Centre universitaire de santé McGill

McGill University Health Centre

Debrief on the management of the COVID-19 pandemic at the MUHC

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Report produced by the

Department of Quality, Evaluation, Performance and Ethics

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Summary

1. Introduction

1.1 Background

In December 2019, a new coronavirus was identified in the city of Wuhan, China. Following a significant increase in cases in that country, the World Health Organization (WHO) declared that the data showed human-to-human transmission. After many cases were confirmed in other countries, the WHO rated the global risk as "high."

Emergency management meetings with the Ministère de la Santé et des Services Sociaux (MSSS) began on January 23, and coordination meetings at the McGill University Health Centre (MUHC) were set up the next day, on January 24, 2020.

On February 28, the province of Quebec identified the first positive case in a woman returning from a trip.

On March 11, the WHO classified the new coronavirus, named COVID-19, as a pandemic. On the same day, the first case of COVID-19 was diagnosed at one of the MUHC sites. The MUHC decided to open its Emergency Measures Coordination Centre (EMCC) the next day, on March 12. Due to a rapid increase in confirmed cases in the province and in the city of Montréal, the MSSS designated the MUHC as a hospital centre for COVID-19 patients on April 2.

In the summer of 2020, the first wave of the pandemic flattened in Quebec, particularly in Montréal and surrounding areas. The activities of the EMCC also slowed, allowing time to reflect on pandemic management at the MUHC and the effectiveness of the EMCC.

1.2 Specific Goals

This report is based on two specific goals identified by MUHC management and members of the EMCC.

- **Assess the management of the pandemic to identify areas for improvement**

  The pandemic has shaken all organizations and strained their structures, processes, operations and resources. Mechanisms were quickly put in place to support and operationalize changes in an emergency at all levels of decision making in the network. How do the MUHC's various stakeholders perceive leadership's management of the pandemic? What lessons can we draw from our experience in recent months to facilitate the management of a second wave?

- **Evaluate the EMCC's performance in managing the pandemic at the MUHC**

  The Emergency Measures Coordination Centre (EMCC) is an entity that can be set up within the organization for any type of disaster, incident or emergency that potentially impacts patient and employee safety or the activities of the McGill University Health Centre (MUHC). The decision to open an EMCC rests with the Emergency Measures Coordinator (or their delegate) or the director on duty. Each emergency situation is

unique and requires the participation of different people. In the context of COVID-19, a group was therefore set up on March 12.

Today, in an effort to improve the overall functioning of the EMCC and to meet the needs of the MUHC community, its members wish to conduct a 360º assessment. The main goal is to gather information to improve the EMCC's functioning in the event of a second wave or other type of emergency.

1.3 Approach

This report does not pretend to provide a comprehensive picture of all the comments raised nor to meet an exhaustive statistical need. It provides guidance to its decision-makers on what could be improved in the future according to its stakeholders.

The following table summarizes the approach used.

	PANDEMIC MANAGEMENT ASSESSMENT	ASSESSMENT OF THE EMCC'S PERFORMANCE
Topics covered	Generally speaking, • The strong points • Areas for improvement • What could be done differently next time	• Pandemic management • Meeting management • Information management • Role of the EMCC
Groups consulted	• Employees • Middle managers • Associate directors • Medical chiefs • Management Committee members	• Members of the EMCC • Doctors • Nurses • Patient attendants • Members of EMCC subcommittees • Management Committee members • Directors not present at the meetings but very much affected by the decisions
Methods used	• Survey • PED virtual tour	• Virtual group and one-on-one interviews • Survey

Approximately 950 people participated in the consultations. It is possible that the same person may be counted more than once if they contributed to more than one group.

2. Methodology and Results

2.1 Pandemic Management Assessment

The following section explains the methodology used and results obtained for each group.

2.1.1 By employees

In order to provide a complete picture of pandemic management at the MUHC, we thought it appropriate to include in this report a summary of the results of an employee survey conducted last May. A detailed report is available from the executive office: "Quality Improvement Analysis of the MUHC COVID-19 Pandemic Response." Here is a summary.

Thanks to Margaret Ruddy N, BScN, M.Mgmt, CCPN (C), Dr Elene Khalil, MD CM, FRCPC, FAAP, Valérie Homier MD, MSc, FRCPC and Franco Carnevale, N, Ph. D. (psych) Ph. D. (Phil), authors of the report for making it possible to integrate the information into this one.

Here is a summary.

Project Information

783 MUHC clinical staff, support staff, and managers participated in a survey that asked for their input on the strengths and limitations of, as well as possible improvements to, the MUHC's response to the COVID-19 pandemic.

