential environments (5 CHSLDs, including one EPC).

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[5] "The living conditions of adults staying in residential and long-term care centres," [Online], June 2016, p. 9, [http://www.assnat.qc.ca/fr/travaux-parlementaires/commissions/csss/mandats/Mandat-32725/index.html] (Viewed on October 15, 2020).

[6] « Rapport d'enquête sur l'éclosion de la COVID-19 au Centre d'hébergement et de soins de longue durée (CHSLD) Sainte-Dorothée », [Online], p. 13, [https://publications.msss.gouv.qc.ca/msss/fichiers/2020/20-834-05W.pdf] (Consulted on October 15, 2020).

The projects' solid results even won the support of network employers who worked with them. While we observed promising impacts, both for patients and healthcare professionals, we also observed an overall increase in the staff's ability to complete professional activities and an overall improvement in the practice. This included higher satisfaction among patients and their loved ones and better management of behaviour in cases of dementia and using restraints, as well as end-of-life care and fall prevention.

Ratio projects even helped to limit flu outbreaks, which is especially important in the context of a pandemic. Would having adequate care teams have helped to better handle the COVID-19 crisis? Scientific research that is beginning to look into ratios and the resilience of COVID-19 is tending, unsurprisingly, to show that, just like for other infections, better staffing also has an impact on preventing COVID-19 infection and subsequent death.

Patients and their loved ones would have everything to gain from safe ratios that guarantee stable, fully-staffed teams in CHSLDs. There is currently no standard that clearly enforces ratios at this time. Concern over the costs of ratios are legitimate. However, a number of very costly incidents and accidents could be prevented, i.e., falls and many workplace accidents. The savings generated from preventing them would finance the ratios.

Safe healthcare professional-to-patient ratios, proven effective by the pilot projects, stand out as an important catalyst for change in the health network, one that would promote workforce availability and bring down certain costs.

EFFECTIVENESS OF INFECTION PREVENTION AND CONTROL MEASURES TAKEN

"Care professionals need to be able to count on clear and transparent communication about COVID-19, justifiable public health decisions, and fair and equitable allocation of available resources, including PPE adapted to current care needs. The institution and employer play a key role in this."[7] (unofficial translation)

The scale of the COVID-19 catastrophe in Quebec isn't surprising (especially the high infection rate of healthcare professionals) given that there hasn't been a culture of prevention in the health network in the last 40 years. Apart from the MSSS's timid action plan to prevent risk and promote overall health, which initially excluded private CHSLDs and only tackled certain targeted risks, the health network has suffered from a lack of prevention since the passing of the AOHS. CHSLDs are completely under the radar when it comes to prevention.

Leading up to the first wave in early February 2020, the Federations were writing to the Public Health Agency of Canada to denounce its lack of leadership, contest its conclusions about COVID-19's modes of transmission and, above all, to express disbelief at the agency's refusal to apply the precautionary principle in the absence of a scientific consensus. Acknowledgement that the virus was potentially airborne would have had a

[7] COLLÈGE DES MÉDECINS, OIIQ, OIIAQ and OPIQ, « Énoncé de position sur la pénurie d'ÉPI », April 2020.

major influence on PPE recommendations and would have provided more protection for healthcare professionals and patients.

On September 3, 2020, the Canadian Institute for Health Information stated that up to 21,842 health workers in Canada were infected by COVID-19, which equals 19.4% of all reported cases. Quebec is by far the most-affected province with 14,007 infected workers (24.1%), while the global average is about 14% according to the WHO. This discrepancy is deplorable.

Incomplete infection prevention and control teams (IPAC)[8] and the chronic underfunding of this activity sector have majorly disrupted healthcare professionals' IPAC work. They deplore the fact that their expertise and recommendations do not receive proper recognition. The Federations believe that vacant positions should be immediately filled and adequate financing allocated.

Role confusion

The government's search for greater flexibility in managing the crisis, in particular through the unilateral suspension of many provisions of the collective agreement, combined with the CNESST's inaction, allowed Public Health and the INSPQ to interfere with the role of occupational health and safety (OHS). This confusion had a significant impact on the low level of protection healthcare professionals received.

