

# Long Term Care Covid-19 Commission Mtg.

Meeting with CUPE  
on Thursday, October 8, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending  
remotely, on the 8th day of October, 2020,  
2:30 p.m. to 3:50 p.m.

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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

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10 David Hauch, Long-Term Care Coordinator, CUPE;

11 Candace Rennick, Secretary-Treasurer of CUPE;

12 Debra Maxfield, Chair, Provincial Healthcare

13 Workers' Coordinating Committee, CUPE;

14 Andrew Ward, Long-Term Care Policy Researcher,

15 CUPE;

16 Jackie Esmonde, In-House Legal Counsel, CUPE.

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18 PARTICIPANTS:

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20 Alison Drummond, Assistant Deputy Minister,

21 Long-Term Care Commission Secretariat;

22 Dawn Palin Rokosh, Director, Operations, Long-Term

23 Care Commission Secretariat;

24 Derek Lett, Policy Director, Long-Term Care

25 Commission Secretariat;

1 Ida Bianchi, Counsel, Long-Term Care Commission  
2 Secretariat;  
3 Lynn Mahoney, Counsel to the Ministry of Health and  
4 Long-Term Care;  
5 Jessica Franklin, Policy Lead, Policy Unit,  
6 Long-Term Care Commission Secretariat.

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9 ALSO PRESENT:

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11 McKaya McDonald, Stenographer/Transcriptionist.

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1 -- Upon commencing at 2:30 p.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Let me, first of all, thank you for meeting with  
5 us. Let me just sort of tell you where we're  
6 coming from.

7 And typically when there's an inquiry  
8 called, something has happened and people are  
9 looking back at what happened trying to figure out  
10 just -- so there can be a public explanation for  
11 what took place. And so you have an investigation,  
12 you have hearings, and you have a report, and that  
13 can take a couple years.

14 We were called to existence in the  
15 middle of something, and so we think that that  
16 model, the old model, doesn't really work in this  
17 situation where you're actually in the middle of  
18 something.

19 So we've decided, more than tentatively  
20 decided, that we will respond fairly promptly on  
21 the recommendation side and without giving up or  
22 compromising the ability to look back at what  
23 happened but in the reverse order. In other words,  
24 we look back a little later.

25 So from our perspective, any

1 suggestions about changes that could be immediately  
2 made that would help everybody deal with this issue  
3 would be very well received.

4 And for that matter, we'll hear  
5 whatever you want to hear. And it, in our mind,  
6 doesn't preclude us from coming back to get  
7 people's views on maybe more long-range thoughts  
8 that we have. So that's generally the context in  
9 which all this is happening.

10 And there's a transcript. We have a  
11 reporter. You know, naturally, this is not as  
12 public as hearings would be, so at least we're  
13 publishing the transcripts of what we're saying and  
14 without precluding or giving up the right to do  
15 something more formal later on.

16 So with having said that, that's where  
17 we're from, and we're in your hands. When you're  
18 ready, we're ready.

19 And I should have introduced  
20 Commissioner Coke and Commissioner Kitts, and  
21 myself. The three of us are the commission.

22 CANDACE RENNICK: Great. Well, thank  
23 you so much. Really appreciate the opportunity to  
24 get to spend some time with you folks today.

25 My name is Candace Rennick. I am the

1 Secretary-Treasurer of CUPE Ontario. I spent most  
2 of my working life, before becoming the treasurer,  
3 on the front lines of a long-term care facility.  
4 So I bring to these discussions the perspective of  
5 the worker but also as a family member, a daughter  
6 who lost her father living in the long-term care  
7 facility albeit pre-COVID.

8           Joining me today is Debra Maxfield.  
9 Debra is the Chair of our Provincial Healthcare  
10 Workers' Coordinating Committee. We have Dave  
11 Hauch who is our Long-Term Care Staff Coordinator.  
12 We have Andrew Ward who is our long-term care  
13 policy researcher. And we have Jackie Esmonde who  
14 is our in-house legal counsel.

