Long Term Care Covid-19 Commission Mtg.

Meeting with Maria Elias, CEO of Belmont House
on Tuesday, October 20, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 20th day of October, 2020, 11:00 a.m. to 12:05 p.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTING:

Maria Elias, CEO of Belmont House

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat

John Callaghan, Counsel, Long-Term Care Commission Secretariat

Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat

Derek Lett, Policy Director, Long-Term Care Commission Secretariat

Jessica Franklin, Ontario Long-Term Care Commission Secretariat

Dawn Palin Rokosh, Director Of Operations, Ontario Long-Term Care Commission Secretariat

-- Upon commencing at 11:00 a.m.

COMMISSIONER MARROCCO: So thank you for agreeing to meet with us. We were very interested in your response, Belmont House's response, because it seemed to have been effective from our perspective. And we thought it would be beneficial, from our point of view, if we could talk to people who had successfully navigated their way through this. And so hence our request to speak to you.

There's a transcript. We have a reporter, so we do have a transcript and we put the transcripts on our website eventually, within a few days.

So we're ready when you are, unless you're waiting for someone. We would like to get your thoughts and impressions, this will be extremely helpful to us.

MS. ELIAS: I want to start first by thanking the Commission for this invitation. It's an honour, but it's also a little nervous for me to present our perspective and how we did things. Because, you know, how we did things six months ago is certainly different than how we're doing things

today. But there are some common themes. And the common themes are to stay ahead and take this virus seriously.

So what I did was, I took the opportunity to do a brain dump actually. So there's a number of slides here, I've got about 30, I think, that almost are like notes. So certainly you can interrupt me at any point in time, and if I don't get through them all, at least you have them for your reference.

COMMISSIONER MARROCCO: All right.

MS. ELIAS: So what I'm going to talk about this morning is basically our perspective and how we handle things.

And so are you able to see the "Belmont House" on the screen?

COMMISSIONER MARROCCO: Yes, I have the slide on my screen. I think everybody can see it.

We can.

MS. ELIAS: Great. Just to give you a basic background.

Belmont House is located in what I consider Downtown Toronto. We're a not-for-profit charitable long-term care home and retirement home. We have 140 long-term care beds and 81 retirement

department. It's important to note that one of our nursing units is located in our east building that houses all the retirement department.

So we do operate as one campus of care. We've been around historically since 1852, where we started off as a Magdalen Asylum and Industrial Refuge for women that were in trouble and evolved to this point today where we have long-term care and retirements living.

So when I talked about our perspective here at Belmont House, I'm going to basically cover what we did before the pandemic -- well, before COVID-19 was declared a pandemic by the WHO. When the pandemic was declared, Wave 1 and Wave 2 of preparedness and our thoughts on that.

And I'll bring you some perspective in terms of Belmont House, but also from some of my colleagues. I won't specifically identify them, because I have not gotten permission to speak on their behalf, but just the feeling of some of my colleagues and other charitable not-for-profit homes.

Before I get into the detail, I think it's important to identify that long-term care providers, and the whole system, the healthcare

system, people think of long-term care as operating the same as hospitals, but we do have three distinct providers that provide long-term care as part of the healthcare system.

So, basically, the three providers are municipal regional homes, like the City of Toronto or the Region of Peel. Then you have not-for-profit charitable homes like Belmont House, or the Hellenic Home, the Copernicus Lodge, Unionville Home Society, the Wexford, Sheppard Village, to name a few. And they operate very similar to the Belmont House campuses.

And then you have for-profit that people generally hear of quite often, especially through this pandemic. And these are the chains like Chartwell and Extendicare.

So what did we do early on? I mean, certainly in terms of Belmont House, and if I can say that our success was related to these things, nobody knows 100 percent for sure, but we feel that what we did implement very early on, certainly led to our success and certainly led to a delaying of an outbreak at Belmont.

So we monitored the world and Canadian situation, and we determined very early on, that

the signs were all there for a pandemic and that we really needed to prepare.

We looked at what we did here at Belmont during SARS. I've been here at Belmont for 20 years, a lot of members of my management team have been here for many, many years, and we recall what we went through during SARS, and we thought, here we go again. We better start thinking.

And we looked at our pandemic plan, we assessed our staffing, our food, infection control, our PPE inventory, and we started looking at preparing for what we felt was the inevitable. Even though at that point in time at the federal level, even at the provincial level, there didn't seem to be that panic. It seemed to be something that was far away on a different land and wasn't going to hit us. But we felt that with the first phase happening in Toronto in February, that we really were in the situation of not whether it would happen, but when it would happen.

So we determined very early on that we needed more PPEs, and we started checking in with our suppliers and we discovered --

COMMISSIONER MARROCCO: Can I stop you there for a second?

When you say "very early on", approximately when?

