REVERA PANDEMIC REPORT: A PERFECT STORM

CHAPTER SIX

Unwritten

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This report is dedicated to Revera's employees, residents, their families, and all those on the front lines of the senior living sector who are working through the worst pandemic in living history.

The findings of the Revera Expert Advisory Panel illustrate the pressing need for a new era of investment in the health system [...] to support the long term care sector

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Through the spring and summer of 2020, nowhere in the country was a Canadian more likely to die of COVID-19 than inside a long term care home. In these homes, built to look after the elderly who can no longer look after themselves, the novel coronavirus took the lives of more than 7,000 residents between March and September – mothers, fathers, wives, husbands, grandparents, friends. The toll will forever stand as a bleak chapter in the history of a nation that prides itself on the protection it provides its vulnerable citizens.

As the pandemic rages on, there are chapters yet to be written. If they are to tell a different story, a better story, it is crucial to act on what can be learned from what came before. It was with this goal in mind that Revera Inc., which operates 170 long term care homes and retirement residences in six provinces, took the unusual step of assembling an independent panel to review the company's experience in the first wave of the COVID-19 pandemic.

More than two-thirds of Revera's 74 long term care homes are based in Ontario. As a result, the Revera Expert Advisory Panel focused its analysis largely on the experience in Ontario, where the most severe of the company's 87 outbreaks occurred during the pandemic's first wave. Additionally, the report largely focused on long term care, the hardest hit sector in the country. With experts from various spheres of medicine – including specialists in geriatrics, infection control and healthcare design – the panel drew on Revera's internal data as well as public health information to identify factors that contributed to the COVID-19 tragedy, and to provide recommendations.

There were, to be sure, circumstances beyond any human control. Compromised by weaker immune systems and, often, a range of underlying conditions, residents in long term care tend to face the highest risk of poor outcomes with any infection. This virus in particular, as the earliest mortality statistics made clear, poses an especially lethal threat to the aged.

Then, too, there was the sobering discovery that the new pathogen had the capacity to be spread by people without noticeable symptoms of infection, and that the infected can be most contagious before they develop any symptoms. Without that knowledge, the novel coronavirus went undetected as it first entered congregate settings, and, in several sites, flourished.

At the same time, in the pandemic's early days, few recognized that COVID-19 is a master of disguise. Its diverse and ambiguous array of head-to-toe symptoms were easily missed.

The panel found that the magnitude of the COVID-19 crisis was amplified by a combination of historical challenges in the long term care sector and the health system's tendency to prioritize acute care over chronic care. Staffing challenges and old buildings that fail to meet current design standards were among the sector's pre-existing problems – all of which were exacerbated by a health system that neglected the needs of seniors' homes as it rallied to support hospitals.

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The starkest example of this oversight was the decision to reserve the country's scarce supply of personal protective equipment (PPE) for hospital staff, and to overlook the requirements of healthcare workers in long term care homes. This move, which provided congregate homes access to government-purchased PPE only if they already had an outbreak, resulted in larger long term care operators with strategic sourcing capabilities, like Revera, creating their own consortium to purchase PPE at the height of the crisis in order to distribute life-saving PPE to smaller operators across the sector.

Meanwhile, surveillance testing that would have identified infected staff members and residents were introduced only toward the end of the first wave in Ontario – and not at all in most other provinces. If regular surveillance testing of staff had been available, it is likely homes would have been alerted when someone was positive, allowing for prompt care, isolation and quick contact tracing to occur.

Although testing lagged across the country, the lack of tests for long term care residents and staff meant that not only did individual cases go undetected, but so did rising caseloads within a home, which, if recognized, would have triggered efforts to tighten infection control and create resident cohorts to keep the healthy away from the sick. As it was, the unfortunate chain of events led to outbreaks where dozens of infections seemed to suddenly appear out of nowhere.

While most of Revera's homes were unaffected, or involved just a single case, some long term care homes suffered mightily in the first wave. Under lockdown, residents endured the psychological pain of going months without seeing loved ones, who had been barred by restrictive visitor policies. Long term care doctors, afraid for themselves and vulnerable family members, declined to visit residents in person. Various health authorities added to the chaos with contradictory directions, while homes were discouraged from transferring their infected residents to local hospitals.

The panel found that the shortage of personal support workers (PSWs) in Canada was compounded by the single-site rule that several provinces rightly enacted to prevent staff from working at more than one site. The numbers of these essential frontline workers also dwindled as they themselves became infected and countless others had to be quarantined, while fear spread among employees. At Revera, more than 500 staff members stopped showing up for work without explanation.

