**INFORMATION BULLETIN**

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# TESTIMONY TO COVID 19 LONG TERM CARE INQUIRY

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[http://www.ltccommission-commissionsld.ca/transcripts/pdf/NATHAN_STALL_Transcript_November_12_2020.pdf](http://www.ltccommission-commissionsld.ca/transcripts/pdf/NATHAN_STALL_Transcript_November_12_2020.pdf)

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***"the long-term care sector in many ways is a real, you know, microscope or a laboratory for… many social inequities in our society and a real display of how when these things are left and neglected, things can go very wrong"*** (Dr. Nathan Stall, Pg. 42)

***"So to segment a community without their consent, really confine them to these indefinite and harmful conditions on confinement, for people who have limited life expectancies and are most susceptible to these conditions of the confinement syndrome is unethical."*** (Dr. Nathan Stall, Pg. 66)

- Comparing "deaths among the community-dwelling population and the long term care dwelling population – all ages – there's a 90 fold increased risk of death" (Pg. 7);
- "Infection among long-term care staff was associated with death among residents with a 6 day lag" (implicatons: single work policy, universal masking, recognition of staff having imported virus) (Pg. 7);
- For-profit facilities have shown "across a number of broad outcomes to delivery slightly inferior care compared to non-profit homes" (pg. 8/9);
- **"53% of for-profit homes as compared to 18% of non-profit and 11% of municipal homes have older design standards" (smaller square footage per room, smaller thoroughfares, smaller common areas, older ventilation systems, double or quadruple occupancy (Pg. 9);**
- **"there was a higher death rate in for-profit homes, and there was a higher percentage of resident deaths in for-profit homes" (Pg. 10);**

- **In facilities that had outbreaks, for-profit had 78% more deaths than non-profits (Pg. 17);**
- No "effect of profit status on whether a home is going to experience an outbreak or not" (Pg. 12);
- **"**strongest risk factor for whether a home is going to experience an outbreak is the transmission of COVID-19 in the communities surrounding homes" (Pg. 13);
- **When there was an outbreak, for-profits had outbreaks that were twice as large as non-profits, even taking into account incidence of COVID in the health region (Pg. 14);**
- **Having chain ownership and older design standards are explanatory factors for large outbreaks in the for-profits (Pg. 14);**
- **"Homes with chain ownership tend to have lower levels of staffing." (Pg. 16);**
- **Three rapid reviews in the literature have found no evidence that family caregivers or visitors have been importing the virus into the facilities ("staff are very important vectors for COVID-19 into homes") (Pg. 19);**
- At onset of pandemic facilities were pretty much at capacity – almost 37% single capacity, 37.3% were double, 25.8% were quadruple (Pg. 21/22);
- No facility in the province had a crowding index of only 1 (single room, single washroom) – crowding index less than 2 – low crowded, 2-4 high crowded, some have crowding index of 4 Pg. 22);
- **86% of infections occurred in just 63 homes or 10% of homes (Pg. 22)**
- **More residents infected and more die in crowded homes – homes with crowding index of 2-4 had an incidence of 9.7 vs 4.5% and a higher mortality rate of 2.7 vs 1.3% - homes with high crowding, nearly 10% of residents infected, low crowded homes 5%. 3% died in homes with outbreaks vs 1.3% in low crowded homes (Pg. 23);**
- **Highest crowding facilities had twice the level of mortality and COVID incidence as low crowded facilities (Pg. 24);**
- If all the 4 bedded rooms were converted to 2 bedded, 1000 casesand 263 deaths would have been averted (1/5 of cases and deaths in the province) which would have requied 5,070 new 2 bedded rooms (Pg. 25);
- Facilities were erecting simple barriers and sheets in multi-occupancy rooms, government directed **at beginning of June, 2020 no longer permitting admissions to rooms with 3-4 residents, but directive did not pertain to existing residents, therefore in the 2nd wave the hardest hit facilities had multi-occupancy rooms fully occupied** (Pg. 27)
- Hospitals are facing increasing pressure to clear their ALC wait times and are pressuring facilities to admit residents, regional coordinators pressuring facilities to fill them up again "up to dangerous levels of crowding" – residents admitted to a 2 bedded room the 2-3 weeks later move them to a 3-4 person room (Pg. 30);