MS. ELIAS: So this part is like February. So in February, because the World Health Organization declared it as a pandemic in March, the second week of March, I believe.

So in February, looking at the world situation, we felt that it might come to, you know, Canada, Toronto, we started looking at our pandemic plan, and started looking at our supplies. And generally, when we look at our PPE supply, we have orders that we place.

And so what happened was, we started calling our suppliers back in February -- sorry, close to the end of February. And we soon discovered that our suppliers, our regular suppliers of PPE were indicating that they would not be able to fulfill the orders for our PPEs.

And after calling a number of them, and then we discovered, oh, those supplies, where are they going? Well, they're going to be stockpiled by government. Now we didn't know what level of government that might be. Were the supplies that we had ordered going to the federal stockpile, the provincial stockpile? We didn't know. All we knew

is that our orders were not going to be completed.

So at that point in time, we started hustling with a number of my colleagues, I belong to an alliance, a group of homes in the GTA. And we started sharing that information, and we soon discovered that many of us were in the same boat. And so we started looking at sourcing different suppliers for PPE, because we wanted to be ready. We didn't want to be in a reactive stage, because we do remember what we went through during SARS.

So we started very early on placing orders, looking at different suppliers throughout the GTA, and even outside of the GTA. Even going as far as ordering things through Amazon, Walmart, wherever we could get our hands on it. And having the network of homes of about 20 homes, all of us were charged with the responsibility that if we found a supplier, that we would share that information amongst ourselves.

So within a couple of, two to three weeks, we were sourcing out new suppliers. So by mid-March, we were actually able to introduce universal masking before the Government even required it. So I do believe that that certainly helped, where we were providing cloth masks to our

staff, because we were actually producing them on-site through our laundry department. And sourcing out the PPE very early through different suppliers, that that made a huge difference in minimizing or delaying COVID coming into our home.

And very early on we started having regular meetings with our Occupational Health and Safety Committee to prepare for a pandemic, and having discussions at the Board level. Because we could see that the prices of these PPEs were climbing, and the difficulty of getting them, and so having -- we have two boards here at Belmont.

We have our Operating Board, which is the Board of Directors, and then we have a Fund-Raising Board. And through the generosity of the foundation, they did support and granted us a quarter of a million dollars to ensure that we had all that adequate PPE.

And so very early on we were faced with the situation of finding the financial resources to help support acquiring these PPEs, and we very early on started looking at fund-raising.

COMMISSIONER MARROCCO: Ms. Elias, just one second. Dr. Kitts.

COMMISSIONER KITTS: I'm interested in

the notion that your suppliers told you that the Government was creating a central stockpile.

I don't know if you deal with from the, I guess from the Ministry of Long-Term Care, did you pursue that thought and whether it was happening and whether you could rely on the stockpile?

Was there something in between you going out to Amazon and paying more, did you have any dealings with the Ministry of Long-Term Care before that?

MS. ELIAS: Well, when we were sourcing out and trying to get supplies, at that point in time, it was early days.

And, basically, the guidelines for using personal protective equipment were similar to what we have today, which is, if someone shows symptoms, then you put on your PPEs.

So we actually didn't have justification to go to government to argue our point about being proactive in this. Keeping in mind, that the World Health Organization hadn't even declared it a pandemic at that point in time.

So we did not try and determine where those supplies were going. Why the supply chain

was having issue delivering those items to us and actually cancelling our orders.

So whether it was true or not, I don't know, Dr. Kitts.

COMMISSIONER MARROCCO: So you figured that even if you found -- correct me if I'm wrong. You figured even if you found it, because you didn't -- you would likely be kind of low on the totem pole, because you didn't have people showing symptoms?

MS. ELIAS: Right, absolutely. I mean throughout the -- in those early days, basically, similar to the SARS days, and when you see what was happening around the world, truly the focus was on preparing hospitals for a surge of patients.

And as I go on in the presentation, I'll emphasize that again. But the thought certainly was that we would maintain the current guidelines in the sense of, if a resident showed a symptom, like a typical cold symptom, then the resident would be tested, then the employees have to put on PPEs, and all that sort of stuff.

So even if a resident had showed symptom, we would not be asked to shut down the whole unit, right? And so pretty much in the early

days, we did feel that the focus was on hospital and preparing the hospitals. And at the time, even long-term care homes, early days, supported that philosophy.

But as we saw as time moved on, we saw that we weren't getting our supplies, outbreaks started happening in long-term care homes, we really felt at that point in time that we weren't being given the proper focus to deal with this pandemic.

COMMISSIONER MARROCCO: Can I just ask you: From the time you figured out that you were going to have to find this PPE yourself --

MS. ELIAS: Yes.

COMMISSIONER MARROCCO: -- to finding a supplier who would supply it, how long would you say that -- can you say how long that took?

