AUDITOR GENERAL
OF NEW BRUNSWICK

VÉRIFICATEUR GÉNÉRAL
DU NOUVEAU-BRUNSWICK

# COVID-19 Pandemic Response – Department of Health

Volume II – Chapter 4
2023 AGNB Annual Report

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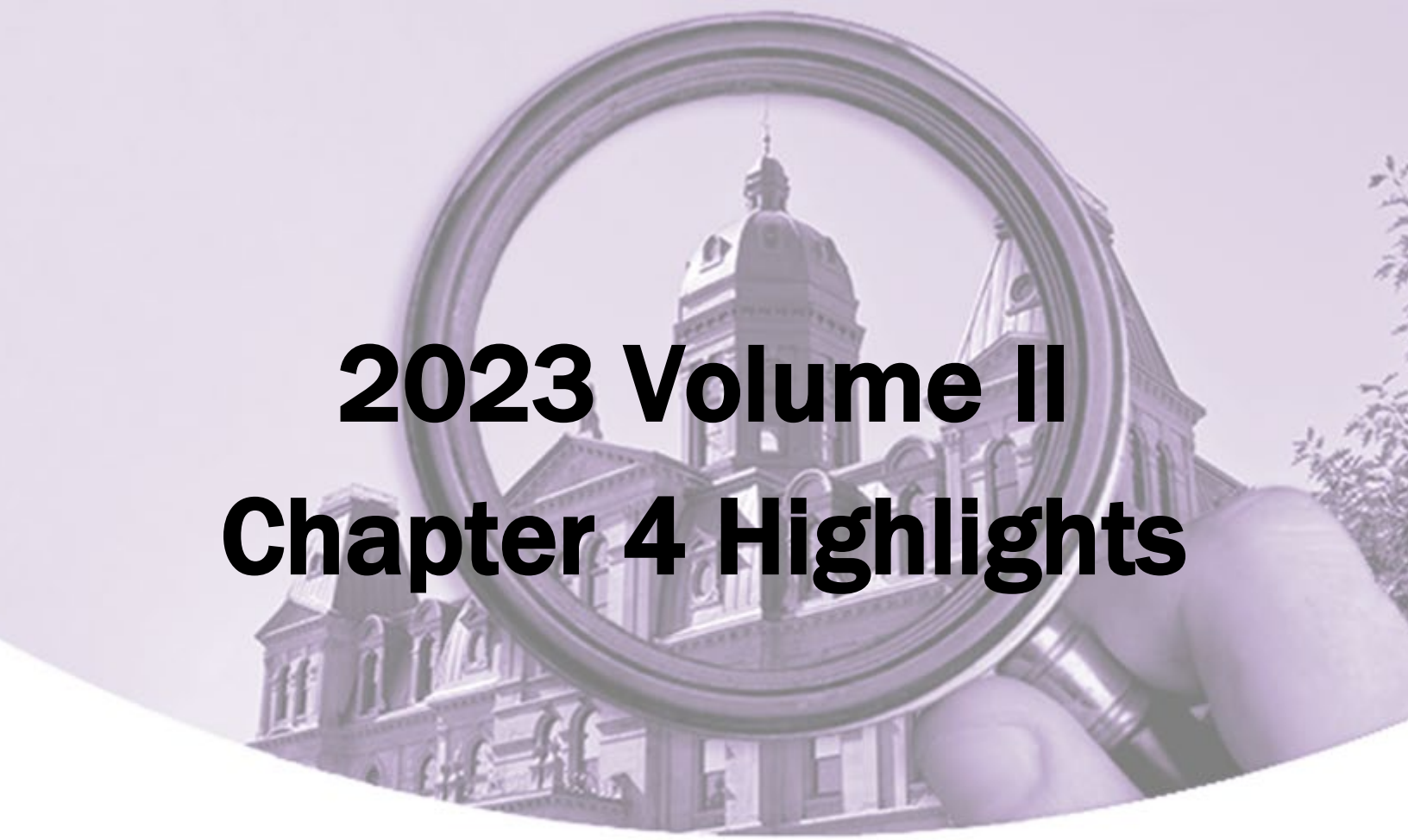


# 2023 Volume II Chapter 4 Highlights

| | | |
|---|---|---|
| **Numerous staff consistently stepped up in the navigation of these unprecedented times** | **While various performance targets were established, outcomes were not consistently monitored, tracked, or used for decision-making** | **Department of Health was designated the lead for the pandemic health response** |
| **We found that the Department and Regional Health Authorities went above and beyond to support New Brunswickers during the pandemic** | | |

## Overall Conclusions

- The Department had numerous systems and procedures designed to reduce the spread of COVID-19.
- Areas for improvement were identified to assist in planning for future pandemics.