15           We do plan to raise a number of issues  
16 with you here during our time. We've split up our  
17 presentation, so you will be hearing from all of us  
18 at some point throughout the course of the time  
19 that we have.

20           It should come as no surprise that we  
21 really are incredibly interested in the success of  
22 this commission both in terms of the collection of  
23 information but also making meaningful  
24 recommendations. And so we want to offer to you,  
25 right off the start, any support that we can

1 throughout this process.

2 COMMISSIONER FRANK MARROCCO (CHAIR):  
3 Well, thank you. And do you mind, we would prefer  
4 to ask questions as we go along rather than wait  
5 until the end and go back?

6 CANDACE RENNICK: Yeah. I was actually  
7 just going to say that we do appreciate the  
8 generous time slot that you've given us today, and  
9 we know that you folks are likely to jump in and  
10 ask questions as you have them, and we welcome  
11 that.

12 We also understand that there's an  
13 opportunity at the end to, further, have  
14 conversations and any questions that might have  
15 been missed. So by all means, whatever you folks  
16 are most comfortable with.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 Okay.

19 CANDACE RENNICK: CUPE Ontario  
20 represents over 35,000 long-term care workers in  
21 the province. Our members work in almost every  
22 classification in our long-term care homes from  
23 administration to environmental services like  
24 housekeeping; laundry; maintenance; dietary;  
25 recreation; of course, in our nursing departments,



1 as PSWs; registered practical nurses; and in some  
2 cases, not many, registered nurses.

3 Our members work in municipal homes,  
4 charitable not-for-profit homes, and for-profit  
5 facilities spread out in communities all across the  
6 entire province.

7 So there is, really, no question in our  
8 minds that our members are the backbone of the  
9 labour force in long-term care homes. And it is  
10 in, in part, for that reason that we want the  
11 opportunity for frontline workers to be heard from  
12 directly during this process in your investigation.

13 You know, if we are being honest, it  
14 is, really, our members who are the eyes and the  
15 ears on the ground in these facilities. That has  
16 even been more so true during the pandemic as, you  
17 know, really managers, doctors, and inspectors  
18 largely disappeared. It's our members who can tell  
19 you what happened on the ground during the first --

20 ( TECHNICAL INTERRUPTION )

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 Just hang on a sec. We're getting some kind of  
23 a -- I'm not sure why.

24 THE REPORTER: Mr. Ward, it's coming  
25 from your device. I just muted you -- sorry, I was

1 just muting each of you to see who it stopped on.  
2 So I might just mute you and leave you muted, if  
3 that's okay.

4 All right. Go ahead, Candace.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 So, Ms. Rennick, before you continue, if there's a  
7 presentation that you want to show, just let us  
8 know, and if -- okay. That's fine.

9 You're on mute, by the way.

10 CANDACE RENNICK: I just unmuted  
11 myself. I didn't know whether McKaya was going to  
12 unmute me.

13 Okay. Yes. So I just was saying that  
14 it really is our members that can talk to you about  
15 what happened during the first wave but also the  
16 plans that are on the ground now and the potential  
17 lack of readiness as we enter the second wave.

18 But with that being said, we would be  
19 remiss if we didn't acknowledge with you that  
20 workers in long-term care really do work under a  
21 culture of fear, and members are intimidated and  
22 sometimes even threatened with discipline and  
23 termination for speaking out about the conditions  
24 in which they work under and they see.

25 So if we truly are going to make space

1 that's safe enough for workers to come forward to  
2 tell their stories without fear of reprisals, then  
3 we really do think there needs to be some changes  
4 or guarantees or assurances that they can do so  
5 without any negative employment consequences.

6 Before --

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Can I stop you there for a minute?

9 CANDACE RENNICK: Yes, you can.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 The way the order in council was drawn, it seems to  
12 vest control over confidentiality outside of the  
13 commission. We have requested that that be  
14 changed.