MS. ELIAS: Until we felt comfortable. I can say, well, we -- right from the get-go, so end of February, like the third week of February, we started working on that, and it was continuous. It was continuous right up to the middle of April, because unless the long-term care home was in outbreak, we were not getting any PPE from any government source. We still had to find our own

supply chain for PPEs. There wasn't -- you know, the only way you that would get PPE is if you were in an actual outbreak.

So there was no mechanism to be proactive to protect our staff from bringing -- you know, and the residents from COVID coming in. So that's what we saw pretty much in those first few months. Even when we went to universal masking in April, still the issue was us finding our own supplier. We did not have a stockpile that we could tap into at a government level, unless you were, you know, in a particular outbreak, and then you'd have to order those supplies.

So it was very, very controlled. And to be very honest with you, we felt that we had to be proactive, and have the supplies here, when we needed them, instead of trying to justify getting those supplies and then waiting for a number of days, you know. So we did test --

COMMISSIONER MARROCCO: The justification for getting it is that you've got people who are sick with the disease, it's a bit late.

MS. ELIAS: Exactly. Exactly. And, you know, that was the situation that all homes

were in during Wave 1. And I think that's important to keep in mind, the whole setup, the whole system was reactive instead of proactive in Wave 1.

Certainly, the common words were unprecedented, it took everybody by surprise. But there are some things that I felt that different levels of government weren't really treating it as a potential pandemic, but were treating it as a less serious situation.

And, also, I think that the big issue was that there weren't enough supplies available through supply chains, for PPEs. So a lot of work was being done in the sense of, do you really need it? Unless people are showing symptoms, you don't really need it. At that point in time, it's late in the game.

So I'll quickly go through some of the other things that we did. Regular communication. We would daily debrief on what's happening in the world, in Canada and in our home. Regular communication with families. And we continued to order PPE, even when we felt that we had enough, we were very, very concerned about not being able to get PPE given we didn't know how long we'd be in

this situation. And given, again, our learning from SARS, that it wasn't just a three-month situation, that it could turn into a one-year situation. So we wanted to continue to be proactive.

Early days. We monitored residents for any signs and symptoms, and staff, and got them tested. We reorganized the work of the management and administrative staff to support nursing and dietary staff.

And very early on, when the Ministry introduced the One Employer Rule, we looked at hiring private caregivers from families to work as nursing aides. So we created some new positions that we were allowed to do, and also hired more recreation staff to support family communication and visits, and increased cleaning in the home. So very early on we acted as if though we were in a pandemic.

Some of the things that we did to keep employee morale up, we had a hero board. We displayed thank you letters from families. Weekly meetings with the Occupational Healthy and Safety Committee. As I mentioned, we did a lot of fund-raising and purchased two-family interaction

Plexiglas screens. So it improved the family and resident experience with indoor and outdoor visits.

And regular communication with both boards on what was happening with COVID, and with the continued need for financial resources to support additional staff, additional screening, and also purchasing more and more PPE. So we did get approval from the boards to overspend.

So we certainly are in a deficit situation, and we continue to be in a deficit situation.

COMMISSIONER MARROCCO: Dr. Kitts.

COMMISSIONER KITTS: Yes, I just want to go back to staffing.

You reorganized, you hired private pay. Did you have a staffing shortage that concerned you going into this pandemic?

MS. ELIAS: Oh, absolutely. Absolutely. If I could just -- I'm not going to be precise in my estimates, but long-term care has always had issue with achieving full staffing. But let me just say that -- let's just use as an example, the Belmont House was at full staffing before the pandemic. We covered all our shifts, we had enough body to cover all our shifts.

Then we go into pandemic mode, and the One Employer Rule, and then we go from 100 percent down to about 70 percent. Because many of our staff, and I'll refer to it later on again, many of our staff had to choose: Where are they going to work?

And Dr. Kitts, you would know this, having run a hospital. You can't create full-time jobs for every person that you employ; it's a 24-7 operation. So you need full-time people, you need part-time people, and you need casual people.

And certainly what we found was our full-time people were staying, but we did lose some because of childcare issues, or health-related that they were frightened to work because of their immunity system.

But we lost some part-time and casual people that were working in municipal homes. That was predominantly municipal and hospitals.

So that One Employer Rule did have a significant impact in lowering the number of employees that we had available to work for us. And then with some long-term care homes that had significant outbreaks, you would see that staffing reduced to below 50 percent.

So, you know, we have issues with not enough staffing in long-term care to begin with. You have a pandemic, and then you have legislation that also constricts you from having a certain number of bodies in the building.

COMMISSIONER KITTS: Thank you.

MS. ELIAS: So I hope that answers your question.

So in terms of from the long-term care sector, what we really felt that our -- in slide ten, the primary focus was ensuring that hospitals were prepared, right?