# About the Audit

## Introduction to the Audit

4.1 The Department of Health (the Department), more specifically the Office of the Chief Medical Officer of Health (OCMOH / Public Health), is responsible for the overall direction of public health programs in the province and works collaboratively with the Regional Health Authorities (RHAs) and other government and non-government health services providers.

4.2 Areas within Public Health's mandate are:

- disease and injury prevention
- surveillance and monitoring
- public health emergency preparedness and response

## Why we Chose this Topic

4.3 A motion was passed in the Legislative Assembly on March 31, 2022, requesting that our Office undertake a review of the provincial government's response to the COVID-19 pandemic.

4.4 The COVID-19 pandemic represents a significant moment in history, impacting the lives of all New Brunswickers.

4.5 The Department was designated the lead for pandemic health response purposes and was responsible for many key aspects of the Province's response.

## Auditee

4.6 The auditee was the Department of Health, and we also obtained audit evidence from the two regional health authorities.

## Audit Scope

4.7 Our audit covered key operational areas intended to reduce the spread of COVID-19, including:

- testing
- contact tracing
- contact management
- infection prevention and control guidance

4.8 We met with departmental and RHA staff, including several front-line workers. Quotes from the front-line obtained from some of our interviews can be found in Appendix IV. Our work included the OCMOH's role in the travel exemption process.

4.9 Our audit scope covered the period from **April 1, 2020** to **March 31, 2022**. We examined information outside this period as we deemed necessary. Details pertaining to the audit objective, criteria, scope and audit approach can be found in Appendix II and III.

## Audit Objective

4.10 The objective of this audit was to determine if the Department of Health had systems and procedures in place to effectively reduce the spread of COVID-19.

## Conclusion

4.11 The Department and RHAs went above and beyond to support New Brunswickers during the COVID-19 pandemic. There are stories of numerous staff consistently stepping up in the navigation of these unprecedented times.

4.12 Our audit work has concluded that the Department had numerous systems and procedures designed to reduce the spread of COVID-19.

## Summary of Findings

4.13 We have noted the following gaps that, if addressed, will improve responses to any future pandemics:

technology was lacking and data was not always used to support staffing-level decisions

while various performance targets were established, outcomes were not consistently monitored, tracked or used for decision-making

there was inconsistent record keeping and documentation pertaining to infection and prevention control decisions

there was a lack of established criteria to support decision outcomes related to exemption requests escalated to the Chief Medical Officer of Health

# Background

4.14 The Provincial Contingency Plan for Health-Related Communicable Diseases was originally developed in 2009 as part of the H1N1 influenza response. Updated in May 2019, the plan's focus was still based on an assumption a pandemic would be from a new strain of influenza. A provincial plan was updated in March 2020 outlining the roles and responsibilities for responding to public health events that are pandemic in nature.

4.15 According to the plan, the overall goal of pandemic response is to:

- minimize and prevent serious illness and overall deaths
- minimize societal impacts
- minimize economic disruption

4.16 OCMOH's role included overseeing the following:

- monitoring and surveillance
- risk assessment and communications
- public education
- case and contact management
- testing
- vaccination
- infection prevention and control
- provision of specific health services and evidence-informed recommendations

4.17 The New Brunswick Health Emergency Operations Centre (HEOC) created a COVID-19 Pandemic Plan which was finalized on July 2, 2020, after the first wave of COVID-19 had occurred.

4.18 According to HEOC, the key components of an effective health response for which the Department is responsible are testing, contact tracing/case management and containment.

