Ombudsman Saskatchewan
Promoting Fairness

Caring in Crisis

An investigation into the response to the COVID-19 outbreak at Extendicare Parkside

LONG-TERM CARE IN SASKATCHEWAN

The Ministry of Health is responsible for the strategic direction, goals, and objectives for the health care system in Saskatchewan including long-term care. It gives funding to the Saskatchewan Health Authority, which is responsible for delivering these services, either directly or under contracts with privately-owned and operated health care organizations. Extendicare (Canada) Inc. operates five long-term care (special-care) homes in Saskatchewan under contract with the Authority. Regina's Extendicare Parkside is one of them.

THE FOCUS OF OUR INVESTIGATION

Following a request from the Minister of Mental Health and Addictions, Seniors and Rural and Remote Health, we investigated Extendicare's handling and response to the COVID-19 outbreak at Extendicare Parkside declared on November 20, 2020. 194 of Parkside's 198 residents and 132 of its staff got COVID-19 during the outbreak. 42 residents who got COVID-19 died during the outbreak – for 39 of them, their cause of death was COVID-19. We investigated whether Extendicare's response to the pandemic and outbreak was reasonable and met provincial requirements. We also investigated whether the Ministry and the Authority provided Extendicare reasonable governance, oversight and support during the pandemic and outbreak. We focused on the administrative decisions made and actions taken by each of them in five key areas that exemplify the challenges and opportunities they had to prevent Parkside's residents and staff from getting COVID-19 and to respond effectively to the outbreak:

1. General Pandemic Planning and Management
2. Parkside's Physical Layout and Limitations
3. Supply and Use of Procedure Masks
4. Limiting the Spread of COVID-19 From Resident to Resident
5. Staff and Staffing

FINDINGS

Provincial legislation requires the Authority and health care organizations to complete a critical incident review of any serious adverse health event related to a health service they provide. These reviews must be reported to the Minister of Health. Their purpose is to improve health system quality and safety so similar incidents do not recur. The Parkside COVID-19 outbreak was a very serious critical incident. Extendicare has not conducted a critical incident review of it as required by provincial legislation.

General Pandemic Planning and Management

The Ministry's *Program Guidelines for Special-care Homes* require all homes to establish a pandemic plan. By mid-2020, the Authority required all homes to complete a detailed pandemic planning task checklist to ensure they were prepared for a COVID-19 outbreak. Extendicare's *Corporate Pandemic Plan*, which it revised to address COVID-19, required Parkside to develop a facility-specific Emergency Preparedness/Disaster Plan that met the requirements of its *Pandemic Plan* and to also follow Saskatchewan's provincial pandemic plan.

Despite having extensive corporate-wide policies and procedures that met the requirements of the Ministry's *Program Guidelines,* Extendicare did not ensure Parkside fully complied with them. Although its corporate leadership consistently communicated the need to be ready for an outbreak and ensured internal resources were available to help with planning, Extendicare did not effectively ensure Parkside successfully implemented a facility-specific pandemic plan to address the particular risks associated with its limited space, its multi-bed rooms, its readiness to manage a serious outbreak, or that it complied with the Ministry's public health orders regarding physical distancing among its residents and staff.

As late as the end of October 2020, Parkside had not yet fully implemented many of the key requirements necessary for it to be able to effectively respond to a serious outbreak. It did not have a staff contingency plan in the event significant numbers of its staff had to self-isolate, and it had not properly implemented good infection prevention and control practices.

Parkside's Physical Layout and Limitations

For many years, the Ministry, the Authority and Extendicare have been aware that the age, condition and layout of the Parkside facility did not meet current, reasonable standards. Extendicare has been lobbying the Ministry to pay it to replace its Regina long-term care facilities since at least 2010 – it continued to lobby the Ministry during the pandemic.

As early as March 2020, Authority and Extendicare officials were aware that Parkside would be in serious trouble if it were to have a major COVID-19 outbreak because so many of its residents were crowded into 4-bed rooms. Despite discussing this concern, neither of them took meaningful, proactive and effective steps to deal with it before the outbreak. Instead of reducing Parkside's population so no more than two residents shared a room, the focus was on having a few vacant rooms available to isolate COVID-19 positive residents.