It's important to point out the CNESST's absence in the health network at the beginning of the pandemic. It decided to end the joint provincial committee on prevention's meetings and to ask unions to postpone the deadlines for the MSSS's provincial prevention plan. Its activities were also significantly delayed due to the declared public health emergency. The Federations deplore the fact that the CNESST's inspectors didn't see the necessity of visiting institutions, and in fact refused to, and held their inspection meetings by phone.

The Federations believe that the CNESST's absence gave too much importance to the INSPQ's recommendations for protecting against infections and, as such, generated confusion around the Public Health's regulations and the employer's OHS obligations. The Federations believe the government should develop specific OHS expertise for the health network that is separate from that of public health.

Protective equipment

On April 24, 2020, the FIQ and FIQP asked the CNESST to immediately send inspectors to all health network facilities, including CHSLDs and private subsidized institutions, to conduct thorough inspections, ensure that fit tests were being done and that all work environments had all of the PPE required to ensure the safety of healthcare professionals' work. This last request stated that a sufficient quantity of N95 masks were required in all facilities throughout Quebec. CHSLDs, both public and private, were seriously neglected with regard to PPE provision.

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[8] The INSPQ's recommendation regarding IPAC teams in CHSLDs states that they must be made up of a full-time equivalent (FTE)/250 beds. For example, at the CIUSSS du Centre-Sud de l'Île-de-Montréal there is 1 FTE/450 beds.

Moreover, the Federations had to go before the Administrative Labour Tribunal (TAT) to demand adequate PPE to protect the safety of healthcare professionals. The FIQ and FIQP hired an expert themselves to analyze ventilation system problems in case the virus was transmitted through the air. They also asked the CNESST to conduct an environmental evaluation of the air quality (SARS-CoV-2 environmental sampling) and ventilation and air recirculation systems. The CNESST did not agree to conduct the evaluations systematically.

Without real infection protection expertise in the health network from an OHS perspective, and in the absence of preventive mechanisms, employers blindly followed the INSPQ's public health recommendations instead of fulfilling their own OHS obligations. However, according to the Federations, the INSPQ applies the precautionary principle arbitrarily when it comes to PPE, and bases it on questionable criteria, most notably on the amount of PPE inventory available, which shows disregard for how dangerous the virus is.

As the PPE inventory decreased, the INSPQ in turn recommended a lower level of protection in care settings without ever raising it again. What's more, some of the INSPQ's views about prolonging the use of masks, reusing them or disinfecting disposable masks are still circulating. This allows employers to resort to these practices despite the potential danger and uncertainty as to whether these methods are actually effective. These are last-resort solutions, and in the event of a real or potential PPE shortage, it is solely up to the employer to determine when such methods are called for.

On several occasions, the Federations called on both the INSPQ and the MSSS to clarify what they meant by "careful use" of resources and by "potential shortage" and "real shortage." They never received any clarifications. Today, it appears as though the employer, backed by the INSPQ, refused to apply the precautionary principle and therefore to offer the highest level of protection against the airborne transmission of the virus to healthcare professionals and, ultimately, their patients.

The MSSS systematically refused to send unions full data on PPE stocks, which was available and precise, as an access to information request later revealed. Without the request, the unions would never have received this information. The MSSS's lack of transparency played a part in weakening the trust between unions, the ministry and employers, a trust that is essential to carrying out any prevention processes.

The beginning of the COVID-19 crisis was marked by a shortage of PPE. What's more, the Premier's contradictory statements on PPE availability, the INSPQ's many temporary recommendations that went beyond its scope of expertise, the confusing information about infection prevention and control circulating in the field (and healthcare institutions' various interpretations of it) all helped to muddle communication and sow uncertainty among healthcare professionals, in addition to complicating how they exercise their clinical judgement.

The government should create a provincial emergency stock of PPE and determine quantities based on the precautionary principle. It should perform annual quality control and produce an annual inventory report. A distribution mechanism should be set up to ensure that all facilities have PPE.