## Testing

4.19 There were two types of testing used during the Province's response to the pandemic:

- Polymerase Chain Reaction (PCR)
- rapid antigen detection tests, often called rapid tests or point of care testing (POCT)

## Contact Tracing and Case Management

4.20 Case and contact management includes follow up for identified positive or probable cases, from a professional with specialized training. The individual's health condition is assessed, a determination is made as to whether additional health resources or supports are required, and exposures and links to other cases are obtained.

4.21 The three key components of contact tracing are:

- case interview/contact identification
- contact listing and risk stratification
- contact follow up

## Containment

4.22 Containment of outbreaks was led by Public Health with guidance from the Public Health Agency of Canada. Quarantine and other control measures were put in place such as physical distancing, and personal protective equipment at workplaces, some of which were inspected by WorkSafeNB and Public Health Inspectors.

4.23 Other control measures put in place by the Province related to restrictions on travel. While the majority of travel exemptions were managed by the then Department of Public Safety, complex cases were escalated to the OCMOH.

## Pandemic Task Force Established

4.24 A Pandemic Task Force (PTF) was established by the Department in April 2020 and was vested with operational decision-making authority and clinical direction with respect to the pandemic response for all aspects of the health care system, including the Regional Health Authorities, Extra-Mural/Ambulance New Brunswick Inc., primary care and the long-term care system. Composed of an infectious disease specialist, an RHA Chief of Staff, and the Chief Medical Officer of Health, this task force reported directly to the Clerk of the Executive Council through the Deputy Minister of Health.

4.25 The Deputy Minister chaired the meetings, supported by the Department of Health's executive management committee. The PTF met every weekday and on weekends as necessary. This schedule was subject to change based on the need to respond to the pandemic situation. The PTF called upon health professionals with relevant experience to provide expertise to inform and/or validate its decisions, where deemed appropriate. Input was also sought from the Department, namely Public Health, by Cabinet when developing response plans, restrictions, and public messaging, which would inform the mandatory orders.

## Lack of Useful Reporting

4.26 An overall theme of our findings was that while data was available, it was not always used, analyzed, and reported upon in order to effectively support key decisions. Antiquated technologies, paper-based records, quick turn around times, and staff shortages were some of the contributing factors to this gap.

4.27 Information pertaining to established targets and staffing capacity were captured at the regional levels pertaining to COVID-19 testing, case management, and contact tracing. However, data often was not compiled into a formal report or accessible on a platform, such as a dashboard, that would inform the Department of performance against targets or where critical staffing shortages were.

4.28 An important component of any public health response is the ability to adjust staff capacity for case management, contact tracing, and testing in response to changing conditions. The Department did, as part of its well-established processes, verbally discuss staffing capacity shortages with regions on a regular basis. Staff informed us this could be often several times a day. While we recognize the immense dedication and sacrifices made by many staff during this period, we have noted some process improvements to consider for any future emergencies of this nature.

## Key Performance Indicators Established but Not Monitored or Reported

4.29 The Department established performance indicators for priority areas in its 2020 Pandemic Plan. Targets were set with documented expected outcomes and service levels. However, the Department did not monitor the level of achievement of the established targets.

4.30 We could obtain no reporting of levels of achievement of established performance indicators that would have gone to senior management, government decision-makers, or the public.

## Targets Were Not Adjusted as Situation Evolved

4.31 With the exception of vaccination rates, targets established in early 2020 were never adjusted. As cases surged with the introduction of the Omicron variant, targets and processes set up by the Department were no longer relevant. The POCT strategy shifted; however, no new targets were created to determine if that strategy was effective. For example, the target of zero COVID spread remained, despite this level of spread being an unrealistic target during the Omicron wave.

### Recommendation

4.32 **We recommend the Department develop, monitor and report on established key performance indicators. Targets should be regularly reviewed for ongoing relevancy, and revised accordingly.**

## Testing

4.33 Testing is essential to identifying cases of COVID-19 and initiating the process of isolating those infected with the virus to reduce spread. PCR testing was the most common type of test used to detect COVID-19.

4.34 Specimens were collected for testing in various settings, including hospitals, long-term care, and assessment centres set up throughout the province.