15 We haven't received an answer yet, but  
16 when we're in a position -- I suspect it will be  
17 changed, and then, you know, we'd be quite prepared  
18 to consider hearing from people who might not want  
19 to otherwise come forward without some guarantee.

20 We quite understand the problem. And  
21 the concern on our end was just we didn't want to  
22 give an assurance that we couldn't back up.

23 CANDACE RENNICK: Understood.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Okay.

1                   CANDACE RENNICK: Jackie, do you have  
2 any comments or feedback on that?

3                   JACKIE ESMONDE: Well, I have some  
4 things to say, but it may be that we need to wait  
5 and hear back from the commission about the  
6 arrangements that are possible.

7                   You know, I know that there are -- and,  
8 you know, the premier's office has said to us when  
9 we raised it with them that, you know, they felt  
10 that there was adequate protections through things  
11 like the Public Inquiries Act which does, you know,  
12 protect against adverse employment action for  
13 workers who disclose information.

14                   I'm sure you're well aware of some of  
15 the issues with relying simply on that in terms of  
16 it being, you know, very active. No employer is  
17 going to come out and say "I'm disciplining you.  
18 I'm firing you because you spoke with the  
19 Commission."

20                   COMMISSIONER FRANK MARROCCO (CHAIR):  
21 Yeah.

22                   JACKIE ESMONDE: So something upfront.  
23 If there's a way to keep information  
24 confidential -- redacting names/identifying  
25 information if materials are put -- transcripts

1 online, if those kinds of things could be put in  
2 place.

3 The members of CUPE are very eager to  
4 speak with you. They have a lot to share. And we  
5 have some thoughts about what that might look like,  
6 a good way to do that, if now is a good time for me  
7 to maybe sketch out really briefly what we're  
8 thinking in terms of --

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Well, I mean, I'll leave that up to you. If that's  
11 the way you want to, that's fine.

12 From our point of view -- and you  
13 probably may be closer to what I'm saying than the  
14 others -- we've asked to amend the terms of  
15 reference to clarify it once and for all. But  
16 we're waiting on an answer.

17 JACKIE ESMONDE: Okay.

18 COMMISSIONER FRANK MARROCCO (CHAIR):  
19 And that's why we've been reluctant to go down the  
20 road because we couldn't give the guarantee  
21 ourselves.

22 JACKIE ESMONDE: Okay. So provided  
23 that there is something in place so workers can  
24 feel secure, you know, our proposal would be that  
25 CUPE could pull together what we're calling kind of

1 a "guided discussion" with a group of workers.

2 We would put together frontline CUPE  
3 members with representation from some of the  
4 different classifications, from the different types  
5 of homes -- municipal, not for profit, for  
6 profit -- and from, you know, across the  
7 province -- rural, urban, northern.

8 We're open to discussion, but that  
9 could include some brief opening statements from  
10 each of the workers, having a chance to tell you  
11 what they think is important for you to know, and  
12 then a period of discussion with the Commissioners.

13 COMMISSIONER FRANK MARROCCO (CHAIR):  
14 Okay. I assume, in the buildup to this, you had  
15 dealt with our counsel?

16 JACKIE ESMONDE: Yes.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 You know, that's probably the most efficient way to  
19 work out -- that probably seems reasonable enough,  
20 but that's probably the most efficient way to work  
21 out what this would look like --

22 JACKIE ESMONDE: Perfect.

23 COMMISSIONER FRANK MARROCCO (CHAIR):  
24 -- you know, whether it would be -- anyway, so that  
25 probably would be the way to do it.

1 JACKIE ESMONDE: Okay. Thank you. And  
2 I can tell you we're really eager to arrange  
3 something along those lines, and we will definitely  
4 follow up with your counsel.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 Okay.