So we did feel ignored, but generally the long-term care sector feels ignored compared to the hospital sector. Let's be honest, we have an inferiority complex in terms of where we fit in the healthcare system.

Whenever you have a severe flu season, or you have a situation like SARS or the pandemic, the Government really pushes to move seniors out of hospitals, to enable the hospitals to have the beds to deal with the crisis, right? So we were finding that, you know, I have a waitlist of 840 people and I have a crisis list that generally runs from 8 to 12 people.

And early on, I saw that jump to 17. And as of this Monday, my crisis list is 73 people. And it's, you know, 95 percent made up of seniors that are in hospital waiting for long-term care placement.

So there's a huge demand for long-term care beds with hospitals trying to move seniors out of there. In the early days, long-term care homes were basically told to take care of seniors who had COVID and not to send them to hospital.

So very early on, we were told that if a resident gets COVID in the home, you have to manage it. Don't even think about sending to hospital. Now did we actually, as long-term care homes push that issue? We did as things got more desperate. You saw the long-term care homes push that issue of having COVID positive residents go to hospital, but very early days, that's what everybody was being told.

So we felt, well, if we got COVID, we had to deal with it in our home, there was nowhere else that we could move these residents to.

COMMISSIONER MARROCCO: Ms. Elias, just one minute, please.

Dr. Kitts.

COMMISSIONER KITTS: Just in terms of your home, do you have ward beds, three or four to a room?

MS. ELIAS: No, no. Our shared accommodation, when we say "basic" at Belmont is two people in a room. So it does make it -- go ahead.

COMMISSIONER KITTS: Do you feel you have the ability to isolate positive patients and cohort patients in your home?

MS. ELIAS: We have the ability to a certain point. So when we looked at our pandemic plan, and we looked at if we were to isolate residents, we took an activity room, for example, and we said, okay, each floor we can turn that activity room into a long-term care room for isolation purposes.

If we had a number of residents, we could turn the auditorium into that. But not that we had specifically dedicated rooms for isolation purposes, we looked at rooms that could be converted into isolation rooms. And so that's what we did.

COMMISSIONER KITTS: Okay.

COMMISSIONER MARROCCO: Can I ask you,

your pandemic plan, was that as a result of SARS and the recommendation --

MS. ELIAS: Yes.

COMMISSIONER MARROCCO: -- from Justice Campbell?

So did you have an actual written or actual plan? Was it in writing or --

MS. ELIAS: Yes.

COMMISSIONER MARROCCO: -- what was it?

MS. ELIAS: We do have an actual plan, but of course you modify it over time, right? Because there was some other outbreaks, I believe in 2008 or something like that.

But we were required, with SARS, to have a pandemic plan, we were required. And so having gone through it before, we knew what we needed to do.

So, basically, it was refreshing all of our memories, what did we do before? How did we deliver trays if people had to be isolated, cohorting and not mixing staff between floors and wearing full PPEs?

And so the issue for us was making sure that we had the proper resources. We knew what needed to be done, but we needed those particular

resources.

I think the challenge with COVID that we didn't see with SARS was the testing issues. And the staffing, it was more a prominence with COVID than I recall during SARS.

So I just wanted to clarify that sometimes people would say, "well, Belmont never had an outbreak". Well, we did have an outbreak, technically. We did show up on the Toronto Public Health listing. At the end of April, we had a private caregiver that tested positive, which then spread that to a Belmont employee. But at that point in time, what was great was, if there is a positive, is that because we started universal masking very early on in March, as soon as we had supplies available that we could do that, we felt that we were able to delay COVID coming into the home to the point where we would have supports, you know, from government, right? In the sense of, at that point in time, the Government had brought up -- sorry, had been able to bring up the testing capacity, and had already implemented an initiative to test all employees, and all residents in long-term care homes. And they had started that in mid-April. And so we found that the timing was

right, and we were able to test all our residents, our retirement tenants and staff, and found that it was only those two individuals that tested positive.

So we had no residents or tenants who tested positive. And, therefore, we got through that without jeopardizing the life of our residents and our staff. Having said that, we did go into full outbreak mode, which meant a higher use of PPE for the whole campus of care. Trade delivery services, everything. And that's where you had our own staff redeployed for management and administrative function now to outbreak procedures.

So I wanted to touch on some of the challenges we've found and break it down into various themes, starting with HR. I did mention the One Employer Rule and how, you know, it just chips away at your ability to have the right number of bodies in the homes, right?

And so the issue of constantly trying to recruit people, but it's difficult to recruit part-time, casual staff when they are only allowed to work at one employer. And also, the fact that we pay less than hospitals and municipal homes, that also is a recruitment and retention issue.

So we did find, and we still continue to find that our own full-time and part-time staff that we converted to almost full-time, are picking up a lot of overtime shifts and hours to ensure that all of our schedule is completely booked.