The survey contained the following questions:
Reflecting on your experience of preparation and deployment of the pandemic response within your MUHC setting:

- Which aspects do you think went well? (please describe with details)
- Which aspects can be improved? (please describe with details)
- What caused you to worry the most?

Survey responses were thematically analyzed. Theme frequencies were tallied and statistically compared across participant sub-groups (role in the response, MUHC site, occupation, and service/department).

Key Messages

- Participants were **most satisfied** with the establishment of screening measures at building entrances, timely pandemic preparation (e.g., surge planning, COVID-unit coordination), and system-wide communications, especially the weekly webinars/townhalls which served to increase transparency and trust in leadership.
- The **most common improvements suggested** by participants were related to coordination (e.g., deployment processes, transition to teleworking), communication (especially with frontline/laboratory/administrative staff, including listening to their concerns), and IPC measures (e.g., evidence-based PPE guidelines, training, environment structure and cleaning).
- Participants were **most worried about** the risk of staff exposure to COVID-19, current and future PPE shortages, and institutional communication (e.g., consultation with employees, information overload, lack of transparency).

Major themes for what participants thought went well and what could be improved in the MUHC's pandemic response

THEME	STRENGTHS (% OF PARTICIPANTS)	LIMITATIONS (% OF PARTICIPANTS)
INSTITUTIONAL COORDINATION	(35.4%) **Planning and preparation** **Quick response** **Deployment of staff and resources** **Leadership**	(41.5%) **Staff re-deployment** **Switch to teleworking** **Planning and preparation** **Scheduling**
INSTITUTIONAL COMMUNICATION	(34.6%) **Webinars/townhalls** **Email updates**	(37.7%) **Communication with frontline staff** **Clear and timely directives** **Excessive number of emails or too many sources of information** **Transparency**
INFECTION PREVENTION AND CONTROL (IPC) GUIDELINES, PROTOCOLS, AND TRAINING	(35.4%) **Screening at entrances** **Testing and monitoring**	(30.0%) **Concern for staff safety** **PPE training and guidelines** **Evidence-based IPC guidelines** **Environment structure and cleaning**
PPE AND OTHER SUPPLY AVAILABILITY AND MANAGEMENT	(10.7%)	(20.6%)

Source : A Quality Improvement Analysis of The MUHC COVID-19 Pandemic Response

2.1.2 By middle managers

Methodology

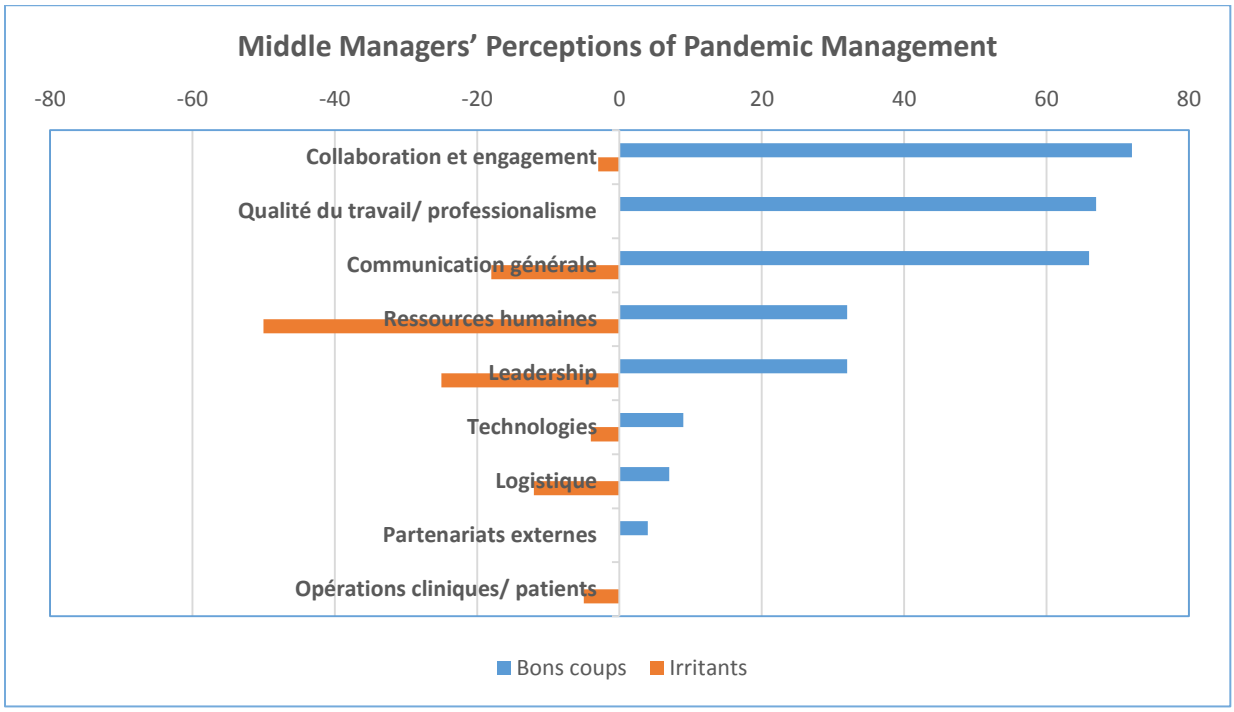
Whether for middle managers, associate directors or medical chiefs, the methodology used was the same. The consultations were initiated and carried out by Dr. Gfeller, PED, accompanied by Martine Alfonso, APED, and Ewa Sidorowicz in the case of the chiefs of medical departments. All consultations were conducted by teleconference in groups of 5 to 15 participants.

