BRIEF

BRIEFING ON THE CANADIAN RESPONSE TO THE OUTBREAK OF CORONAVIRUS

Submission to the Senate Standing Committee on Social Affairs, Science and Technology

July 3, 2020

The Canadian Nurses Association is a powerful, unified voice for the Canadian nursing profession. We represent regulated and retired nurses in all 13 provinces and territories. We advance the practice and profession of nursing to improve health outcomes and strengthen Canada's publicly funded, not-for-profit health system.

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Introduction

There are more than 431,000 regulated nurses in Canada — registered nurses, licensed practical nurses, registered practical nurses, registered psychiatric nurses and nurse practitioners. They are the largest group of care providers in our health system. The Canadian Nurses Association (CNA) is the national and global professional voice of Canadian nursing. CNA represents 135,000 nurses across all 13 provinces and territories and hundreds of Indigenous communities.

The COVID-19 pandemic clearly escalated broadly and rapidly. We must maintain our guard in supporting Canada's nurses and all health-care professionals who are confronting and mitigating its impacts. CNA appreciates the measures taken by all levels of government across Canada to minimize the spread of COVID-19 and we have particularly benefited from the incredible and courageous leadership of our public health professionals, including the nurses who are integral to that sector.

CNA is grateful for the strong communication from Dr. Theresa Tam, who leads the Public Health Agency of Canada. We would like to note that we have had good communication with Health Canada, including Health Minister Patricia Hajdu, and Dr. Tam and her team.

To have the most timely information, CNA has been speaking with and polling nurses across the country every week. Through these mechanisms we have been able to identify and validate key areas of concern related to COVID-19. We continue to monitor these issues.

This brief will highlight key areas of concern to date. We would like to emphasize the need to harness the lessons of this pandemic and urge a strong course correction at a systems level.

Ongoing issues of concern for nurses across Canada include the following:

Personal protective equipment

Four months into the pandemic, the consistent, reliable supply of personal protective equipment remains an issue for health-care workers across the country. It remains CNA's position that decisions about the use of personal protective equipment should be driven by evidence and not availability or fear of shortages. CNA has sent several letters advocating for this, including one addressed to Hajdu and Dr. Tam (jointly signed by CNA and the Canadian Federation of Nurses Unions[1]) and another to Prime Minister Justin Trudeau and all of Canada's premiers (jointly signed by CNA, the

Canadian Association of Social Workers, the Canadian Indigenous Nurses Association, the Canadian Medical Association and the Canadian Pharmacists Association[2]). Nurses, physicians, and all workers need clear guidelines for the use of this equipment and access to it so their health and safety are not compromised.

Testing

The World Health Organization has urged large-scale viral testing,[3] but COVID-19 testing in Canada still falls behind many other nations. Despite having expanded its testing, with more than two and a half million tests conducted by late June,[4] as of July 1, Canada falls 10th in testing; at 73,398 per million, Canada is far behind countries such as Spain, Italy, Russia, the UK and even the United States.[5] Nurses are concerned that without this information the pandemic response and recovery efforts will not be informed by evidence.

Mental health

Prior to COVID-19, nurses were already suffering from high rates of fatigue and mental health issues. CBC's Fifth Estate found in 2018 that some 40 per cent of registered nurses reported feeling a high degree of burnout.[6] A study from the Canadian Federation of Nurses Unions, released in June of 2020, noted high rates of mental illness, including major depressive disorder, generalized anxiety disorder, clinical burnout, PTSD and panic disorder.[7] The COVID-19 pandemic response and recovery has made matters worse, with nurses in all settings facing significant challenges to their mental and emotional well-being. Looking internationally, there is already some evidence that health-care providers (including nurses) caring for patients with COVID-19 had significantly more depression, anxiety, insomnia and distress than those who did not care directly for these patients.[8] This is no surprise since we are also seeing an overall rise in mental health issues in the general population.

Mental Health Research Canada[9] has noted that since the start of the pandemic, rates of depression have doubled and rates of anxiety have quadrupled. As nurses, we are impacted by that twofold. First, because we too are feeling the tremendous psychological burden of this pandemic, and second, because in addition to the physical impact of the pandemic on our patients, clients and communities, we are seeing the mental health impact.

CNA is actively advocating for rapid access to no-cost mental health support services for health-care providers during the pandemic and long after. We are also working with our jurisdictional partners and other stakeholders to identify and develop support

services tailored for nurses. When the immediate crisis eases, the tremendous backlog of surgeries and procedures will mean that the demands on the health system — especially its nurses, physicians and other health professionals — will extend just as the rest of society may have some respite. So, a series of recovery supports for individuals, teams, organizations and communities will be required over the longer term.