7 CANDACE RENNICK: Thank you. That's  
8 great. We wanted to start our presentation today  
9 by addressing, really, what we consider to be the  
10 largest and most significant failure in long-term  
11 care which, we believe, has absolutely contributed  
12 to the death and destruction that we saw during the  
13 first wave of the pandemic.

14 And it will probably come as no  
15 surprise to any of you that that is the issue of  
16 this staffing crisis and the unstable and  
17 precarious nature of the workforce in long-term  
18 care.

19 Right now, in Ontario, there is no  
20 standard for which homes rely upon to staff their  
21 facilities. There is certain standards and  
22 guidelines in place like having an RPN on duty  
23 24/7, guaranteeing residents two baths a week  
24 should they choose that, but these lack of  
25 standards linked to staffing mean that the levels

1 are completely left up to each individual facility  
2 which has resulted in unacceptably low staffing  
3 levels, even pre-COVID, but COVID has made these  
4 unacceptable and untenable levels, you know,  
5 downright dangerous.

6 So right now, before the Ontario  
7 Legislature, is a Private Members' Bill called  
8 Bill 13. You may be familiar with this bill. It  
9 is the bill that will enshrine into law a  
10 guaranteed staffing standard of four hours of care  
11 on average for every resident every day.

12 Now, one might say to us "but not all  
13 residents need four hours, and this isn't a  
14 cookie-cutter approach." And to that, we would say  
15 "we absolutely agree," which is why the formula to  
16 determine a care level under this method would be  
17 based on acuity levels.

18 So if you would need more, you would  
19 get more. But there would be a legislated baseline  
20 and a guarantee by which service providers would be  
21 held to account. We cannot leave it up to  
22 individual homes, especially homes -- so many of  
23 them are being driven by profit motives to do the  
24 right thing.

25 So this recommendation was also



1 reinforced by the government's very own expert  
2 staffing panel that released its report this  
3 summer.

4           The bill will come, the second reading,  
5 on October the 28th. And if you are, which I think  
6 you just said you are, making interim  
7 recommendations to the government on things that  
8 can happen now, we offer to you that encouraging  
9 the government to keep Bill 13 alive in the  
10 legislature and truly examine the positive impact  
11 that this law could bring to the lives of those  
12 living and working in long-term care, that would be  
13 a really solid recommendation and, we think, a  
14 concrete step towards making life better and safer  
15 in our long-term care facilities.

16           COMMISSIONER FRANK MARROCCO (CHAIR):  
17 Can I just ask you there, in your experience, the  
18 staffing shortage, is that financially driven, do  
19 you think, because they want to employ as few  
20 people as possible? Or is it driven by a shortage  
21 of people to do the jobs? What drives the  
22 shortage?

23           CANDACE RENNICK: Well, I think in some  
24 ways it's both. Long-term care facilities are  
25 chronically underfunded, and as a result, they are

1 understaffed.

2 But we know that there's a retention  
3 and recruitment problem in the sector as well  
4 because these are not very favourable jobs.  
5 They're incredibly precarious. They're  
6 backbreaking. It is, often times, a demoralizing  
7 place to work, and people can't meet the needs of  
8 the residents the way they want.

9 So we're not seeing people rush into  
10 this line of work because the pay is so precarious.  
11 The workforce is so precarious. The work is so  
12 undervalued. The people are so devalued. And, you  
13 know, until we see some real systemic and  
14 meaningful changes, I think the retention and  
15 recruitment problem is going to continue.

16 DAVID HAUCH: And, Candace, if I can  
17 just add to that, I think we focus a lot in the  
18 discussions generally right now around the idea of  
19 recruitment and getting people in the door. And I  
20 want to make sure that we don't lose sight of the  
21 real retention problem.

22 Because it's not just a supply problem,  
23 but it -- which does exist. Don't get me wrong.  
24 We don't have enough people going into the training  
25 programs at the college level to be able to meet

1 the demand that's there.

2 But once people are in and it -- so  
3 we've heard stories over and over again from staff  
4 who have come in and don't last their first shift.  
5 They get halfway through their shift, and they walk  
6 out. It's too much for them to cope with and to  
7 handle.