Participants had the opportunity to express their views on the management of the pandemic at the MUHC, on what went well, what did not go well, what had not been planned, and what could be done differently next time. They were not provided with any themes.

An Excel file was used to record the number of times an item was raised in order to measure its importance. To synthesize the information and make it easy to understand, it was grouped by theme.

Results

In total, nearly 100 middle managers participated in the meetings. Of course, since we are dealing with the participants' perception and experience, certain points were perceived as strengths by some and as areas for improvement by others. We have therefore opted to illustrate the results in this graph. Nine themes were identified.



Note: The numbers shown indicate the number of times a participant identified an item within a theme.

The following paragraphs provide more details on what participants appreciated, their main irritants and, where available, recommendations or suggested improvements.

Collaboration and Commitment

Collaboration between management and other departments, as well as between adult and pediatric departments, was greatly appreciated. Outstanding teamwork. This "crisis" has made it possible to break down existing silos and to better understand each person's reality. Strong bonds were created, a family atmosphere was established. The clinical and administrative services teams joined forces towards a common goal. The opening and transformation of care units is a fine example of success and mobilization made possible by this valuable collaboration.

Quality of Work and Professionalism

Pandemic management revealed an omnipresent team pride in terms of adapting to the many changes, reacting to them with agility and making decisions and executing them with exceptional speed. The organization of work has increased the teams' ability to respond to the needs and problems encountered. Creativity and problem-solving were repeatedly stressed.

The teams also expressed satisfaction with the quality of the work done and the respect of best practices.

Communication

The webinars offered to all staff were a resounding success. They have proven to be a popular communication channel to guide the teams and keep them informed. Teams appreciated the transparency with which the management team provided both relevant information and opportunities for everyone to interact and ask context-specific questions. Some mentioned the inspiring and calming aspect of these meetings. MUHC Updates and the information available on the intranet were also appreciated.

Others, however, complained that the information was more focused on clinical services and less on administrative ones. The language used in some cases was less appropriate for administrative teams. In short, having the information gave a sense of purpose.

Generally speaking, the information provided was highly appreciated, and some even called it "fantastic." However, others felt the amount of information relayed, from the EMCC, nursing and the DHRCLA, for example, was overwhelming. In some cases, the information was difficult to navigate. A lot of information was shared top-down. The inconsistency of information depending on the sender was also raised. The guidelines could present conflicting information.

Suggested improvements	• Increase the frequency of webinars. Keep holding them now to reassure people and prepare for the future. • Avoid communications and guidelines to be implemented on Fridays. • Revise the communication strategy to centralize information, make it more accessible and manage changes better. • Keep administrative services in mind in communications.

Human Resources

Human resources management and support elicited the most comments of dissatisfaction during these consultations.

Let us begin with the positive comments. It was noted that the accommodations offered to employees were particularly appreciated, such as teleworking and access to free parking. Some people noted their appreciation for access to telephone support lines and group debriefings.

Many are concerned about the stress the teams experienced, the feelings of distress and exhaustion observed. Some observed resources were wasted through misuse, lack of preparation and the impact on remaining teams when resources were moved. It was mentioned that doctors should avoid going from hot zones to cold zones in order to limit the risk of contagion. Dissatisfaction was also reported with respect to the compensation and bonuses granted under COVID. Finally, the complexity of the COVID-specific payroll codes was a challenge for many.

Suggested improvements	• Offer “virtual care” to employees through online wellness sessions. • Make better use of resources and balance workloads. Have access to additional staff. • Support teams (follow up with individual employees, show empathy, anticipate post-traumatic stress). • Ask employees for their preferences when they are reassigned. Try not to reassign the same employees. • Provide training before redeployment, especially at CHSLDs. • Review the protocol and the management of employees when they return from reassignment (debriefing group after CHSLD reassignment to discuss the experience). • Communicate clearer symptom guidelines that indicate whether an employee should come into work. • Make known the method for contacting employees from other departments that are working from home or elsewhere. • Provide clear instructions for working from home and adequate tools.