The One Employer Rule is a significant issue that we face. Because when you look at hospitals, they are not restricted. So if someone works in a hospital, they can work in three hospitals. But in long-term care, you can only work in one long-term care home. You can work in retail and long-term care, but you can't work at another long-term care home.

If you look at private pay caregivers that are hired by the employees, they also don't have that restriction. They can work at a number of long-term care homes or, you know, in the community, plus a long-term care home.

So we do find that certainly, you know, a One Employer Rule would be the best practice; there's no denying it. But in the reality of staff shortages, sometimes you can't live to that best practice. And we are finding that why are we being held to this certain standard of a one employer; when hospitals aren't, or private pay caregivers,

or healthcare agencies, you know, nursing agencies aren't being held to that level.

So we certainly do need more work on how we can increase the human resources, healthcare professional so that we can have more individuals that we can hire. It isn't just a matter of throwing more money to it, we actually need the bodies to fill these positions.

COMMISSIONER KITTS: Can I just ask a question about the private aide caregivers?

So those would be caregivers who's family of the resident were paying them to come in and provide care.

MS. ELIAS: Right.

COMMISSIONER KITTS: So they were exempt from the visitor policy?

MS. ELIAS: Sorry. They are exempt now. Right, they can work in the community, they can work.

In the early days, no. When in Wave 1, we shut down and we did not allow private caregivers to come in. But because we were short-staffed, because of the One Employer Rule, we went to those families and said: Can we actually hire your private caregivers and consider them

Belmont House employee?

So they actually went on our payroll system and because of that, they only worked at Belmont.

So we then -- go ahead.

COMMISSIONER KITTS: So what about the caregivers of families that weren't being paid? Could they come in and --

MS. ELIAS: Yeah, the ones that we didn't hire, they were not allowed to come in.

COMMISSIONER KITTS: Right. But the thought is then, if you pay them, they can come in; that's not true, is it?

MS. ELIAS: Well, the thought was that we were going to hire them as employees. So once you hire them as employees, then they're on your payroll, you train them accordingly, and then we hired them as nurse's aids.

So they weren't hired as PSWs, they were hired to help the PSWs. And so they were also non-regulated nursing staff, but they were there under the supervision of the PSW to help our PSWs.

And so we did not hire every private caregiver that was hired by a family. We only hired an additional person per nursing unit, and

made them an employee and had them here for five shifts a week, so that they had full-time hours.

At this point in time for Belmont, we do not have those individuals working now as employees any longer. Because now, during this time period, families have been able to identify a private pay caregiver as an essential caregiver. And all residents are allowed to have two essential caregivers for an unlimited number of hours or days during the week.

So the visiting guidelines now enable a private caregiver to come in as compared to, you know, what was happening in March, April, May or June, and July, tell you the truth.

I mean, the essential caregiver provision was implemented in August. So for those months from March to the end of August, we actually were using those individuals as employees paid by Belmont.

COMMISSIONER KITTS: And for the rest of Wave 2, you foresee that these caregivers, aide or family members, will still be allow to come into the home?

MS. ELIAS: Yes. They will be allowed to come into the home, and they're now being paid

by the families, so we don't that additional expense.

Having said that, we may tap into looking at how we can hire more people, if we're in an outbreak and look at different strategies there.

COMMISSIONER KITTS: Thank you.

MS. ELIAS: Along with the other HR challenges, pandemic pay, which was great. And certainly was a huge retention, it wasn't great for recruitment, because again, municipal homes and hospitals pay more.

So when Belmont employees got $4 an hour more, so did the municipal home who already pays us more got $4 an hour more. So it didn't help with recruitment, but it certainly did help with retention. That ended in August, as you know.

And certainly with the introduction now of the new PSW only special rate of $3, it is creating an imbalance and disruption to our internal equity within the home, but there isn't anything we can do about it. But it does not deal with recruitment. You know, the difficulty that we still have with recruitment. But it would be great to see a pandemic pay reinstated until a vaccine is available.

I touched on the recruitment and retention issue that we were talking about a number of things. But I think it is important to note that, you know, if you work in a hospital, your wages are pretty similar across the whole Province of Ontario. But when you work in long-term care, hospital and municipal homes pay higher hourly rates, they have better benefits, they have better pension.

Then you look at charitable homes, which are sort of in the middle of the road with wages and benefits. And then for-profit homes generally have a lower wages and lower benefits.

So in terms of recruitment and retention, I think it's important to ensure that we do have those adequate PPE. If there was a way to get rapid COVID-19 tests available in our home that don't require lab work, I think that we'd have better success of recruiting and retaining staff.

Other issues related to extra staff workload. Early days, you know, physicians went on Virtual Care, and we didn't get them back until the summer. So there was significant extra workload on the nursing staff.