Health-care worker data and information

At present, there is no timely, consistent, accurate way to track COVID-19-related health-care worker infection, illness and death rates nationally. Current efforts to measure the scale of the issue are made up of labour-intensive tracking of various sources, including news pieces and provincial case reporting. Often, health-care worker information is not classified by profession.

CNA is working with the Canadian Medical Association and the Canadian Institute for Health Information to determine the impact of COVID-19 on the health of all health-care workers. We urge governments to fund systems to support the tracking of this important data. This is a longstanding issue.

Vulnerable populations

CNA remains very concerned about populations who are more at risk for the spread and impacts of COVID-19, including many Indigenous people (especially those in remote settings), people in congregate settings (such as prisons and shelters) and the homeless. Often, Black, Indigenous and people of colour are disproportionately represented in at-risk settings, which also include densely populated urban areas. Public health measures, along with access to health and social care, must be stepped up to meet the needs of these vulnerable populations. While we have seen examples of some jurisdictions collecting race and ethnicity data related to COVID-19 infection, this needs to be done across the country. We need to be able to accurately measure who is infected, or at risk for infection, to have evidence-informed targeted interventions.

Consistent information

CNA recognizes that developing and disseminating consistent information and guidance can be a challenge in a federation across thousands of employers in many sectors of health care. However, we must double down on efforts to collaborate and reduce the confusion caused by different guidelines and directives appearing across jurisdictions or practice settings.

Cautious reopening

Given the lessons of history, we urge a very guarded, evidence-informed and cautious reopening of services across society. We are concerned that the virus is still quite prevalent, still spreading, not well understood and may sweep across society in successive waves. In mid-April, the World Health Organization's director general Tedros Adhanom Ghebreyesus outlined six criteria[10] that should be met prior to lifting public health restrictions. Canada has not yet met all six, and for those conditions that have been met, measures must be put in place to remain vigilant. Canada is still falling short in its capacity to test, isolate, and treat each case and trace all contacts. The country also faces challenges reducing the risk in specialized settings such as long-term care.

Long-term care

Due at least in part to an aggressive "flatten the curve" public health campaign, our hospitals have, in the main, been spared the devastation wrought on their counterparts in China, Italy, Spain and the United States. But at the same time, the pandemic has laid bare the crippling lack of standardization, funding, strong leadership, appropriate staffing, and proper training and equipping of the people who deliver services in our long-term and home care sectors. These vulnerabilities have been thoroughly documented over the past 20 years.

The result is that while just 20 per cent of COVID-19 cases in Canada are in long-term care settings, they account for 80 per cent[11] of the deaths — the worst outcome globally.[12]

While health systems across Canada certainly have many strengths, a series of robust, thorough and well-researched examinations of health systems undertaken by governments and civil society groups at federal, pan-Canadian, provincial and territorial levels since 2000 have revealed a now familiar litany of weaknesses and outright gaps. This same research has also recommended solutions to close them. These solutions include timely access to pharmacare, home care, mental health care, long-term care and primary health care — all *based on need and not on the ability to pay*.

The outcomes of COVID-19 in long-term care are largely due to two main factors: first, decades of neglect of the sector and, second, a growing mismatch between the level of care required by people living in those settings and the human and other resources being deployed to look after them. Many patients now living with complex ongoing conditions in long-term care settings would have been treated in a hospital 20 years ago. It may be hard to imagine that a generation ago, some people living in long-term

care institutional settings still drove their own cars. People requiring that level of support now receive it in retirement settings or in their own homes. Many residents are over 85 years old. Dementia is a major contributing factor to admission.[13]

The rising pace, volume and complexity of care that has been shifted from hospitals to nursing homes has coincided with a decline in the proportion of regulated nurses in the staff mix over a generation. Long-term care facilities have fewer regulated nurses, fewer clinical educators, fewer recreational therapists and aides, fewer social workers, and fewer physio and occupational therapists than ever before. This story of "fewer" exerts a dramatic impact on the unregulated workforce, which is responsible for up to 80-90 per cent of all care in these settings.

The workforce in long-term care is dominated by caring, loving and well-intended health-care aides and support workers who are not backed up with the professional nursing and other resources they desperately need. The sector is heavily dominated by women, often racialized women, who are paid low wages and often are precariously employed, cobbling together a living wage by working across multiple employers and working extremely long hours. COVID-19 has exploited these longstanding vulnerabilities and exposed cracks in the foundation of an already-struggling long-term care sector.