Leadership

A number of factors contributed to the establishment of a trusting atmosphere, including the provided directions, the regular transmission of information, management presence on site, and the structure and frequency of meetings. The medical leadership was also emphasized and appreciated. The organizational focus was greatly appreciated.

Pandemics certainly result in rapidly evolving information. That being said, the constant changes sometimes destabilized the teams. Some people complained about the lack of time for applying the information, while others were disoriented by changing and vague guidelines that differed from person to person.

Suggested improvements	• Establish a priority-based schedule for better resource planning. • Avoid the shutdown of operations as far as possible. • Share MUHC expertise with the rest of the network. • Switch from the top-down mode required at the start of a crisis to a more collaborative management model.

Other points were raised:

- Technology – Some people appreciated the tools made available to staff working from home. However, clear guidelines for their use were lacking in some cases. Some people mentioned that it was difficult to access the protocols remotely.
- Logistics – The management of medical material and equipment elicited both positive and negative responses, with some people appreciating the work that was done and others expressing concern about the problems encountered, particularly with respect to personal protective equipment (PPE).

Suggested improvements	• Make sure there is enough equipment.
	• Keep the employee N95 “fit test” database up to date.
	• Develop a standardized COVID office layout guide.
	• Clinical Operations
	  ○ Avoid moving patients with cognitive problems.
	  ○ Be more flexible about relatives visiting the dying.
	  ○ Consult patient partners about patient visits.
	  ○ Find a better balance between infection control and individual patient needs.
	  ○ Evaluate the risks of emergency measure protocols (based on H1N1 and SARS).
	  ○ Centralize pre-ops at MGH.
	  ○ Decrease COVID test result wait times.

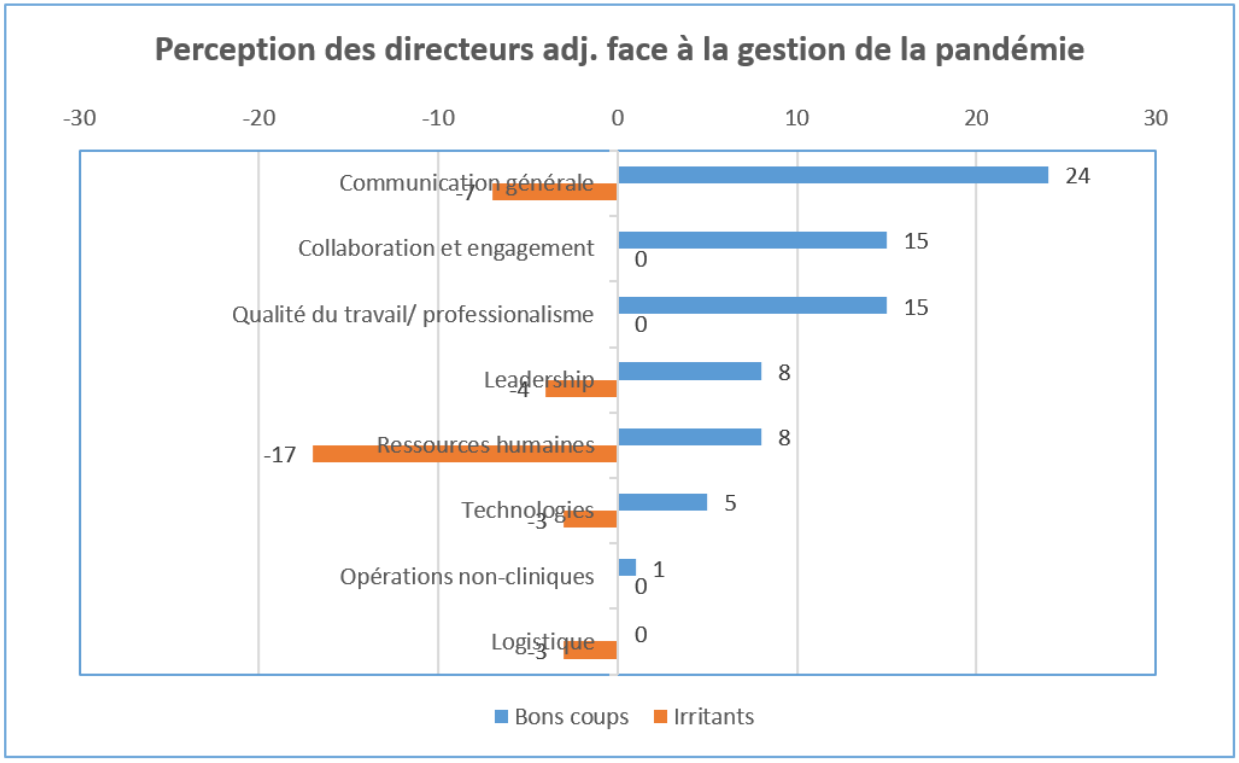
2.1.3 By the associate directors

Methodology

The methodology used with middle managers also applies to this section.