And the physicians were told early on

that they should not send residents to hospitals. So I think in terms of all the individuals or associations that you speak to, you should also be speaking to the Ontario Long-Term Care Clinicians Association, as to how they handle things in Wave 1 and where they're going in Wave 2.

Additional workload was also with the coroner. All of a sudden, funeral homes couldn't come into the building to get resident's bodies. So that was an additional workload on nursing staff.

And keeping in mind that you have less staff in the building, and now we're putting more things on their shoulder, because others don't want to come into the building, whether it's physicians, or funeral home. And even staff testing -- and I'll talk about the hospital partnerships -- we have to do our own staff testing. So it's our own employees our nursing staff that do that.

So it's additional workload on our employees.

COMMISSIONER MARROCCO: So was it the coroner that directed that they not come in, that's how that happened?

MS. ELIAS: Right, yes. That's how

that happened, the coroner.

And again, early days, so everybody was afraid to come into the building. Which didn't give a comfort level to my employees, that everybody is afraid to come into the building, but I'm expecting my employees to come into the building every day. So, you know, it certainly doesn't help with staff or morale.

In terms of PPE, we talked a lot about it. Still, I feel that there's issues related to PPEs. You may know that the ONA requested and -- I think it was an arbitration decision that enabled ONA members to get N95 masks. And now there's been a more recent decision, the Government has agreed with all unions that employees can demand a N95 mask during an outbreak.

So the issue for us is, I'd love to give all my employees an N95, but I just can't find them. So again, we're in a situation where I have to rely on a requisition system through government to get those particular supplies. And whether I will be given the full amount that I need is still a work in progress.

There's been a recent announcement about government giving homes eight weeks of

supply. And then we got a letter from Government actually saying "up to eight weeks". So again, some unclear messaging. We'll see what we end up getting.

We have put in an order this week, and we expect that order to be completed shortly. And we'll have a better idea as to whether we've got the full order or not.

So again, it goes back to PPEs should really be used as a proactive measure in infection control, and not reactive. And we need to have everything that we need to have.

COVID testing continues to be a challenge. I mean, it was pretty good during the summer. We were able to get all staff tested in mid-April, but the partnership with the hospital is not always consistent.

And I'll talk about hospital partnerships in a while. And when the hospital is not available, then we have to look to a private lab, like LifeLabs. And with hospitals we generally get our results within 48 hours versus a private lab, which can be anywhere from four or five days as a turn around.

And ordering swab kits from Public

Health can also take three to five days.

So we're always having to be on top of testing and ordering our supplies. So when we look at Wave 2, it would be great if the hospital can handle all of our capacity, so that we're not trying to figure out every two weeks who's going to do our analysis of our swab test.

With residents, the testing is going well. But certainly we've gone back to a model of only testing residents with symptoms. Essential caregivers, testing availability, when we look at what's available for essential caregivers, if you've been -- I'm sure you have been listening to the media -- we've gone from being able to handle 40, 50 thousand tests a day to now not being able to handle them.

And then the testing centres have been shut down for essential caregivers, they can't go to the testing centres. And so the only thing that's available to them now is the pharmacy for non-symptomatic essential caregivers.

And we've had a lot of complaints from family members that it's taking anywhere from, you know, taking days for them to get an appointment, then when they get an appointment it can take three

to four days, and then another four to six days to get results. So certainly it's not an effective or efficient process.

The Government introduces the ability for essential caregivers, and in some cases, they are family members, to be able to come into the long-term care home, but now those individuals are frustrated because they can't get their tests on a timely basis.

So one of the things that we have looked at here, is to do the testing at our own long-term care home for our own essential caregivers. So that they're not struggling with getting the appointments at the pharmacies, and waiting for those delays.

We just did it last week, so we'll see how it progresses. But we still do continue to have challenges as to who will analyze those test results.

In terms of screening -- I mean, what I'm giving you today is a perspective of the operations in a home and things we had to deal with. A lot of time taken away staff, we needed staff to cover all three shifts to test. You know, take temperatures and to check the paperwork on

everyone entering the building, our employees and essential caregivers.

So it would be helpful if there was a way, not only today but in the future, to use technology that would take temperatures and take a record of all those questions and keep that data in a database, instead of boxes and boxes of thousands of sheets of screening information for everybody coming into the building.

Infection, prevention and control. Certainly staff spend a lot of time with that. My assistant director of care is, slash, you know, the infection control and prevention nurse. But I've had to now give her some assistance so that she can more properly focus on the infection prevention and control.

So it would be helpful to have dedicated staff in our homes, in particular, during this pandemic, that focus on infection control. And not every home has that expertise and that staffing.

In terms of financial challenges, I mentioned earlier on how significant the cost of PPE were, and the additional staffer screening and the overtime cost. But just to give you a sense of

our home.