4.35 RHA Assessment Centres collected specimens and were responsible for registering the results in the RHA Laboratory Information System. Results were then sent to Public Health and, if applicable, the ordering physician. Initially, RHAs were calling patients with test results; however, as the pandemic progressed, a Department-led outbound call centre was established to support the health regions. Once MyHealthNB was made available, this was used as a communication channel for patients.

4.36 Indicators established by the Department used to determine successful testing programs included:

- number of tests conducted per day
- testing positivity rate
- wait time from test referral to receiving results
- availability of test supplies

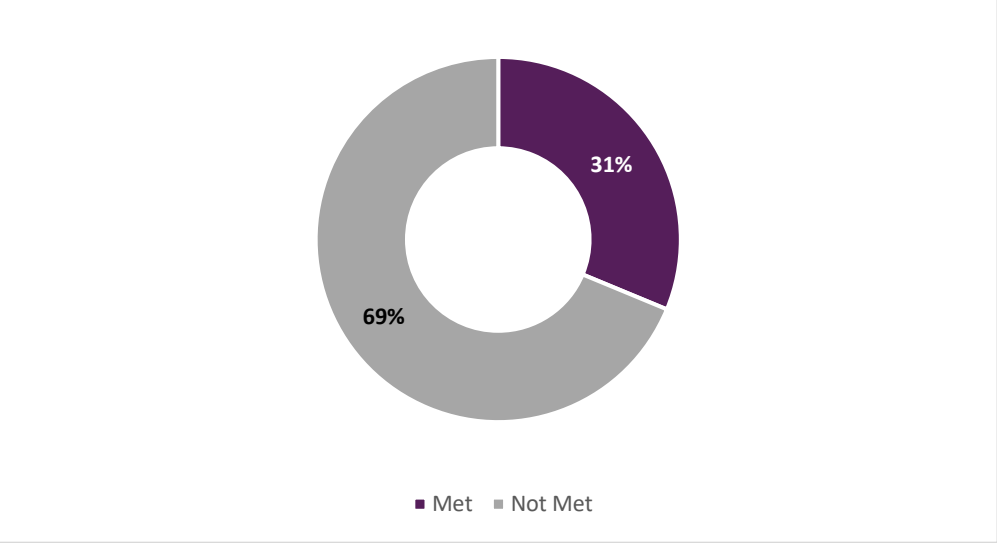
4.37 Targets set by the Department pertaining to testing were:

- 24-hour average time from assessment to specimen collection
- 24-hour average time from specimen collection to result

4.38 As data was not available at the Department, we obtained information from the RHAs for our audit purposes. In order to evaluate actual performance levels against targets, we had to obtain data from various information systems and patient files.

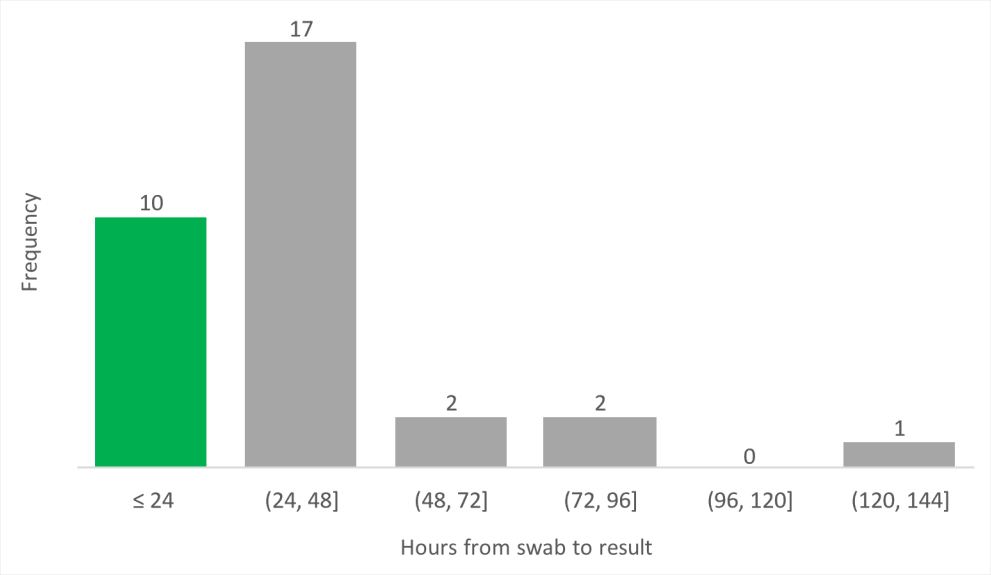
4.39 As part of our audit, we sampled data from 32 tests to determine specimen to collection turnaround time results. As shown in Exhibit 4.1 and 4.2, only 31% (10 of 32) met the established target of 24 hours, however, most tests 84% (27 of 32) were completed with results being provided within 48 hours. The longest time we observed in our sample was one test that took 144 hours (6 days) to obtain results.