Results

A total of 20 associate directors participated in the meetings. Of course, since we are dealing with the participants' perception and experience, certain points were perceived as strengths by some and as areas for improvement by others. We have therefore opted to illustrate the results in this graph. Eight themes were identified.



Note: The numbers shown indicate the number of times a participant identified an item within a theme.

The following paragraphs provide more details on what participants appreciated, their main irritants and, where available, recommendations or suggested improvements.

Communication

For the associate directors, the strongest element of the pandemic response appears to be communication. Both the webinars and the "cascade-escalade" communication structure were greatly appreciated. Other successes were identified, such as the holding of daily caucuses in different departments, the electronic updates ("MyMUHC"), the

two-way information sharing with the EMCC, and the employee recognition systems (photos, champions, Facebook Live).

On the other hand, communication was also felt to be too intense, with a large number of changes made on a daily basis. The information included in the Frequently Asked Questions changed rapidly and it was difficult to track updates. On some occasions, different teams worked on the same subject because of a lack of communication. Other communication difficulties were raised with McGill University and its residents, the MSSS and professional federations.

Suggested improvements	• Improve the "cascade-escalade" communication structure. Proposal/example: EMCC (8 a.m.) – Management: managers (9 a.m.) – Managers: team (10 a.m.) Managers: Management (1 p.m.) – Management: EMCC (3 p.m.) • Create multidisciplinary "swat teams" (at the tactical level), with members from all departments brought together to look for optimal solutions to problems. • Improve communication of changes. Avoid protocol changes on Friday evening, wait until Monday instead. • Hold short daily meetings (15-20 min) with executives to transmit EMCC information and decisions and standardize actions (priorities for the day). • Improve the website by integrating a better search function.

Collaboration and Commitment

Both the inter-departmental collaboration and the organizational focus were greatly appreciated. The fast access to the DHRCLA, the EMCC and specialists was also mentioned in the context of the rapidly evolving changes.

Quality of Work and Professionalism

The MUHC teams have shown agility in quickly adapting to the changes. The "Surge-COVID capacity plan" is viewed as a success.

Leadership

A number of factors contributed to the establishment of a trusting atmosphere, including leadership, the directions provided and the top-down decision mechanism. Support from senior management was appreciated. The organizational focus on the crisis and respect for each site's local particularities were also important. The pandemic has highlighted the leadership of certain employees.

On the other hand, the communicated information and changes were felt to be too numerous and rapid, leaving no time to apply the new guidelines. The intense pace put a lot of pressure on the teams.

Suggested improvements	• More balance in shutting down operations and managing the pandemic.

Human Resources

Of all the discussion topics, participants were most dissatisfied with human resources.

First of all, we would like to emphasize that there was appreciation for working from home, the employee assistance program and group debriefings after reassignments. The individual debriefing sessions were also a success.

However, psychological distress and human resource shortages were repeatedly mentioned, raising concerns about the psychological health of employees and managers. The reassignment of human resources was a difficult experience for some employees, and they may be reluctant to experience it a second time, even if that means quitting. Faced with this situation, concerns were also voiced about the potential lack of manpower for both the resumption of activities and a second wave. Also, working from home sometimes led to additional work for employees working on site. Communicating with remote employees was sometimes a challenge. Other points were raised, such as the non-optimal use of certain teams and excessive COVID test result wait times.

Suggested improvements	• Distribute work better between teams. • Establish post CHSLD deployment debriefing groups.

Technology

The telehealth effort was viewed as a success, as was the use of the Digital Learning Environment (DLE) platform on which COVID-related training was shared. Remote work tools such as Zoom and Teams were appreciated, as well as the establishment of a COVID WiFi connection that made it possible to use personal tools.

However, difficulties related to telehealth were mentioned (PC fleet not up to date). Also, some provincial management tools did not meet the expectations of clinicians. Finally, the heavy dependence of the finance sector teams on Canada Post was mentioned.

Suggested improvements	• Increase the use of electronic solutions to reduce dependence on Canada Post.

