Health policy pundits often observe that COVID-19 exposes healthcare's grave deficiencies, inequities and underdeveloped capacities – factors hobbling Canada's COVID-19 pandemic response. This issue of *Healthcare Quarterly* explores some of these weaknesses, illuminating systemic problems that persist despite the cascading damage they cause. It also features accounts of how healthcare leaders, providers and stakeholders did what was possible – not perfect – to contain COVID-19's consequences. Other submissions remind us that even with or without COVID-19 and its all-consuming demands, work on other imperatives must continue.

Responding to the COVID-19 Pandemic

The ominous phrases "flying blind" and "gambling with suffering" in the titles of the opening COVID-19 papers are portents of the consequential and concerning findings that follow. The authors reveal that in areas essential to mounting a defence or offence against COVID-19, Canada is too ill-equipped to slow the pandemic's trajectory and lessen the hurt it has unleashed. They show what happens when essential and complex functions falter.

Findings from an important national study conducted by Snowdon and Forest (2020) reveal a paucity and poverty of data infrastructure and a deficiency in supply chain expertise, rendering informed decision making impossible. They state that Canada needs – and the pandemic demands – the right digital tools and interconnected systems for proper population surveillance, contact tracing and inventory tracking. Without that, transparency, workforce confidence and wellness and the ability to identify and mitigate risk will suffer.

Pereira et al. (2020) note that problems with reliable access to palliative care pain medication predate COVID-19, but the pandemic – and the more than 12,000 deaths it has caused across Canada – has made shortages more dire. This scarcity is as serious as curative medication supply shortages, they argue, and causes avoidable human suffering. Valuable information on shortfalls and distribution problems surfaced during Pallium Canada webinars, pointing to worse-than-anticipated scenarios. By July 2020, 22% of medications within the tier III drug shortage category were first-line palliative care medications.

The healthcare community had scant research to rely on during COVID-19's early days and no option but to act, and fast. Jowett et al. (2020) describe how CorHealth – a cardiac, stroke and vascular services advisor to governments and healthcare providers – used data-driven crowdsourcing tools to quickly gather and update stakeholders, eliciting their input to create provincial policies and local procedures to guide the community. Stakeholder forums and guidance memos helped them navigate patient-care challenges within a system-wide context. The authors describe this crowdsourcing crisis management approach as promising, adding that it offered "a safe space" and created "unity during a time of intense uncertainty" (Jowett et al. 2020: 24).

Havaei et al. (2020) present a case study based on interviews with leaders at a long-term care facility in Vancouver, BC, without a single COVID-19 case. The authors probed the facility's pandemic-management policies, practices and preventive changes, assessing them against a COVID-19 infection-control checklist adapted from the BC Centre for Disease Control. The facility had most requirements in place by early March 2020 but fell short in areas such as single-occupancy rooms, sneeze-guard barriers and an N95 fit-testing and use plan. Strong crisis leadership and safety prioritization are cited as enablers of the facility's infection-free status. The leaders raise internal and external concerns, including incomplete or inaccurate lists of providers working multiple sites, strained staffing levels and poor communication practices, such as publicly announcing resumption of family visits without notifying the facility, for example.

No pandemic issue is more front and centre – literally – than personal protective equipment. Chiu and colleagues (2020) describe the stringent quality assurance processes Sinai Health created for collecting, sorting, inspecting and decontaminating N95 respirators (licensed for single use) and face shields. The authors point out that this is a crisis strategy and not standard operating procedure. The 2,800 decontaminated N95 respirators and 65,000 face shields are in storage, and distribution has not begun. Their use as a conservation strategy is under review.

Environmentally Sustainable Healthcare

Moving outside the pandemic bubble and from conservation to sustainability in Canadian critical care, the article by Yu and Baharmand (2020) reports on results from a survey of the country's intensive care units (ICUs) on environmentally sustainable practices in medical waste management. Responses from all provinces and close to 30% of Canada's ICUs showed variable practices. For instance, of the 76.5% of ICUs using nursing server carts inside patient rooms, 38.7% indicated that all contents were discarded after the patients' discharge even if the patients had no infections from antibiotic-resistant organisms. Responses reflected financial interests as well as environmental concerns. One sustainability innovation reported an 80% decline in the amount of unused equipment waste, yielding annual savings of Can$110,000. Other ICU sustainability efforts include reducing stocking quotas in nursing server

carts, bedside cabinets and central supply rooms and relying on bedside nurses to restock in-room supplies based on their knowledge of patients' needs.

Patient Safety

Collins (2020), chief executive officer of Humber River Hospital, details the development of the HRH Command Centre (CC1) and its enhanced version (CC2), both driven by a singular, steely-eyed aim to alleviate and eliminate patient harm. Collins states that since the 2017 launch of the command centre, the equivalent of 35 additional in-patient beds has been generated, despite an 8% growth in emergency department visits. Collins calls CC2 a world's first, integrating standardized early warning systems with predictive analytics to generate real-time data drawn from automated systems identifying subtle changes in patient conditions and early recognition of safety threats.

Workplace Safety

Corovic et al. (2020) describe the careful creation of the Hamilton Health Sciences (HHS) Behaviour Safety Risk Communication and Care Planning program to reduce workplace violence – a mandated quality-improvement indicator. The program identifies and communicates patients' risk of unsafe behaviour, striving to safely manage behaviour with fairness, dignity and respect. Changes emerged during development, adding support for improved communication to and with families and patients and providing better caregiver information to involve families in care planning. Corovic et al. observed an "emotional overlay" to the project, reporting staff concerns about negatively labelling patients. Purple wristbands identifying patients with risks were introduced to address recognized gaps in clinical and non-clinical staff communication during patient transfers. Surveys conducted post-implementation show stronger staff confidence and increased screening completion at several of HHS's six sites.

Engaging with Patients and Their Families

Patient-centred care is far from being entrenched in the institutions, culture and practice of healthcare – a reality reflected in a project to create mandatory caregiver-identification badges with preferred names and pronouns (Duan et al. 2020). The aim is to improve communication and partnerships among family caregivers, patients and healthcare providers. The pandemic accelerated the production of new badges, prompted by increased hospital screening procedures to identify caregivers. The project team will pursue inclusion of preferred names and pronouns on caregiver badges and plans to test caregiver satisfaction with a larger group and evaluate healthcare provider perceptions of the new badge.

Quarterly Columns

In this issue's regular columns, ICES reports that "snowbirds" returning to Ontario suffered no disproportionate impact from COVID-19 (Shariff et al. 2020). In a Canadian Institute for Health Information survey, Cho et al. (2020) report three new, highly relevant baseline indicators released as part of a collective effort to improve access in two sectors, namely, mental health and addictions service and home and community care: self-harm, including suicide; caregiver distress; and new long-term care residents who potentially could have been cared for at home.

– The Editors

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