With rising case numbers, containing COVID-19 became an epic struggle that stretched into months in some homes, particularly at older, outdated sites in Ontario. These '70s-era homes, with their four-bed wards and communal bathrooms, were the most powerful predictor of Revera's longest and deadliest outbreaks. More than a third of the province's 79,000 long term care beds are in similarly outdated facilities, yet efforts to upgrade them have stalled for 22 years.

Together, these factors added up to a system that failed to protect the vulnerable seniors in its care. But the panel has pinpointed measures to mitigate their impact, which, if implemented, may prevent history from repeating itself.

THE WAVES BEYOND

Armed with knowledge that was unavailable when the pandemic first emerged, science now understands more about the wily nature of this novel coronavirus – and this can make a profound difference to containment efforts. A deep supply of medical-grade masks, for example, and other elements of PPE must be on hand for all long term care employees and the various healthcare workers, doctors included, who might visit a home. Congregate living supervisors must monitor COVID-19 prevalence rates in

the communities where the home is located as well as in the areas where staff members live. As Revera data clearly shows, rising caseloads in communities lead to more infections within long term care homes and retirement residences. When community prevalence increases, so too should public health's prioritization of surveillance testing of staff, visitors and residents – since more than a third of infected individuals may be asymptomatic. Once available in Canada, the government should prioritize senior living settings when providing access to rapid, point-of-care tests, with the goal to integrate these into active screening procedures – particularly when COVID-19 cases are known to be rising in the area.

A positive test result of a staff member or resident should immediately set in motion efforts to isolate, conduct contact tracing and quarantine those who may have been exposed, particularly as it relates to separating residents from one another as needed. The risk of transmission will be further reduced by eliminating shared rooms wherever possible and, as the panel's design team recommends, expanding areas that allow for greater social distancing between residents, staff and visitors.

Working to create more full-time staff positions, with employees trained in infection prevention and control, is also bound to improve outcomes. As Revera's own data indicates, the ability to retain PSWs, and to ensure their satisfaction on the job, depends in large part on their full-time status. Indeed, in B.C., where cases and deaths among long term care residents were significantly lower than the toll in Ontario, the province took measures early in the first wave to promote promote full-time work, standardize wages among staff, and enable working in a single site.

The efforts of staff in long term care homes in the midst of outbreaks were, in many cases, heroic when they were left short-handed to look after residents, especially given the absence of family caregivers. Designating family caregivers as essential visitors, despite the pandemic, would benefit both the mental health of residents and the workload of those employed to care for them.

Similarly, the panel recommends that long term care homes forge closer relationships with infection control specialists and their local hospitals – well before the moment of need.

AIM HIGH

The loss of life in the long term care sector accounts for most of Canada's deaths during the pandemic's first wave, a proportion of COVID-19 mortality rates unrivalled by any other wealthy country. The impact has forced a national reassessment of the state of long

term care, and underscored the urgent need for reform. While this report has explored some of the factors that contributed to the scope and severity of the COVID-19 experience in long term care homes in the first wave, it cannot fully address why the needs of a sector that is home to nearly half a million seniors were not prioritized by the health system in pandemic preparedness and planning. What can be said is that there has never been a more powerful catalyst for change.

The findings of the Revera Expert Advisory Panel illustrate the pressing need for a new era of investment in the health system by all levels of governments, and a new era of collaboration among the system's many players – public health units, hospitals, physicians, nurses and their governing bodies, healthcare and personal support workers and their unions – to support the long term care sector and its employees, residents and their families.

While the review based its conclusions on data collected through the first wave of COVID-19, the panel's recommendations should serve as a guide to navigate not just further waves of the current pandemic, but whatever future contagions appear on the horizon. The novel coronavirus is not the first pandemic microbe to humble the world, and it is unlikely to be the last. At the same time, the population most vulnerable to infection, the elderly, is a burgeoning demographic that will inevitably require various levels of care in a range of congregate settings. For them, their families, and the staff who will care for them, it is critical to act on the hard lessons learned from COVID-19 in order to live up to the aims of a compassionate society.

Our Expert Advisory Panel

Special thanks to our expert advisory panel for their hard work and insights:

Dr. Bob Bell, Chair, Former Ontario Deputy Minister of Health and former President and CEO of University Health Network. Dr. Bell agreed to participate in and chair this advisory committee. Revera agreed that Dr . Bell will have final editorial approval of the committee's report.

Dr. Diana Anderson, Healthcare architect and board-certified internist, Dochitect

Bob Bass, Bass Associates Professional Corporation

Dr. Vivek Goel, Vice President, Research and Innovation at the University of Toronto; Founding President and CEO, Public Health Ontario

Santiago Kunzle, Director and Principal, Montgomery Sisam Architects Inc.

Dr. Mark Loeb, Professor, Departments of Pathology and Molecular Medicine and Health Research Methods, Evidence, and Impact, McMaster University

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