140 long-term care beds, and 81 apartments. We have spent -- keeping in mind that the pandemic hit March. We have spend $1.1 million related to COVID so far this year. And we have received approximately $575,000 from the Government. And if we do get another $92,000 for October, November, December, but we don't know 100 percent, we would be looking at receiving from the Government, approximately, $851,000 still leaving us with a shortfall of a quarter of a million dollars that the home has to cover.

So, certainly, Belmont is not unique in this is that there's going to be significant debt and deficits in long-term care homes to cover these costs from COVID.

Visiting guidelines, I touched on that a bit already. Wave 1, visiting guidelines were extremely strict. No family members or private caregivers were allowed in the building. So a lot of time was spent on Skype visits, window visits, so on.

We increased staff hours in order to accommodate all these visiting guidelines. When we went to the new guidelines in August with the

essential caregivers coming into the building and the introduction of short accesses and temporary overnight accesses for long-term care residents, we did feel that it didn't make sense that if a family member and essential caregiver came into the building, they had to attest to a COVID negative test. And yet our residents would be allowed to leave the building, to go out with people that had never been tested.

And so when those guidelines came out in August, I have to tell you, all long-term care homes went ballistic. How is that logical, or now it's opening up, increasing the risk level of having long-term care residents going out, unsupervised absences with individuals that we don't know whether they were tested or not.

So that coincided actually with weeks later, the numbers increasing in Toronto. I can't actually tell you that there's a correlation there, you know, I don't know whether some of my residents went to weddings, or indoor restaurants, or they went to crowded beaches, I couldn't tell you that because they go out during the day, with their family members in a very uncontrolled, unsupervised environment.

In September and October, we felt that the Government was taking too long to react to the increasing COVID positive cases in Toronto. And we were pushing for them to revisit these guidelines and high alert area, like Toronto. So just to give you that example.

At the end of August, we're letting people out of the building, we're letting residents out of the building into uncontrolled environments. And then in early October, the Government indicated that only essential caregivers were allowed to come into the building. Yet there was no mention of cancelling short absences or overnight absences.

And we took the position, well, since the Government was silent on it, rightly or wrongly, I said here -- and I checked with all my other colleagues. I said, well, I'm cancelling absences, short absences, and temporary overnight. I'm not letting the residents out of the building. Because if only essential caregivers could come in, it doesn't make sense to me that residents could leave the building.

So I shut that down, effective October 5th. And then just last week, we got notice from the Government that they finally did

hear our advocacy efforts on that issue, and they shut down short absences and temporary absences as of October 16th.

So certainly it would have been helpful if the Ministry of Long-Term Care had gotten more advice from our association or individual homes as to, you know, the messaging that they were going to give out, or the guideline, the changes to those guidelines and get our reaction in how to operationalize that particular issue.

I touched briefly on the hospital partnerships. It did take two emergency orders to direct hospitals to help long-term care homes. It's unfortunate, we feel that we have an integrated system, and we talk about Ontario Health Teams, and yet long-term care homes did feel they just did not have the support that they needed.

But in the defence of hospitals, we are expecting a lot from them. When you look at the number of long-term care homes in Ontario, and you compare it to the number of hospitals, it's not possible for one hospital to help that many long-term care homes, in terms of PPEs, testing and redeployment of hospital staff.

So for Belmont House, in our

partnership with our hospital, we were only entitled to testing, right, using their lab, and having their infection control team come out and do an assessment on our practices here. But we did not have access to hospital staff.

With Wave 2, we have been specifically told that we would not be having access to hospital staff. But again, even in this Wave 2, we're having issues because our hospital partners cannot do our testing of our staff. They can't analyze it in the labs.

So it's pretty hit and miss. We don't know from week to week whether the hospitals there could do the lab processing or not.

So again, looking at some things like on-site rapid tests, it doesn't require lab processing, but would certainly help our industry. There's a lot going on, and we have to try to find ways where we can be more self-sufficient in the long-term care sector and not rely so much on the hospital sector, because they have their own issues and they can't shut down their surgeries and so forth.

COMMISSIONER KITTS: Can I just ask: Do you have a relationship with the hospital CEO?

Do you have an open lines of communication, should you need them?

MS. ELIAS: Our partnership is with UHN, so it's a very large and complex hospital. And so we have relationship with staff in that, but not a direct relationship with the CEO of UHN.

But the issue is that they just don't have the capacity to support all these long-term care homes that have been assigned to them. And when we started seeing outbreaks in a number of downtown Toronto homes, UHN said, well, they couldn't do any more of our testing for this time period, because they're focusing on these particular homes that have outbreaks; which is understandable.

But again, you know, we look at setting up a system that sometimes realistically can't work. So we always need to look at backups and how to find ways where we're not always relying on hospitals, you know, in terms of providing staffing, which they could not provide.

And I was told very early on when I asked about -- when we were looking for more PPEs, I said to UHN, "Can you provide me with PPEs?" And they said, "No".