8 And, you know, as we head into the  
9 second wave now, we're also hearing a lot from  
10 staff who flaunt through and really -- like, one of  
11 the reasons that homes were able to make it through  
12 the first wave. But the impact that that's had on  
13 people's mental health and the trauma that they've  
14 experienced --

15 They form individual and very personal  
16 connections with the people they're caring for.  
17 And you know, in some of these homes, the  
18 destruction that's been reaped by, you know, dozens  
19 of those residents dying in a short period of  
20 time --

21 As things pick up again, you know,  
22 we're hearing from more and more people that they  
23 can't do it again. They can't go through that  
24 again. And we're starting to lose people even now.

25 So I think a lot of these pieces

1 revolve around working short, and I think it's a  
2 systemic problem that needs a systemic solution and  
3 not sort of tinkering at the edges to try and  
4 address some of the issues.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 Thank you.

7 CANDACE RENNICK: And I think that  
8 leads us nicely into the next section that I was  
9 going to address which is the need to stabilize the  
10 workforce.

11 Again, like, there is no secret that  
12 the crisis in staffing is a result of both a  
13 recruitment and retention problem.

14 And compensation is a factor, but it's  
15 only one small part of the story. And to be  
16 meaningful, it really has to be addressed in a  
17 systemic way. We cannot deal with this through  
18 temporary piecemeal measures, which is what, I  
19 think, we've been seeing so far.

20 The government staffing report  
21 recommends an evidence-based systemic review of  
22 compensation across the entire healthcare sector,  
23 and we support this recommendation.

24 The recent wage enhancement for PSWs  
25 was welcome. It recognizes that, for a long time,

1 PSWs have been undervalued and under paid, but it's  
2 worth noting that it still falls far short of the  
3 more comprehensive programs that have been  
4 introduced in British Columbia and in Quebec.

5 And given that the pandemic pay ended  
6 and this new enhancement has been created, we are  
7 expecting it to cause tremendous conflict on the  
8 floor among classifications.

9 So just to give you an example, the new  
10 announcement in some cases, especially for the  
11 lower-paid facilities, will all but eliminate the  
12 wage differential between the personal support  
13 worker and the RPN.

14 So this enhancement will create a  
15 dynamic where the RPN, who went to school and who  
16 has a two-year diploma and who is taking on greater  
17 and greater responsibilities on the front line  
18 performing many of the core competencies of an RN,  
19 could, in some cases, be making an equal or lesser  
20 amount than the personal support worker whom  
21 they're working side by side with.

22 So let me be clear that this is in no  
23 way about begrudging the PSW wage enhancement. It  
24 is a good way to recognize the PSWs, but the PSWs  
25 are part of a team, and many people on that team

1 are also underpaid and undervalued, and we fear  
2 that the consequences of this decision will lead to  
3 animosity amongst coworkers and a greater level of  
4 demoralization on the front lines.

5 I also want to just touch on the  
6 disturbingly precarious nature of the work in  
7 long-term care, and the studies have shown that  
8 working conditions have a direct impact on care  
9 conditions. I know you know that.

10 There is an overreliance on part-time  
11 and casual staff industry-wide particularly among  
12 for-profit providers. The vast majority of jobs in  
13 these facilities are part-time jobs with no  
14 benefits, no paid sick days.

15 And the issuance of the single-site  
16 order -- which, we want to say, for the record, is  
17 good public policy that we support during a health  
18 crisis like COVID, but it is shown clearly that  
19 there are flaws in overreliance on part-time and  
20 casual staff.

21 The wage enhancement doesn't come close  
22 to compensating people for what they've lost by  
23 having to give up another job. And so we have seen  
24 no corresponding increase by way of additional  
25 full-time jobs to help compensate for that, and we

1 continue to rely on part-time and casual and agency  
2 work to fulfill these jobs. And really, that's  
3 just not sustainable.