The Authority's pandemic planning efforts focused on having extra temporary acute care space for COVID-19 patients, not on eliminating Parkside's 4-bed resident rooms to prevent them from getting COVID-19. It had hundreds of empty beds across the province in case it needed them for acute care, but it did not eliminate Parkside's and other facilities' 4-bed rooms. When the outbreak was declared, many of Parkside's 198 residents were crowded into 4-bed rooms. Since the outbreak, Parkside has no more than two of its 160 residents share a room. Extendicare and the Authority should have reduced Parkside's resident population in mid-2020 before the outbreak.

The Minister of Seniors specifically asked the Ombudsman to investigate whether the conditions in Parkside impacted the transmission of COVID-19 within the facility. The answer is yes. But this should not come as a surprise. The Ministry, the Authority and Extendicare have been aware of Parkside's overcrowded rooms, crowded office areas and break rooms, narrow hallways, and lack of adequate storage for over a decade.

Supply and Use of Procedure Masks

There were initially concerns about a shortage of procedure masks, but by late April 2020, there was a steady supply available. Since then, the Authority has been providing all special-care homes, including Parkside, with procedure masks free of charge, ensuring they would have enough to comply with the Authority's continuous masking principles and guidelines. To deal with the risk of self-contamination, these guidelines required all staff working with residents to wear a mask at all times, and to discard them if soiled, when taking breaks, and at the end of each shift. This meant giving staff at least four masks per shift. Extendicare's *COVID-19 Universal PPE Strategy* directed its Saskatchewan managers to follow these rules. However, Parkside did not. Instead, it followed Extendicare's practice in other provinces: giving staff one mask per shift and a paper bag to store it in during breaks – though they could get another one if it became damaged or soiled. This practice continued into the outbreak.

While the Authority made it clear to Parkside that it should be using four masks per day, it did not try to enforce it. Both Extendicare and Authority officials believed that Parkside did not have to comply with the Authority's masking guidelines, even though the *Principles and Services Agreement* under which Extendicare provides long-term care at Parkside provides for the Authority to insist that Extendicare follow the standards and practices the Authority follows in its own long-term care homes. The Authority's 'hands-off' approach and Extendicare's 'back off' approach was detrimental to ensuring Parkside managed the pandemic consistently with other long-term care homes.

Limiting the Spread of COVID-19 From Resident to Resident

Communal Dining

Parkside was required to comply with the public health orders limiting the size of indoor public gatherings. For a period, indoor gatherings were limited to 10 people. It was practically impossible for Parkside to feed all its residents from its dining rooms and comply with this limit. The Ministry's and Authority's dining guidance to long-term care homes on how to implement the orders, was insufficient for Parkside, which did not have adequate space to maintain social distancing among residents while they ate. The dining guidance relied on basic, incomplete assumptions about how long-term care homes are laid out and about what it takes to seat, feed, and clean up after 200+ residents. While the Ministry had the legal authority to impose gathering limits on the long-term care sector, it took no role or responsibility for ensuring they could be implemented. It left it to the Authority and long-term care home operators to figure out how they were going to comply.

Extendicare immediately understood that it would essentially be physically impossible for it to comply and relayed this to the Authority. Steps could have been taken to reduce Parkside's resident population then, which would have made it much easier for Parkside to maintain social distancing among residents and have reduced the risk of a serious COVID-19 outbreak.

Resident Masking

A public health order came into effect in Regina, Saskatoon and Prince Albert on November 6, 2020, requiring Parkside residents to wear masks when not in their private rooms, unless they were eating, had a medical condition that prevented them from wearing a mask, or a cognitive impairment that made them unable to understand the requirement. This order became province-wide on November 18, 2020.

Extendicare and some Authority officials responsible for long-term care were not aware of this requirement until late December 2020. As a result, Parkside did not comply with the public health

order for the two weeks leading up to the outbreak, and likely other long-term care homes also did not comply with it, possibly for most of November and December 2020.

By the time the Authority and Extendicare realized Parkside had not been complying with the masking order, the Authority had already taken over Parkside, almost all of Parkside's residents had contracted COVID-19, and many had already died.

In our view, ensuring Parkside's residents wore masks outside their rooms, would have reduced the risk of serious outbreak.