Other points were raised:

- Non-Clinical Operations The lifting of certain financial reporting requirements by the MSSS was appreciated and enabled the reallocation of resources. Conversely, the increase in COVID-specific reporting, most of which is manually generated, has led to stakeholder dissatisfaction.
- Logistics: Some irritants were mentioned in connection with the management of medical supplies and equipment (PPE, N95, etc.). Also, difficulties were encountered when shipping from Quebec.

Suggested improvements	• Create a standardized COVID office layout guide (operating room airlock, office Plexiglas, etc.).

	• Automate desired information as much as possible and leverage existing systems to support decision making.

2.1.4 By the medical chiefs

Methodology

The methodology used with middle managers and associate directors also applies to this section.

Results

As interviews are still ongoing, the results will form part of an addendum to this report.

2.1.5 By members of the Management Committee

During a meeting of the Management Committee, Dr. Gfeller asked about the members' perspective on pandemic management in order to understand what was well done, what could have been done better, what was unexpected, and what could be done differently if a second wave occurs. Here are some their comments, which were taken from the meeting report.

Subjects	Positive points	Suggested improvements
Communication	• Surprised at how quickly information changed and how quickly people adapted. • Communication through the webinars was very well done. • One participant mentioned taking notes during meetings and passing them on to his team, which worked well.	• Decisions that were made at the EMCC were either not communicated to directors who were not present, or the received information was in bulleted form, which was difficult to follow without context. Some information could have been better communicated. • Some people thought they could have done more to reassure others.
Logistics – PPE management	• Internally, the work was collaborative.	• It was difficult to obtain information on PPE from the MSSS and other hospitals. • The availability of supplies was sometimes a problem. • The challenge was to have a stable logistics team for the management of PPE.
Leadership	• Impressed by the speed of the discussions and decision making, this was a very significant asset. The changes were made at an appropriate time (for example, waiting for a weekday rather than implementing the changes on the weekend). • The EMCC's structure was good. • The pandemic provided a good opportunity to do things differently.	• It is important to prepare for the return to work while respecting the protocols.
Human Resources	• The most important factor was the agility of the teams.	• Concerns for the health of staff working seven days a week. • Disability insurance is on the rise. • In the future, a different group of people should be involved.

2.2 360º EMCC Assessment

The objective of the 360º assessment was to determine each person/group's perception of the performance of the EMCC in its management of the pandemic, its management of meetings and its communications.

Three groups were approached in this process: EMCC members, naturally, a small sample of stakeholders directly affected by the decisions/actions of the EMCC, and the representatives of doctors, nurses, patient attendants and members of EMCC subcommittees.

2.2.1 By members of the EMCC

A first exercise was conducted with EMCC members, where they were asked specific questions related to different topics. The members were free to interact with each other. The interview took place by teleconference and was conducted by a representative of the DQEPE. Here are the points raised by the members.

Subjects	Positive points	Suggested improvements
Pandemic management	• Strong leadership from the Emergency Measures Coordinator and senior management • The expertise of each of the members enabled great synergy and cohesion • Ability to make decisions and deliver quickly • Strong clinical coordination	• Communication with Public Health practically non-existent • Discrepancies between the guidelines from OPTILAB management and MUHC guidelines • Discrepancies between guidelines from the FMSQ, MSSS and MUHC
Meeting management	• Rapid establishment of the EMCC • Centralization of decision making	• Insufficient communication about the role of the EMCC and its functioning to the community • Difficult for the community to know how to report information to the EMCC
Themes and subjects discussed at the EMCC and representation	• Topics were well-structured.	• Evaluate the suitability of having a representative of the Direction régionale de la santé publique at the EMCC when required. • Evaluate the suitability of having an emergency representative from the MUHC at the EMCC.
Information required for decision making	• The contributions made by nursing care are very relevant to decision making and the establishment of the many protocols.	• Lack of time between EMCC meetings for reading the documents that need to be approved, especially at the start of a pandemic

Subjects	Positive points	Suggested improvements
Satellite sub-committees	• Ability to create subgroups quickly • Relevant and effective contribution of all sub-committees • Allowed the EMCC to be relieved of certain files to focus on the general coordination surrounding the event • Provided a communication link with the field and allowed information to be brought back to the EMCC	• Coordination between adult and pediatric sites
Conduct of meetings	• Organization and adaptability of meetings • Prompt cancellation of non-COVID-19 meetings in order to focus on the event	
Management of internal and external communications	• Webinars greatly appreciated by the community • Very useful intranet site for communicating new protocols to the community • Appreciation from foundations when MUHC expertise is presented to the public	• Use of NextCloud: assess the possibility of having a training session • Document management on the intranet: difficult to find information or the latest updated documents • Assess the suitability of informing the community of in-progress work • Need a clinical resource person to help with document management • Review the frequency of webinars

2.2.2 By stakeholders affected by the decisions and actions of the EMCC

The approach was made with a small group of stakeholders directly affected by the decisions and actions of the EMCC. Six one-on-one interviews were conducted on the role of the EMCC, access to information and pandemic management. The people we met came from the DRF, the DQEPE, Lachine and clinical sectors. As the number of people consulted is small, the comments are not necessarily ranked in order of importance.