4 COMMISSIONER FRANK MARROCCO (CHAIR):  
5 Let me ask you this: The decision to resort to  
6 part-time staff, is that, in your view, economic,  
7 you know, to pay benefits, or is there some other  
8 reason?

9 CANDACE RENNICK: I mean, I think --

10 COMMISSIONER FRANK MARROCCO (CHAIR):  
11 I'm just really trying to understand that.

12 CANDACE RENNICK: Yeah. I mean, I was  
13 going to mention this in my next point which is  
14 that I think, in large part, it is economic.

15 They don't have to pay people health  
16 and dental benefits. They don't have to give  
17 people access to paid sick days, and so it's easier  
18 to have a pool of casual and part-time and  
19 precarious workers for economic reasons,  
20 absolutely. But if any of my other colleagues want  
21 to add to that, by all means.

22 COMMISSIONER FRANK MARROCCO (CHAIR):  
23 Do you think there's a role for part-time workers  
24 in this system or not?

25 CANDACE RENNICK: Absolutely. And I

1 mean, I was just going to say that we really do --

2 COMMISSIONER FRANK MARROCCO (CHAIR): I  
3 haven't read your presentation, really, I want to  
4 ensure you.

5 CANDACE RENNICK: Yeah, no. I mean,  
6 it's good. It's good. These questions are great.  
7 Thank you.

8 We work and acknowledge that there is a  
9 need for part-time positions, but it doesn't make  
10 any sense for these homes to rely on so many  
11 part-time and casual jobs. Because not only does  
12 it result in completely precarious situations for  
13 workers, it does impact the resident's continuity  
14 of care and the familiarization with the staff who  
15 provide their care.

16 So, you know, yes, there's a role for  
17 part-time staff, but we don't think it makes any  
18 sense that the vast majority of jobs in this  
19 industry are part time.

20 DAVID HAUCH: I will just --

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 It's an overreliance.

23 CANDACE RENNICK: Yes.

24 DAVID HAUCH: It is, yeah. And I will  
25 tell you, we should acknowledge that there is a



1 percent in lieu that's worked into the vast  
2 majority of contracts. When it comes to the  
3 provision -- so there isn't a provision of benefits  
4 or sick time.

5 But what's covered by that percentage  
6 in lieu is absolutely a moving target as you move  
7 across the sector from contract to contract. It's  
8 covered everything from those health and welfare  
9 benefits to sick days to holiday pay to, you know,  
10 even jury duty pay and, like, witness pay.

11 It really depends, and it varies from  
12 contract to contract. But what we do see is  
13 that -- like, when we look at the costing in the  
14 context of bargaining, more often than not, the  
15 cost of providing benefits and the cost of  
16 providing a percent in lieu, the percent in lieu is  
17 still cheaper than the provision of benefits.

18 And I think the intent of this in  
19 the -- when you think about it in terms of the  
20 higher level in terms of bargaining generally, it's  
21 that the percent in lieu would basically compensate  
22 for what they're not getting. And in some cases, I  
23 think the minority of cases, that's true. But we  
24 do see a gap, and it's a gap that's been growing  
25 over time.

1 I think the other big challenge that we  
2 have is, like, of course there's a need for  
3 part-time staff, especially when it comes to being  
4 able to cover vacations; to cover, you know, when  
5 people are off sick; and to be able to fill gaps in  
6 a schedule of a 24/7 operation. We would  
7 absolutely say that there is a need there.

8 But you should never have a facility  
9 where there are more part-time staff than there are  
10 full-time staff. Like, that just fundamentally  
11 doesn't make sense in our view, and we see that in  
12 greater numbers than we would certainly be  
13 comfortable with.

14 ANDREW WARD: And just to tag on to  
15 there, too, the staffing study that Ms. Rennick  
16 referenced, it stated clearly that "long-term care  
17 cannot become a better place to work nor a better  
18 place to live without increases to staffing  
19 levels."