The precautionary principle should be a constant and integral part of health sector policies, regulations and legislation. Moreover, the government should oblige the health network to implement the four prevention mechanisms stipulated in the AOHS. Prevention approaches must involve all stakeholders equally and be organized locally to suit local situations.

CHSLD ORGANIZATIONAL AND FUNDING PROBLEMS HIGHLIGHTED BY THE HEALTH CRISIS

The health and social services network had barely recovered from a major reform started in 2003[9] when the Liberal government in power undertook another major reform in 2014.[10] This reform created the CISSSs and CIUSSSs, institutions that grouped all missions provided for in the *Act Respecting Health Services and Social Services* (ARHSSS).[11] They are responsible for providing populations in a given territory with all care and services, in addition to recovering certain responsibilities that had been entrusted to the regional health and social services agencies.

Several parties, including the Federations,[12] voiced opposition and serious concerns about the impacts of the new restructuring, both for patients and healthcare professionals working within the network institutions' various missions. As Bill No. 10 was being analyzed, the Federations voiced their fears about how it would shrink the importance of certain missions within the mega-institutions. They mentioned how "the lack of guidelines covering the protection of the missions in the bill will end up promoting hospital-centrism and a curative mission to the detriment of missions that focus more on prevention and social aspects and receive less financial and other resources."[13]

These two major reforms over the course of ten years were supposed to tangibly improve care access and continuity and put the patient first. Clearly, these objectives were not met. The health and social services network is weak and in unprecedented danger. The restructuring and budget cuts were particularly damaging to components that are essential during a pandemic, such as public health. The pandemic exacerbates the extreme vulnerability of the health system (as illustrated in the CHSLDs), a system that is very dear to the Quebec people.

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[9] Act respecting local health and social services network development agencies. Passed under a gag order in December 2003.

[10] Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies. Passed under a gag order in February 2015.

[11] R.S.Q., chapter S-4.2.

[12] FIQ, Bill 10 - *Prelude to an announced dismantling*, brief, 2014.

[13] *Id.*, p. 14.

Hospitals at the centre of the governmental strategy

In February 2020, there was already news from Europe that institutions providing care to the elderly were getting hit hard by COVID-19. In British Columbia in early March, two residential centres were affected by an outbreak and many deaths followed. Despite these documented and publicized situations, Quebec was slow to react and to take measures to protect against the pandemic, especially in CHSLDs.[14] The MSSS asked institutions to free up beds in hospitals, and several seniors from these hospitals were transferred to public and private CHSLDs. CHSLDs, already struggling with a longstanding staff shortage, had to continue providing patient care and properly protect care staff during a pandemic. What's more, healthcare professionals had to provide care similar to that provided in hospitals since patients were no longer being transferred to hospitals, all while short staffed and without the same access to resources and PPE.

As the Federations see it, the choice to focus all efforts on hospital centres needs to be seriously re-evaluated. CHSLD healthcare professionals have been asked to perform miracles in a catastrophic situation, often to the detriment of their own health and that of their patients, in an effort to compensate for shortcomings in health care organization. The expression "keeping the network afloat" rings all the more true for healthcare professionals, especially in the last few months. According to the Federations, it is absolutely urgent to lighten the enormous burden on healthcare professionals and to recognize the true value of their work.

Lack of proximity managers and communication flow

The last two reforms' centralization efforts translated into the absence of proximity managers in CHSLDs during the first wave of the pandemic. The absence of proximity managers created many problems, making it more difficult for healthcare professionals to carry out daily tasks. The imposing hierarchy in CISSSs and CIUSSSs combined with the absence of proximity managers made it difficult to make quick, effective decisions. There was a total lack of managers who knew the care settings, which created a sense of insecurity among CHSLD staff and a serious communication breakdown.

This problem is well-documented in the recent report on the COVID-19 outbreak in the Ste-Dorothée CHSLD.[15] According to the investigator, the many findings apply to almost all CHSLDs that have the same problems. This finding was mentioned in the government's action plan for the second wave, published in August.[16] The government stated that from now on there will be one manager per CHSLD within the CISSSs/CIUSSSs. Moreover, the Federations firmly believe that the MSSS and healthcare institutions should review their whole communication process in order to make it smoother and better aligned with the reality in care settings.