*Exhibit 4.1 – Specimen Collection to Result Turnaround Times vs. 24-Hour Target*




*Source: Prepared by AGNB with data from RHAs and the Department (unaudited)*

*Exhibit 4.2 – Frequency of Hours from Specimen Collection to Result*




*Source: Prepared by AGNB with data from RHAs and the Department (unaudited)*

## Incomplete Situation Reports

4.40 The Department monitored new cases reported, number of tests performed, and positivity rate in its daily situation reports until April 26, 2022. We sampled reports for 29 days during the pandemic and found the Department could not provide reported data for 34% of the days sampled.

## Testing Kit Inventory Not Formally Monitored

4.41 Point of Care Tests (POCT) were an important component of managing the pandemic. Between January 2021 and December 2022, a total of 17,700,195 tests were received from the Federal Government. As of January 2023, the Province had distributed 17,127,735 tests to New Brunswickers. This was done via several distribution channels:

- RHA pick-up sites
- libraries
- municipalities
- businesses

- First Nation communities
- The Department of Social Development
- New Brunswick Medical Society (physicians)

4.42 The Department did not have a formal way of tracking the demand for test kits and available inventory levels. During Fall 2021, distribution was based on a "first come first served" basis, but staff informed us of:

- long line-ups and challenges in managing flow of clients
- public frustration
- limited storage space at distribution sites resulted in stock being depleted daily

4.43 Therefore, the Department changed the POCT strategy partway through the pandemic. An appointment-booking system was created, but poor data systems still did not allow for adequate monitoring of inventory levels and distribution could not be matched with demand. Tests were distributed with no tracking done by the Department as to how, when, or if these tests were used. POCT wastage was not recorded. The approximate volumes of test used in specific sectors, based on data from May 2022 to November 2022, were as follows:

| Sector | Approximate Volume of Tests (Every Four Weeks) |
|---|---|
| Social Development | 300,000 |
| Large Employers* | 130,000 |
| First Nations | 8,508 |
| *Large employers are those with 300 or more employees. | |

*Source: Prepared by AGNB with data from the Department (unaudited)*

4.44 The approximate volume of tests used over a four week period for the Province was as high as 600,000 in early December 2022 and as low as 370,000 in January 2023. Documents provided by the Department indicated test availability could have been improved in rural locations and when demand was high. Nearing the end of the global emergency, in March 2022, the Department's estimates indicate the POCTs were not being utilized adequately, however, staff informed us inventory data was unreliable.

### Recommendation

4.45 **We recommend the Department of Health increase data-systems capacity to adequately monitor test inventory during a pandemic to ensure supply meets demand.**

## Case and Contact Management

4.46 Contact tracing is a key public health measure to slow down or stop the spread of the virus. Throughout the pandemic, contact tracing was completed to contact those individuals who had been identified as having had a close contact with a probable or confirmed case of COVID-19 and to communicate public health requirements. The purpose of contact tracing is to:

- advise the individual about potential exposure to COVID-19
- advise the person to self-monitor and seek healthcare if required
- inform the person about any self-isolation requirements

4.47 The departmental indicators established to determine the effectiveness and capacity of contact tracing included:

- all contacts reached by Public Health and actively monitored
- close contacts reached and actively monitored
- all contacts reached in a timely manner
- close contacts reached in a timely manner

4.48 The Department's established targets for contact tracing were as follows:

| Contact Tracing Indicator | Target |
|---|---|
| All positive cases reached by Public Health and actively monitored within 24 hours | 90% |
| Reach or actively monitor identified close contact after the results has been communicated to the positive case within 48 hours | 100% |

4.49 The Department informed us that these targets were set as a guideline, and that there was no intention to monitor or report on the level of achievement.