In its final report in 2012, CNA's National Expert Commission[14] laid out nine practical recommendations to address many of the same problems across health systems identified by the Romanow Commission,[15] Senator Michael Kirby[16] and others. Many of the solutions recommended by CNA's commissioners could drive better health outcomes, better care, and better value for taxpayer dollars — and most of them continue to go unheeded nearly a decade after the report was tabled.

If there is any silver lining in the anguish of COVID-19, it is the gift of the pause that has been forced on us all. For example, in that pause:

- "Hallway medicine" disappeared virtually overnight
- Primary care has leaped forward to join the rest of the world, with most of this care taking place quite satisfactorily by telephone or digital connections
- Many emergency departments are half empty and their legendary long wait times are a thing of the past
- Nurse prescribing has been safely extended
- Nurse practitioners can ably manage long-term care just as they are educated to do

CNA recognizes fully that some of these outcomes are the result of the great disruption of COVID-19 that has, for example, instilled a fear of going to the emergency

department among some people who are quite ill and should indeed be going. But the point is that COVID-19 has forced us to achieve goals that we have tried to attain for decades. We have the capacity to address the gaps now and sustain these results. We must not go back.

Meeting the care demands of older adults requires major changes to the health system at large; immediate attention must be paid to the role of personal care assistants and nursing expertise in long-term care facilities particularly. Redesigning the ways we provide care for seniors and those with complex continuing care needs will go a long way to resolve other gaps and pressure points across Canada's health systems.

We have a shared, national accountability to re-imagine aging in this country, including home care, institutional long-term care, and end-of-life care — and then put in place the bold changes we know are needed. On May 27, just days after our May 20 appearance before the Senate Committee on Social Affairs, Science and Technology, CNA released a report entitled *2020 Vision: Improving Long-term Care for People in Canada*, calling on governments to redesign long-term care to address serious vulnerabilities.

Conclusion

As COVID-19 has shown us, once again, nurses are a mighty force in achieving better health. The profession is dedicated to caring for the people of Canada even when nurses themselves are worried about their own health and safety.

The public health crisis we face today is exactly the time we must work together to deploy nurses safely and to their full effect.

Clear information, adequate medical equipment and supplies, and additional support for both the health system and health-care workers are needed and will continue to be needed beyond the immediate threat. We all must do better to support Canada's nurses and other health-care workers so that we are not left in the same situation we find ourselves in today.

CNA verbally presented the information in this brief to the House of Commons Standing Committee on Health on May 11, 2020 — a date that happened to be in the International Year of the Nurse and the Midwife, during National Nursing Week, and on the eve of the 200th anniversary of Florence Nightingale's birth. And perhaps ironically, 200 years after her birth, we find ourselves talking her language — wash your hands, keep the environment clean and gather good information to guide system change. On

May 20, 2020, CNA brought forward this same information to the Senate Committee on Social Affairs, Science and Technology.

CNA set aside years of planned celebrations out of respect for the tens of thousands of nurses who were working at points of care, some even coming out of retirement to do so. Nurses answered the call nobly.

Nurses, their knowledge and their leadership are essential in responding to COVID-19 and moving forward with solutions to address long-overdue system changes. CNA implores the committee to recommend that nurses be placed in leading roles in the analyses of the COVID-19 response that lie ahead. Listen to them. And know that they, and CNA alike, will deliver the best evidence to help governments and health system decision-makers restructure systems so that we stop papering over the cracks and implement real change.

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[2] https://cna-aiic.ca/-/media/cna/page-content/pdf-en/first-ministers-joint-letter_covid-19_march23-2020_e.pdf?la=en&hash=FFD5358DFF297A87F96A5BF0BCABB5C534701F84

[3] https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---16-march-2020

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[5] https://www.statista.com/statistics/1104645/covid19-testing-rate-select-countries-worldwide/

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[7] https://nursesunions.ca/research/mental-disorder-symptoms/

[8] https://www.cmaj.ca/content/192/17/E459

[9] https://www.mhrc.ca/our-research/

[10] https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--13-april-2020

[11] http://cmajnews.com/2020/05/15/coronavirus-1095847/

[12] https://ltccovid.org/international-reports-on-covid-19-and-long-term-care/

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[15] http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

[16] https://sencanada.ca/content/sen/committee/372/soci/rep/repfinnov03-e.htm