20 It's these high preponderances of  
21 part-time staff that we notice where we feel that  
22 it can create a larger prevalence of workplace  
23 incidents as well as create unreasonable workloads  
24 for staff. The continuity of care that Ms. Rennick  
25 referenced early, though, is one of the core pieces

1 of this.

2 The only other thing I wanted to  
3 mention was just on the percentage in lieu in terms  
4 of benefits. The actual origin of that was not to  
5 create a package or an option for part-times, but  
6 it was actually intended to discourage hiring more  
7 part-times so that we could ensure that we got  
8 properly funded and adequate places for folks to  
9 work as well as for those residents to reside, for  
10 these very reasons.

11 DAVID HAUCH: And as time has gone on,  
12 that's just been factored in as part of the cost of  
13 doing business.

14 CANDACE RENNICK: We want to touch on  
15 the classification of the resident --

16 Oh, I'm sorry. Go ahead, please.

17 COMMISSIONER COKE: Sorry. I just  
18 wanted to ask a question. I noticed in some other  
19 material there's talk about another sort of  
20 classification or stream of support person to the  
21 PSW.

22 So, you know, I'm curious about your  
23 thoughts on having another layer that may really  
24 replicate some of the issues of the PSWs, but I'm  
25 interested in your observations on that.

1                   CANDACE RENNICK: You people are  
2 absolutely reading our minds because we were just  
3 about to go to the issue of the resident caring.

4                   COMMISSIONER FRANK MARROCCO (CHAIR):  
5 We're just --

6                   COMMISSIONER COKE: We're on fire  
7 today.

8                   COMMISSIONER FRANK MARROCCO (CHAIR):  
9 We're just having a good afternoon. We can't  
10 represent that it's like this every day.

11                   CANDACE RENNICK: I was just actually  
12 going to say that, you know, to make some matters  
13 worse, the resident caring classification, these  
14 are not new. This is not a new classification.

15                   Operators, especially in the for-profit  
16 sector, have been seeking these positions for the  
17 last number of years or at least the last couple of  
18 years.

19                   But in our experience, barriers to  
20 recruitment but, more importantly, barriers to  
21 retention have been workload and compensation and,  
22 really, the total devaluing of the lives of people  
23 living and working in long-term care, not the  
24 education required.

25                   So this new level of classification is

1 jobs that are really deskilled. They deskill the  
2 incredibly important work required to provide high  
3 quality and dignified care to individuals who have  
4 really complex medical conditions.

5 And those skills include, you know,  
6 among other things, infection prevention and  
7 control procedures, which are crucial during a  
8 pandemic.

9 So the resident caring classifications,  
10 they do not have any formal training. And when  
11 they have been used by employers through the  
12 emergency powers to hire them, without the  
13 involvement of the union, they've hired individuals  
14 with no training relevant to the long-term care  
15 sector; no experience, in some cases, with  
16 geriatric issues; and so understanding of the  
17 important role of infection and control practices.

18 So, you know, on that other layer of  
19 classification, I think that's what we would offer  
20 to you at this point.

21 COMMISSIONER COKE: Thank you.

22 CANDACE RENNICK: And lastly, on the  
23 precarious nature of the work, I just want to  
24 address the issue of sick time, specifically paid  
25 sick time or the lack thereof, and we just touched

1 on this briefly.

2 But people in the sector need to be  
3 able to take sick time not just for COVID-related  
4 reasons. Often sick leave is treated by employers  
5 as an issue of absenteeism that needs to be  
6 managed. It creates a culture where people  
7 frequently come to work sick to avoid repercussions  
8 or attendance management programs.

9 And one of the benefits of employing so  
10 many part-time workers is that part-time workers  
11 don't get access to benefits including paid sick  
12 time. So many workers really are forced to choose  
13 between paying their bills or coming to work when  
14 they are sick and possibly bringing a virus or an  
15 illness into the facility and exposing an  
16 incredibly vulnerable population.