A. Role of the EMCC	**Results**			**Suggested improvements**	**Recommendations**
Agreement with the statements	**Yes**	**+/-**	**No**		
The role of the EMCC is clear	67%	33%	0%	**Consultation** • Lack of consultation with stakeholders affected by a decision. • Impacts/issues for management not well understood by the EMCC. • Lack of Neuro, Lachine, Montreal General Hospital (MGH) and Research Institute representatives at the EMCC. • No access to the EMCC / no dialogue. Must transmit the info through an EMCC member. Difficult when the information is complex. **Vision** • No long-term vision / day-to-day vision	• Distribute tasks more evenly. Do not place everything on one person's shoulders. • Greater nursing care representation at the EMCC (currently 1 nurse for 9 physicians). Have an EMCC representative for research from start to finish, including at the time of resumption of activities. • Provide clear guidelines for all.
The establishment of the EMCC has allowed for good management of the pandemic.	83%	17%	0%		
Our issues were well represented	17%	33%	50%		

B. Access to information	Results			Suggested improvements	Recommendations
Agreement with the statements	**Yes**	**+/-**	**No**		

Information was adequate and allowed time to carry out expected actions and/or measures	33%	17%	50%	• Decision-making was communicated with difficulty (information not provided, lack of context or detail in notes provided, no follow-up to questions asked)
				• Committees created by EMCC almost exclusively clinical
				• Consistency of messages
				• Too much info / too many updates
				• Communication tools
				  ○ Intranet (structure, information difficult to find)
				  ○ Links to information shared do not open on mobile, need to use a computer
				  ○ FAQs (not up to date, unclear, created confusion among employees)
				• Relocation of the DHRCLA created a lot of anxiety
				• Teleworking (slow decision making)
					• Systematically send communications to managers.
					• Have an up-to-date library/document section for COVID.
					• Intranet: Create an open field in which questions, comments and suggestions can be addressed confidentially to the EMCC. This would encourage an exchange of constructive suggestions.
					• Management Committee should take 15 minutes per day or per two days with all directors and others to discuss issues, concerns and answer questions.
					• Find a communication mechanism to relay complex information (expert presence at the MUHC).
					• Have more people relaying information (not putting everything on one person's shoulders).

The tools used met our needs	50%	50%	0%		

Positive points raised

Communication tools, webinars especially, were greatly appreciated. The frequency and completeness of the information, as well as the consistency between stakeholders, were all reassuring.

C. Pandemic management	
Strong points	**Suggested improvements**

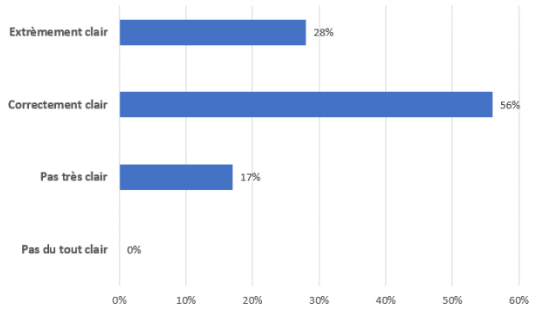
• High appreciation of the EMCC leadership
• Adaptation to sites and strategic and operational issues
• Agility/speed in decision making
• Collaboration
• Communication (webinars)
	• Better representation on the EMCC
	• Send minutes to managers who are not on the EMCC
	• Clinical operations management
	  ○ Have a dedicated location for COVID-positive patients
	  ○ Decrease activities on a single site and keep the others functional
	• Material management
	  ○ Consumer behaviour needs to change
	  ○ Inventory management was creating stress among employees
	  ○ Reassure the teams regarding the supply of materials
	• Teleworking and relocation: HR were unreachable

2.2.3 By physicians, nurses, patient attendants and members of EMCC subcommittees

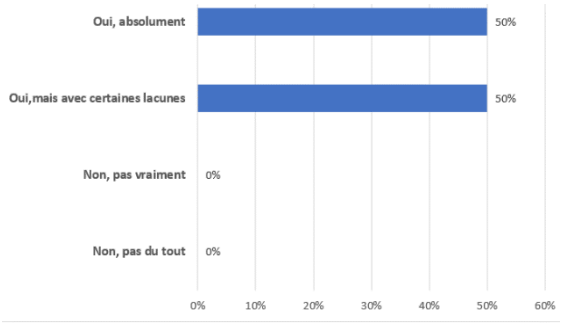
Eighteen people, out of the 66 invited, participated in the survey. These individuals constitute only a sample of all those affected by the decisions and information provided by the EMCC. They were asked nine questions: five were multiple choice and four were open-ended. Here are the results:

A. ROLE OF THE EMCC

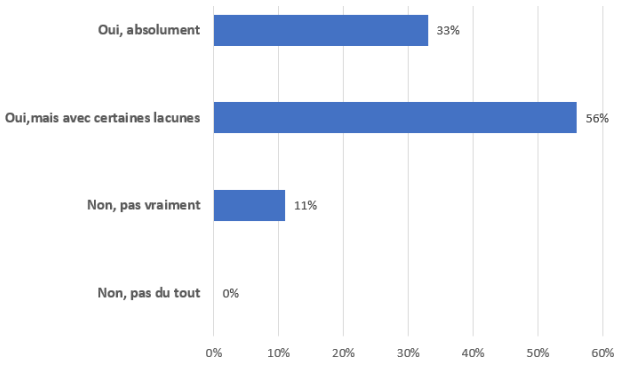
1. **To what extent was the role of the EMCC clear for you?**



2. **In your opinion, has the establishment of the EMCC allowed for good management of the pandemic?**



3. **Were your issues well represented within the EMCC?**

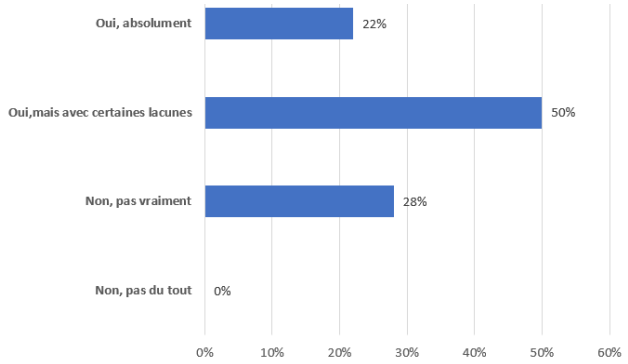


Suggested improvements

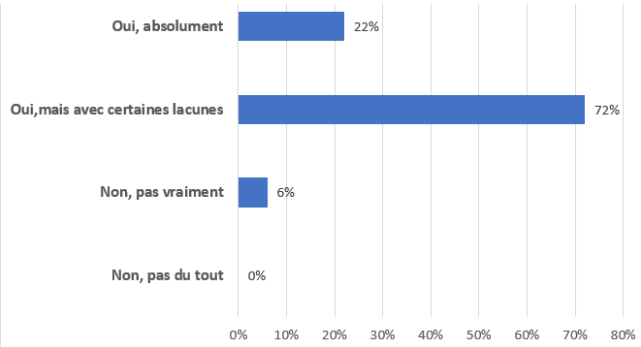
- Hierarchy/structure, roles and responsibilities need to be communicated or established.
- Our unit's leadership felt like it was on its own in terms of policies and procedures.
- The team knew neither the "chain of command" nor how to align our operations with those of the EMCC. Suggestion: publish the EMCC's organizational chart and send a notice of entry into effect.
- Plan B decisions were long to make. We would have had fewer pitfalls had we been more proactive in preparing our plan Bs in advance.
- Several purchasing opportunities were lost due to long response times.

B. ACCESS TO INFORMATION

4. Did you receive information that was adequate and allowed time to carry out expected actions and/or measures?



5. Did the communications tools meet your needs (webinars, FAQs, intranet, etc.)?



Suggested improvements

- Review access to information as not all employees have an MUHC email address.
- Improve the request mechanism.
- Provide more concise information and try to reduce the number of policy changes.
- Develop a better communication plan. Information is not getting to the field quickly enough at the moment.

C. PANDEMIC MANAGEMENT

What was most appreciated	Areas for improvement
• Daily news with protocol updates • The seriousness of our management team and the commitment of most departments to finding solutions for the best possible care • Managers led by example • Dr. Gfeller's webinars • Staff mobilization and support from the foundation	• Commitment of the logistics team, even regular service went out the window. • Communication from the occupational health and safety sector. Clear guidelines in relation to employee returns to work. • Well-defined roles and responsibilities. • PPE management • Better communication plan.

Conclusion

Lots of comments, lots of discussion, lots of suggestions for improvement that will certainly provide food for thought to our decision-makers and teams in their ongoing quest for improvement and renewal. It was a pleasure to participate in this exercise. We hope that this information will meet the two goals we set at the start.

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