4.50 We sampled 36 positive test cases and determined that 97% were contacted about their positive status. 96% of the cases we sampled received case management from Public Health when it was applicable.

4.51 Of that sample, there were 15 positive tests that would have required contact tracing. We reviewed those to determine how many cases:

- had close contacts notified
- had close contacts notified within 48 hours

4.52 We determined that:

- 100% of close contacts were notified
- 67% of the close contacts were notified within the 48-hour established targeted timeframe
- one contact from our sample was not notified for potential exposure for 142 hours (approximately six days)

## RHAs Adjusted Staffing Levels

4.53 At the start of the pandemic, there was an informal process whereby a call for support was made to all trained staff. However, a very limited number of staff were trained in contact tracing, so nurses and managers travelled throughout the Province during the first wave to work in different zones.

4.54 Subsequently, each health zone created its own system for adjusting staff capacity. Public Health managers would assess what would be required for that day and, on an ad hoc basis, would reach out to other zones for assistance. Once the nurse supply was exhausted, registered dietitians and health inspectors were added to the training pool. Various other staff members were assigned non-clinical roles, such as assisting in case assignment.

4.55 Each manager charged with oversight of a particular health zone created the schedule for their zone. Although this was an ad hoc process, we found the RHAs were able to adjust for changes in demand relatively well.

4.56 We tested the RHAs' ability to adjust capacity by examining nine waves of positive cases across the seven health zones throughout the pandemic. We found in 47 of the 63 instances (75%), the RHAs were able to adequately adjust staff capacity in response to demand.

## Standard Operating Procedures and Training Provided to Statistics Canada

4.57 Due to capacity issues, the Department outsourced some parts of contact tracing to Statistics Canada. We noted there were standard operating procedures developed and training provided.

## Staffing Crisis Plan Lacked Clarity

4.58 The Department developed a Hospital Staffing Crisis Management Plan (HSCM). The plan denoted under what circumstances to move to the next level of action. For example, the progression from phase 1- 2 of the action plan, would be triggered with:

- significant hospital admissions, COVID cases and community spread
- increasing staff/physician absenteeism

4.59 The lack of clear targets for moving from one phase to another contributed to confusion and differing interpretations amongst regions. Associated operational status reports provided to our office were incomplete and showed no evidence that the Department monitored the implementation of the established parameters for the different risk levels or phases.

### Recommendation

4.60 **We recommend the Department of Health provide clear targets to support the decision-making process when moving between various phases of a staffing crisis action plan. This should form part of an up-to-date pandemic plan.**

## Critical Care Nursing Initiative Established to Support Capacity

4.61 The Department established a Critical Care Nursing Deployment Initiative in early January 2022 that ran until March 1, 2022. The intent was to support critical care staffing needs due to an increase in staff absences caused by the Omicron variant.

4.62 Nurses were offered incentives to participate, including a $1000 sign-on bonus, an additional weekly premium pro-rated ($1000 per 37.5 hours worked), 15 hours of vacation time per 37.5 hours worked to a maximum of 75 hours, as well as travel, lodging and meal compensation.

4.63 Statistics pertaining to the program were as follows:

- 252 inquiries
- 136 applications
- 32 applications screened in
- 27 applications accepted and nurses deployed accordingly

4.64 The Department did not formally review the efficacy of the program, and we were unable to obtain assurance that the initiative was successful in meeting the identified need.

### Recommendation

4.65 **We recommend the Department of Health review the efficacy of the critical care nursing initiative to determine if it accomplished its intended objectives and note any future improvements should the need arise again.**

## Over-Dependence on Key Personnel

4.66 Public health guidance would pivot quickly in response to changing epidemiological conditions. Changing plans meant modifying associated guidance documents, often several times within a short period of time. Senior leadership and staff informed us that key staff were relied upon to continue performing their day-to-day tasks, as well as the COVID-19 emergency work and that this continued for

months on end. This has reportedly led to exhaustion, fatigue, mental health challenges, and in some cases job changes or resignations.