Moving Residents After the Outbreak

Parkside's pandemic plan included isolating all COVID-19 positive residents in a hallway of its north wing. Instead of implementing its plan, when the first several positive residents were from the main wing, it decided to leave them on the main wing. This was a mistake. Staff working with residents on other wings had to frequently travel through the main wing to get supplies, so Parkside could not keep staff working on the non-COVID-19 wings out of the COVID-19 wing – this increased the risk of transmission. Then, by the time it realized it had positive cases all over the facility, it had to quickly convert its entire north wing (not just one hallway as planned) into a COVID-19 wing, and move all COVID-19 positive residents, which it did over three days.

By the time this decision was made, a few things were clear. Parkside's pandemic plan did not have any details to help staff safely and effectively move its entire north wing population out while simultaneously moving all COVID-19 positive residents into it in such a short period of time. Its plan only addressed minor outbreaks in which one or a few positive residents needed to be moved. As well, because Parkside was cramped and by then understaffed because so many of its staff were in isolation, it did not ensure residents were continuously masked (and gowned), and it did not fully clean and disinfect resident rooms each time positive residents were moved. Even after the move, because it was so short-staffed, Parkside continued to not cohort staff to the COVID-19 unit. Not cohorting staff, coupled with staff not socially distancing during their breaks, seriously increased the risk of staff transmitting the virus from the COVID-19 unit to the non-COVID-19 wings.

Staff and Staffing

Access to Professional Health Care Services

In April 2020, changes were made so physicians providing care in long-term care could only bill for one visit every 14 days for non-urgent care. At the same time, changes were made to allow physicians to provide care through telephone and virtual assessments. This effectively eliminated on-site physician visits to Parkside for most of 2020. It created additional pressure on its nursing and other care staff when the pandemic was already placing once-in-a-lifetime pressures on them. We were told that December 2, 2020, was the first time a doctor physically entered Parkside since the start of the pandemic.

Staff Screening for COVID-19 Symptoms

Upon entry to Parkside, staff were required to get their temperature taken, complete a COVID-19 screening tool and sign a form acknowledging that they had done so. Any staff member who displayed or disclosed COVID-19 symptoms was to be denied entry. When we asked for copies of staff sign-in forms to confirm this was being done leading up to the outbreak (since it was evident staff were entering Parkside with symptoms), Extendicare told us they had been destroyed.

While both the Authority and Extendicare had policies and tools in place to screen staff before entering a facility – to help keep COVID-19 away from vulnerable, captive residents – they were of no use if they were not properly implemented. Parkside management told us its screening protocols were consistently followed, but many of its staff said they were not. Since so many of its staff came to work with COVID-19 symptoms and entered the facility, we found that Parkside did not effectively implement and administer staff screening protocols to comply with the public health order.

Staff Testing for COVID-19

Since June 2020, Extendicare lobbied the Ministry to bring on-site rapid testing to its Saskatchewan homes – citing that it was successful in limiting the spread of COVID-19 in its Ontario homes. The Ministry refused its requests, because, it said, it did not have enough resources to roll it out province-wide, and that the other measures in place at the time were effective in keeping COVID-19 out of long-term care facilities. It did not know that Parkside was not properly implementing these measures. Rapid testing was implemented at Parkside beginning on December 8, 2020 – too late to save any of its residents. Province-wide rapid testing was introduced at continuing care facilities in January 2021.

The Minister of Seniors specifically asked the Ombudsman to investigate the extent to which early learnings from other jurisdictions informed Parkside's pandemic planning. However, the Ministry knew as early as June 2020 when Extendicare first began advocating for it, that rapid testing long-term care staff on-site in Ontario helped stop the spread of COVID-19.

Staff Social Distancing

Some Parkside staff were not following physical distancing and other prevention measures while at work (i.e., on their breaks). This contributed to the spread of COVID-19 leading up to and during the outbreak. Staff were entering Parkside with COVID-19 symptoms and then eating and visiting with one another on their breaks without wearing masks or staying apart.

Parkside failed to ensure that its staff complied with the public health orders to maintain proper social distancing and wear masks when social distancing was not possible. This continued even after the outbreak was declared. While each employee who did not comply with the orders is personally responsible for their behaviour, Extendicare was responsible for the safety of its residents.

Staff Cohorting

The April 17, 2020 public health order required health service providers to restrict the movement of their staff so they only worked in one facility during the pandemic. This 'cohorting' order was to reduce the risk of staff transmitting COVID-19 among long-term care homes and other facilities.