- Funding is quite low for Home Care per capita compared to OECD countries and other jurisdictions have done remarkably well to reduce need for their long term care system by investing in home and community care systems, the challenge being limits of home and community care for the complexities (dementia, extensive assistance for cognitive and functional abilities) being admitted to facilities - 1-2 hours of care a day wholly insufficient – so no choice between long term care and community (Pg. 35);
- **"Had all these residents not been in congregate care settings which are outdated, crowded, with staff who are underpaid, living often in the COVID hotspots of our city and…unknowingly importing virus and facing difficult decisions themselves about whether to work or not because an absence of sick pay, I'm confident we could have avoided hundreds if not thousands of deaths" (Pg. 35);**
- "Denmark is a classic example that's often used about not having to build new long-term care beds because they properly apportioned resources and invested in home and community-care services" (Pg. 36);
- Re: policy – "Cognitive biases in public health policy that made us prioritize our responses to those lives that we most identify with" – lopsided response to long term care – can't advocate for themselves, don't vote, may not be alive for the next election – **"people in long-term care have several intersecting forms of discrimination that plague them" – ageism one of the last socially accepted forms of discrimination, dementia and discrimination against the workforce – largely women of color (**Pg. 39 - 41);
- "many people in long-term care have goals of care or advanced directives that may not include transfer to the hospital" (Pg. 51).
- **Community-dwelling people hospitalized prior to death is between 75.9 – 88.8% (stable during March and April during the surge) but in long term care residents, in March and April it was only 15.5% out of 1,028 who died that were transferred. In May it was 26.9% and June and July 41.2%, in August to October it was 30.8%. Men were more likely to be transferred to hospital than women** – "there's gender-based biases where men are more likely to be offered aggressive care." (Pg. 51/52);
- **People were not transferred to hospital during the first way and that may have contributed to death rates – people who could have benefited from medical care that may have saved their lives – people were also not transferred for just basic care when facilities were in crisis, nor were they transferred for palliative care to be able to die with dignity in the first wave. "officially triaged out" (Pg. 53);**
- **People were being heavily drugged with anti-psychotics, benzodiazepines, anti-depressants to "allow them to tolerate the conditions of the lockdown or**

**because the homes were in crisis, there was no one to provide care for them and they were responding with chemical restraints for these residents" (Pg. 54)**

- "About 50% of all long-term care15residents are on an antidepressant" sharp uptick in prescribing trazadone and other anti-depressants (Pg. 56);
- **Metformin and statins in sharp decline - "**So either this means that those medications weren't refills because of the collapse of medical care; the people who are on metformin and statins were the ones who were more likely to die, which is the possibility because they're more -- diabetes and high blood pressure and cardiovascular risk factors are known cardiovascular risk factors for COVID-19 outcomes."(Pg. 57);
- **Residents on lockdown had extreme collateral damage – dehydration and malnutrition, people who could walk now wheelchair bound, exacerbation of chronic medical and mental health conditions, worsening of responsive behaviors, could no longer recognize relatives when they were finally let back in (Pg. 59/60)**
- **No mechanism for appeal of lockdown by relatives (Pg. 64);**
- "Before we came, they were using coat hangers to hang up bags of normal saline. They didn't have enough oxygen tanks. They were looking on Amazon to secure concentrators for the oxygen. So this is -- you know, this is happening in Canada, so this was the level of crisis that this home was in when it came to supply." Sent a dozen RN's and PSW's to help with care as well as PPE – residents tested and moved to hospital or safety – taxied over oxygen tanks from Mt. Sinai – 2 doctors available24/7 for medical emergencies – pharmacist consolidated and streamlined medications – psychogeriatric care and trauma care for front-line staff (Pg. 74);
- Many doctors practice at 5 or 6 long term care homes (Pg. 79);