4.67 The Department does not have a staffing contingency plan that would reduce reliance on key personnel. Such efforts would allow the right staff to be utilized for emergency purposes, while allowing other staff within the Department, or Government, to continue to perform day-to-day duties. We acknowledge a great deal of work was done under the "One Team One GNB" approach, providing much needed assistance across various departments where possible. However, there were key roles within the Department that were unable to be backfilled due to a lack of cross-trained staff.

### Recommendation

4.68 **We recommend the Department of Health develop a contingency plan, as part of its business continuity planning, that outlines back-up procedures for key personnel, both at the Department and regional levels.**

## Compassionate Travel Exemption Process Lacked Decision Criteria

4.69 The compassionate travel process established by the then Department of Public Safety included escalation to the OCMOH for cases in which "the reason for applying is unclear or a decision cannot be discerned based on the information provided". A total of 314 applications were referred to the OCMOH.

4.70 Due to the risk and sensitivity pertaining to an exemption process such as this, we audited the existence of:

- established decision making criteria, that were equitably applied to all
- adequate documentation to support the decision

4.71 We determined there were no established decision-making criteria that would support decisions and ensure consistent application. In our sample of 25 cases, we determined that documentation pertaining to the rationale behind the decision was available for only 16 applications (64%).

## Recommendation

4.72 **We recommend the Department of Health ensure:**

- **decision criteria are established and consistently applied for any process which may result in exceptions for adherence to mandatory orders**
- **rationale used for decision-making for exemptions is well-documented**

# Inconsistent Documentation Pertaining to Infection Prevention and Control

4.73 The PTF was vested with operational decision-making authority and clinical direction with respect to the Infection Prevention and Control (IPC) measures specific to the pandemic response. It was comprised of the Chief Medical Officer of Health, a lead physician from each of the two Regional Health Authorities, and it called upon other health experts to inform and/or validate its decisions.

4.74 The PTF communicated clinical direction via memoranda distributed to staff in hospitals, RHAs, Extra-Mural/Ambulance New Brunswick Inc., the primary care sector, and the long-term care system.

4.75 Our office reviewed 35 IPC memoranda to determine if guidance provided to the healthcare system was based on evidence. We noted that:

- 31 were substantiated with expert opinion, or had sufficient evidence
- in 1 case, directives were provided by the Deputy Minister regarding the movement of physicians and staff outside the province
- in 3 instances, the Department could provide no records or supporting documentation for its IPC policy decisions

4.76 We were told the PTF decision making worked via consensus, however, record keeping was such that no clear evidence of deliberation was retained.

## Lack of Documented Evidence to Substantiate Public Health Recommendations

4.77 Our office selected a sample of 33 OCMOH recommendations and asked the Department to provide evidence-based documentation to substantiate the decisions. The Department was unable to provide requested documentation, acknowledging that they "did not create a compendium or a repository of all of the scientific articles, papers, publications and analyses it consulted during the pandemic and therefore we cannot provide a fulsome and detailed list of all of the evidence consulted and used when recommendations were being formulated."

### Recommendation

4.78 **We recommend the Department of Health ensure the development and retention of adequate documentation to substantiate public health measures.**