We have this false impression that this hospital partnership was going to solve all the issues, without realizing that the hospitals themselves don't have the capacity to deal with their own operation and then a dozen long-term care homes that have been assigned to them.

So I think we have to be more realistic in the capabilities of our partners. With Public Health we saw a lot of inconsistencies in the early days. And what was shocking to me was that I believe that one of the homes that had the first outbreak, and had the most significant outbreak, that Public Health unit had not even tested for COVID-19. So there were symptoms in the home, and it wasn't even identified as COVID-19, and then that particular home then spread very quickly.

So we certainly could do a better job in consistency across all Public Health units, how they determine an outbreak, and how they work together as a consistent force during a pandemic instead of individual silos.

Government communication and policy development -- I think I've run my time. So are you okay for another five minutes or so?

COMMISSIONER MARROCCO: We are. For

another five, no problem.

MS. ELIAS: Okay. So for government communication and policy development. I know that things are fast and furious during a pandemic. But what I think is important to note is that overall, we need clearer messaging in the early days, but even now it's very confusing.

Who's in charge? We have Ontario Health, we have Toronto LHIN, Ministry of Health, Ministry of Long-Term Care, they all have their own communications and we get directives from different bodies. We get the same documents coming from these different branches of government, and it becomes very confusing and overwhelming, all these documents and communications from these various sources within one government.

So one source of information, and clear message, and identifying who does what would be very helpful.

Employee view. I mean, certainly, you know, we've covered this. You know, lots of expert work for the employees. We feel that the downloading to the sector has not been appreciated in the sense of the additional work.

And long-term care homes continue to

feel anxious and would like to restrict the number of people coming into the homes, and they're anxiously looking at what rapid testing would do for our homes.

In terms of being prepared, I feel that we still haven't dealt with the key issues of PPE, testing and human resources. There were issues in Wave 1, and I believe that they continue to be issues in Wave 2. And we still don't have a comfort level on that.

How far have we come? We've made some good strides with the PPE during July and August, but now we're feeling that supplies might be limited and prices are climbing, and we certainly feel that there's a limit on N95 masks.

In terms of testing, it was very hit and miss and wasn't really effective in the early days. And then when you look at, you know, July and August, everyone that wanted to be tested, could be tested. And now we seem to be back in October, it looks a little bit different, but it's the same old thing, which basically is: Not everyone is able to be tested. And it takes a long time to get tested now that we're back on an appointment system like we were in the early days.

And the test results are taking far too long.

So as a long-term care home, as a healthcare professional, we are just confused as to how we've ended up back in this state, when we've been hearing all summer long that the Government was able to, and is continuing to be able to process 40 to 60 thousand tests per day, and yet we can't seem to process it now, and we're controlling it by the appointments.

We're still in this situation with staff shortages. The pandemic pay certainly helped with retention, but we need to look at different ways of increasing our ability to have more people enter education programs to become healthcare professionals. And we're still losing staff to hospital and municipal homes.

In conclusion, what worked well. I do believe the Government is doing the best they can, there's no doubt in my mind. But I do believe that we should move faster. And not take so long to analyze all the numbers, and then we're missing the mark, we're too far behind.

I do believe that we need more additional funding. We appreciate all the funding that we've gotten from the Government, but we can

certainly use more to pay for those expenses of PPEs, screening and overtime.

And so I did say that I still don't feel that we've resolved the issues of PPE testing and staffing shortages. And that the costs are not fully covered by Government.

So thank you for taking the time to listen from a perspective of a long-term care home. I know I've covered a lot of material in the sense of all the things that we've been having to do and deal with. And it is challenging to, I think the word for 2020 should be "pivot". It's every two weeks we have to pivot, and we have to do something new, or some new guidelines or deal with some new situations. So it's an ongoing challenge, but certainly we'll do the best we can to get through it.

COMMISSIONER MARROCCO: Well, thank you.

MS. ELIAS: Any questions?

COMMISSIONER MARROCCO: No, I don't think so. I think we asked them as we went along. Do either of the Commissioners...

MS. ELIAS: Great.

COMMISSIONER MARROCCO: I think we've

asked the questions. Thanks very much.

We were looking for this kind of perspective, a home that is managing with whatever the difficulties are. And we do appreciate you taking the time. And in fairness of, and the detail in the presentation.

Thank you very much.

MS. ELIAS: You're very welcome.

And certainly I'm available if you have any other questions.

COMMISSIONER MARROCCO: Well, we'll certainly bear that in mind.

MS. ELIAS: Thank you very much everyone.

COMMISSIONER COKE: Thank you.

COMMISSIONER KITTS: Thank you, bye.

-- Hearing concluded at 12:05 p.m.

REPORTER'S CERTIFICATE

I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 21st day of October, 2020.

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