The Authority and its official affiliates signed a letter of understanding (LOU) with employee unions so it could temporarily redeploy and assign a labour pool of workers and deploy a temporary COVID-19 supplemental workforce to address temporary health care needs during the pandemic. Extendicare is not an affiliate of the Authority, so it could not access the Authority's labour pool.

Because Extendicare only had access to its much smaller labour pool of workers from its five Saskatchewan homes, and because it was already having difficulty getting enough staff due to the high demand for health care workers brought on by the pandemic, it did not have enough of its own staff to be able to transfer them to Parkside to help during the outbreak – though some of its staff did volunteer to help.

Parkside's management and Authority officials who worked with Parkside did not understand this. They thought the Authority would be able to provide Parkside with staff in the event of an emergency. This significant misunderstanding contributed both to Parkside's failure to have an adequate outbreak staffing contingency plan, and to the time it took for the Authority and Extendicare to realize that the Authority needed to step in and take over managing Parkside under the co-management agreement. Had they been aware, they might have worked together to develop a COVID-19 supplemental workforce made up of non-union Authority, Extendicare and Authority affiliate staff and independent contractors to act as an outbreak staff replacement team to help with the Parkside outbreak.

Despite arranging for Parkside to have access to a labour relations consultant and other HR-recruitment resources, and despite understanding how important it was based on its early learnings from outbreaks in its Ontario homes, Extendicare did not – as was required by its own corporate pandemic plan – ensure Parkside had a plan to replace the Parkside staff who had to self-isolate because they got COVID-19 or were a close contact of someone who did. Because it did not have a sound outbreak staff replacement plan, when the outbreak hit, it was left scrambling – ineffectively – to find people to help. It arranged for members of the City of Regina's Fire and Protective Services to help, but they were not trained in long-term care. It arranged for continuing care assistant students from the Saskatchewan Polytechnic to help, but because it did not do this in advance and did not get input from Public Health, there was confusion about whether the students were allowed to be on-site, so they were initially sent home, only to be approved to return a few days later.

Had Extendicare planned for and arranged to have access to a temporary emergency replacement staffing team whether on its own or in collaboration with the Authority, it would not have struggled as much as it did when so many of Parkside's staff got sick or were sent into self-isolation.

Staffing Crisis

When the outbreak was declared, many Parkside staff were ordered to self-isolate because they were identified as a close contact of someone who had tested positive for COVID-19. Extendicare alleged that Public Health changed the definition of "close contact" during the outbreak, causing Parkside's staffing crisis. This is incorrect. The definitions of "close contact" applied to Parkside's staff were not new and Public Health did not make them up during the outbreak. They had been in place for at least six months before the outbreak.

We found Public Health did order two of Parkside's management staff to self-isolate without clear evidence that they met the definition of "close contact" out of an abundance of caution, but we found no evidence of this for the many other Parkside staff who were found to be close contacts.

Extendicare's allegation appears to be premised on an assumption that its staff consistently and correctly used appropriate PPE when dealing with COVID-19-positive individuals. While this may have been true for its staff's interactions with residents, it was not true for its staff's interactions with each other – many of them did not wear masks or maintain proper physical distance when eating and visiting together during their breaks, or while carpooling together, or while visiting with each other and others. This is why they had to self-isolate.

It was virtually impossible for Parkside to find adequate replacements for the large number of its staff that had to self-isolate after the outbreak started, but this was not because Public Health changed the self-isolation rules at the last minute. It was because of the general shortage of health care workers during the pandemic, because it was not an affiliate of the Authority so had no right to access the Authority's staff under its LOU, and, most significantly, because Extendicare did not have an outbreak staff contingency plan for when its staff got COVID-19 or had to self-isolate.

RECOMMENDATIONS

There are no recommendations an Ombudsman can make that could ever adequately address the tragedy that happened at Parkside or provide the basis for a public policy debate over how long-term care should be structured or funded. We do believe, however, that apologizing to its residents and their families is the least Extendicare could do. Further, in keeping with our mandate under *The Ombudsman Act, 2012*, our recommendations are made with a view to, hopefully, encourage those responsible for governing, supporting, overseeing, and providing long-term care to fully and honestly review all the circumstances of Parkside's response to the pandemic and the outbreak, to work together to fully understand what went wrong and what could have been done better, and then to make improvements to the way long-term care is provided, managed, and accounted for in Saskatchewan. We expect Extendicare and the Authority to report publicly on whether they accept our recommendations and on the timelines for their implementation.