# Appendix I: Recommendations and Responses

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **4.32** | develop, monitor and report on established key performance indicators. Targets should be regularly reviewed for ongoing relevance and revised accordingly. | The Department of Health agrees with the need to monitor and report on key performance indicators.<br><br>The Department will be participating in GNB's after-action pandemic review which will aim to update the provincial pandemic plan based on the lessons learned from the COVID pandemic, including recommendations from this report. | By end of 2024-25 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **4.45** | increase data-systems capacity to adequately monitor test inventory during a pandemic to ensure supply meets demand | The Department of Health agrees with the recommendation.<br><br>The Department will be participating in GNB's after-action pandemic review which will aim to update the provincial pandemic plan based on the lessons learned from the COVID pandemic, including recommendations from this report. | By end of 2024-25 |
| **4.60** | provide clear targets to support the decision-making process when moving between various phases of a staffing crisis action plan. This should form part of an up-to-date pandemic plan | The Department of Health agrees with the recommendation.<br><br>The Department will be participating in GNB's after-action pandemic review which will aim to update the provincial pandemic plan based on the lessons learned from the COVID pandemic, including recommendations from this report. | By end of 2024-25 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **4.65** | review the efficacy of the critical care nursing initiative to determine if it accomplished its intended objectives and note any future improvements should the need arise again | The Department of Health agrees on the need to assess all programs, such as the critical care nursing initiative to ensure they meet their intended purpose. | Ongoing |
| **4.68** | develop a contingency plan, as part of its business continuity planning, that outlines back-up procedures for key personnel, both at the Department and regional levels | The Department of Health agrees with this recommendation.<br><br>The Department will update the department's business continuity plan based on the lessons learned from the COVID pandemic. | By end of 2024-25 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **4.72** | ensure:<br>• decision criteria are established and consistently applied for any process which may result in exceptions for adherence to mandatory orders<br>• rationale used for decision-making for exemptions is well-documented | The Department of Health agrees with the recommendation.<br>The Department will be participating in GNB's after-action pandemic review which will aim to update the provincial pandemic plan based on the lessons learned from the COVID pandemic. | By end of 2024-25 |
| **4.78** | ensure the development and retention of adequate documentation to substantiate public health measures | The Department of Health agrees that documentation related to meetings and decisions should be reinforced to ensure greater transparency on the decision-making process during health emergencies. The Department will ensure that enhanced record keeping practices are integrated into its health emergency operations. | Ongoing |

# Appendix II: Audit Objective and Criteria

The objective and criteria for our audit of the Department of Health's Pandemic Response are presented below. The Department reviewed and agreed with the objective and associated criteria.

| | |
|---|---|
| **Objective 1** | **To determine if the Department of Health had systems and procedures in place to effectively reduce the spread of COVID-19.** |
| Criterion 1 | The Department of Health should have adjusted capacity for case management, contact tracing, and testing in response to disease prevalence and in accordance with good practice. |
| Criterion 2 | The Department of Health should have established targets based on good practice, monitored results, and taken corrective action when targets were not met. |
| Criterion 3 | The Department should have provided evidence-based guidance to the healthcare system regarding COVID-related Infection Prevention and Control policies. |
| Criterion 4 | The Office of the Chief Medical Officer of Health should have made evidence-based recommendations. |
| Criterion 5 | The Office of the Chief Medical Officer of Health should have followed a defined travel approval process for applications referred to the Chief Medical Officer of Health. |

# Appendix III: Independent Assurance Report

This independent assurance report was prepared by the Office of the Auditor General of New Brunswick on the Department of Health. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the Department of Health on its response to the COVID-19 pandemic.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook – Assurance.

AGNB applies the Canadian Standard on Quality Management 1 – Quality Management for Firms That Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement, and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit
- acknowledgement of the suitability of the criteria used in the audit
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided
- confirmation that the findings in this report are factually based

**Period covered by the audit:**

The audit covered the period between April 1, 2020 and March 31, 2022. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters that occurred outside the audit period.

**Date of the report:**

We obtained sufficient and appropriate audit evidence on which to base our conclusion on December 8, 2023, in Fredericton, New Brunswick.

# Appendix IV: Quotes from the Frontline

As part of our work, we interviewed several front-line workers to obtain insight into their experiences during the pandemic. This appendix contains excerpts from some of these interviews.

| Frontline Worker | Interview Excerpts |
|---|---|
| Nurse | *"I worked 14-hour days 6 days per week for 7 weeks. That was to give the minimum level of care – to make sure no one was starving, people were hydrated and getting medications."* |
| Paramedic | *"It was chaos."*<br><br>*"There were three separate instances where I received phone calls asking me to work in facilities because regular staff just left. In describing these situations, 'horrendous' is a nice term."* |
| Doctor | *"I had trouble navigating the list of exposures provided – it was difficult to sort by anything besides alphabetically – not by region or by date. I would have liked to be able to sort by most recent, instead of just seeing the multiple exposures at A&W, for example."*<br><br>*"The people worked hard – people were definitely stretched – and I think having to manage patients who were totally upset because they couldn't have visitors was hard on doctors."* |

*Source: Prepared by AGNB, unaudited*