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[14] [https://www.tvanouvelles.ca/2020/06/09/la-colombie-britannique-a-bien-mieux-gere-la-crise-1]

[15] MSSS, « Rapport d'enquête sur l'éclosion de la COVID-19 au Centre d'hébergement et de soins de longue durée (CHSLD) Sainte-Dorothée », July 15, 2020, p. 12.

[16] GOUVERNEMENT DU QUÉBEC, "COVID-19: An Action Plan for the Second Wave," August 18, 2020.

Staff mobility

Unlike Quebec, British Columbia adopted restrictive measures to prohibit staff mobility as soon as the pandemic broke out within residential centres. As a result, the spread slowed and work teams stabilized. Meanwhile, in Quebec, moving staff around remains a regular practice despite an announcement to prohibit it and the clear proof that it is often the source of outbreaks within institutions. An employer will move workers around within the same CISSS/CIUSSS as well as staff from private employment agencies. Agencies have profited from the pandemic without government intervention up until very recently. Workers who are transferred between facilities can unfortunately become vectors of transmission for staff and patients.

The Federations have seen very little effort from management to stop this practice or to propose sustainable solutions that would benefit healthcare professionals and patients. Time is running out: the government needs to take immediate steps to improve healthcare professionals' day-to-day and that of resident patients. It also needs to regulate hiring from private agencies.

The responsibility of CISSSs and CIUSSSs to residential institutions (private subsidized institutions and private CHSLDs) within their territory

Since the 2015 reform, it has been up to the CISSSs and CIUSSSs to monitor and oversee the quality of services in private institutions located within their territory and to support them. Many healthcare professionals who work there have noticed a lack of cooperation from CISSS/CIUSSS managers. Private institutions' repeated requests for PPE and additional staff were not paid much heed. The lack of support from managers created a lot of uncertainty and insecurity among healthcare professionals providing care to residents. The Federations second the recommendation in the investigative report on the Herron CHSLD[17] regarding the need to review the legislative provisions in the ARHSSS in order to better define the responsibilities and obligations of the Ministry and CISSSs/CIUSSSs to private institutions.

[17] MSSS, « Rapport d'enquête sur les événements survenus dans le cadre de la pandémie de la COVID-19 au CHSLD Herron », June 2020.

Funding

CHSLD funding is still way too low to meet residents' needs. The current government's budget for them is not sufficient. Every day there are stories that confirm the staff's inability to meet residents' different needs, despite healthcare professionals' determination to provide all the care needed in these institutions. Serious efforts must be made to improve the care and services offered and to ensure respect and dignity for all. However, to achieve this, the government needs to increase funding to these institutions and to stop using accounting management principles that use the budget to determine the care offered rather than people's needs. The pandemic laid bare the consequences of this underfunding and management style.

CONCLUSION

There should never be another high death toll like the one we saw last spring. The Federations believe that an autopsy of the COVID-19 crisis in Quebec CHSLDs is essential. They will conduct one to the best of their ability and broadly share their findings. That said, this situation is not fully behind us and the dust has not completely settled.

Looking beyond the tragic events, some solutions used during the pandemic should be implemented long-term. The Federations have long been advocating to break down professional barriers and to allow healthcare professionals to be able to fully exercise their field of practice, however, it has taken a pandemic for it to happen.

The cracks through which COVID-19 infiltrated into CHSLDs, freely wreaking havoc, are the result of a series of poor political, budgetary and management decisions made over the last 20 years, all stakeholders agree. The indifference over the years significantly contributed to this tragedy.

However, it is up to the current government to manage this crisis. While this situation requires a deep analysis and reflection from us all, this does not prevent the government from quickly adjusting its approach to ensure that the trust needed to get through this crisis isn't broken down further. The seniors home project the government is clinging to seems insignificant in light of the gravity of this crisis, especially as it seems to be missing the point as it focuses solely on humanizing the living environment while neglecting to humanize care. The government will need to take stock of the scale of the post-crisis findings and take into account the solutions that emerged and were proposed if it wants to strengthen the public health system.