Extendicare (Canada) Inc.

Parkside was lax in enforcing the public health orders and implementing effective infection prevention and control measures with its staff to ensure that COVID-19 stayed out of the facility or was at least better contained. Nearly all its residents got infected. It was woefully unprepared for the COVID-19 outbreak despite all the corporate-level planning Extendicare did, and all the support offered and provided to it by the Authority.

We recommend that:

1. **Extendicare (Canada) Inc. issue a formal, written apology to each of the families of the Extendicare Parkside residents who passed away as a result of the COVID-19 outbreak, and to all other Extendicare Parkside residents whose lives were disrupted because they got COVID-19, because they were displaced from their home to other facilities, and because they had to live through the outbreak.**
2. **Extendicare (Canada) Inc. conduct, in collaboration with the Saskatchewan Health Authority, a comprehensive critical incident review of the COVID-19 outbreak at Extendicare Parkside as required by *The Provincial Health Authority Act* and *The Critical Incident Regulations, 2016*.**
3. **Extendicare (Canada) Inc. develop and implement effective administrative and management processes to ensure its Saskatchewan special-care home administrators and staff comply with its own corporate policies, procedures, plans and standards, and any Saskatchewan Ministry of Health or Saskatchewan Health Authority policies, procedures, plans, practices and standards that it either has agreed to comply with, or is required to comply with under any Act or regulation.**
4. **Extendicare (Canada) Inc. ensure that Extendicare Parkside has on site, sustainable resources to effectively support its staff's compliance with all relevant infection prevention and control management processes, standards and practices, including good quality education, auditing, and managerial oversight.**

Saskatchewan Health Authority

The Authority is the operational arm of the provincial health system. Whether it provides health services itself or contracts with health care organizations to provide them, it is responsible to ensure health services in Saskatchewan meet reasonable standards. It cannot allow private long-term care operators to run their facilities without ensuring they at least meet and follow the standards and practices it has for its own facilities.

From the perspective of administering long-term care across the province in an integrated and consistent way, there cannot be fractured and inconsistent practices and standards from one home to the next. Residents should be able to expect the same quality of care no matter which long-term care home they live in, whether an Authority-run home or a privately-operated home.

Based on our investigation, the Authority generally gave Parkside reasonable support during the pandemic and outbreak. However, there were some areas where effective oversight was lacking, and where the Authority should have taken a greater, leadership role.

We recommend that:

1. **The Saskatchewan Health Authority immediately stop the practice of having four special-care home residents share a bedroom.**
2. **The Saskatchewan Health Authority update its standard written agreement (Principles and Services Agreement) for special-care home operators without delay, and ensure all operators it enters into agreements with to provide services are required to comply with care-related policies, standards and practices, including infection prevention and control measures, that are acceptable to the Authority.**
3. **The Saskatchewan Health Authority establish and implement a detailed annual review and reporting process to ensure that all special-care homes in Saskatchewan are following all required care-related policies, standards and practices, including infection prevention and control measures, and that it publicize information about each home's level of compliance at least annually.**
4. **The Saskatchewan Health Authority ensure its communicable disease prevention and control management standards and practices are consistently applied in all special-care homes in Saskatchewan, including completing comprehensive infection prevention and control inspections of all special-care homes at least annually.**

Ministry of Health

The Ministry of Health communicated with the public on pandemic-related initiatives and issues, but it provided no direct oversight or support to Parkside during the pandemic or outbreak. Its top contributions to the long-term care sector's response to the pandemic were issuing public health orders directed at keeping residents from getting COVID-19 and approving additional COVID-19 funding for the Authority to distribute to long-term homes. Since our investigation focused on the Parkside outbreak, and, as its officials told us many times – the Ministry did not provide any direct oversight or support to Parkside - we did not make any recommendations directly to the Ministry in this investigation. However, this does not mean its role is not critical.

It is responsible for establishing the governing framework for the long-term care system and for deciding how much, and on what initiatives, public money will be spent. It makes decisions with fundamental implications for the long-term care system, residents, and the professionals who care for them. For example, it decides when and where to spend money for new long-term care spaces, and when facilities will be replaced. The Ministry has a great deal of control over how and how well the system functions. We strongly encourage the Ministry to ensure that something like the Parkside outbreak does not happen again – to make meaningful and lasting systemic and structural improvements to Saskatchewan's long-term care system.