17 So ensuring workers have and take sick  
18 leave when they need it is critical to infection  
19 prevention and control as well as to resident  
20 health and safety.

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 So this is in reference to a part-time --

23 CANDACE RENNICK: Yes.

24 COMMISSIONER FRANK MARROCCO (CHAIR):  
25 -- worker --

1 CANDACE RENNICK: Yes.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 -- who can stay home and forego the money --

4 CANDACE RENNICK: Yes.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 -- or come to work and get paid. And if you stay  
7 home, there's a suspicion that you're not really  
8 sick?

9 CANDACE RENNICK: Yeah, exactly.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Okay.

12 CANDACE RENNICK: Yeah. So we believe,  
13 really, that staffing and the care crisis at the  
14 bedside, the retention and the recruitment  
15 challenges, and the undervalued and demoralizing  
16 nature of this work in terms of compensation and  
17 workloads really have contributed to the conditions  
18 that we saw during Phase 1, and they need to be  
19 addressed in a meaningful and systemic way in order  
20 to prevent a redo of what, you know, so many of us  
21 experienced during the first wave of this, you  
22 know, gross pandemic.

23 And so I am now going to turn it over  
24 to our long-term care coordinator, Dave Hauch, who  
25 is going to talk about health and safety including,

1 specifically, the N95 mask issue.

2 But I'm sorry. Go ahead, please.

3 COMMISSIONER COKE: Just one other  
4 question before you go on. You were talking about,  
5 obviously, the need for the increase in staff, but  
6 what are your thoughts about what the right mix of  
7 staff should be in terms of --

8 You know, these homes have a lot of  
9 people with high acuity and complexity of care.  
10 Just your thoughts about what the right mix of  
11 skills and levels needs to be to make a good team.

12 CANDACE RENNICK: Well, right now, we  
13 believe based on the lived experiences of our  
14 members and, you know, what we're hearing from  
15 family is that the crisis in long-term care really  
16 is at the bedside, and so we need enhanced staffing  
17 levels in those facilities that are going to  
18 enhance the quality of lives of people at the  
19 bedside, and we know who are performing the vast  
20 majority of that work. It really is personal  
21 support workers, registered practical nurses.

22 So we want to see staffing improvements  
23 that are going to, you know, enhance the quality of  
24 life for people at the bedside.

25 DAVID HAUCH: And I think it's



1 important to recognize, like, there is a team that  
2 goes into this, right? So we have activation aides  
3 and dietary aides, cooks who work in the kitchen.  
4 Like, all of these are essential components to  
5 care, and I think we have to always look at it in a  
6 dynamic, team-based approach.

7 I will say it's one of the reasons why  
8 we support the notion of a care standard that is  
9 based on an average across the home and why we  
10 don't support the idea of ratios because, you know,  
11 I think you have to look at care plans on an  
12 individual basis. You have to look at the acuity  
13 of each of those residents, and you have to figure  
14 out what is best for them in those circumstances.

15 So what might fit in one home with one  
16 set of residents is going to be very different from  
17 what needs to happen in another home for another  
18 set of residents. And we think that the four-hour  
19 care standard and looking at it in that way  
20 achieves that kind of a flexibility and dynamism in  
21 how we approach the levels of care far more than a  
22 cookie-cutter, ratio-based approach to it.

23 COMMISSIONER COKE: Okay. Thank you.

24 CANDACE RENNICK: Thank you.

25 Dave, go ahead.

1 U/T DAVID HAUCH: Sure. Thanks, Candace.

2 I'm going to talk through some issues  
3 around PPE and our interactions with the Public  
4 Health and with the Ministry of Labour over the  
5 course of the first wave and into the second.

6 So I think one of the things that we  
7 want to be -- and we will provide you, just the  
8 numbered recommendations that we're working our way  
9 through in the presentation. We'll give you a list  
10 of these afterwards just so you have them in one  
11 concise place.

12 But one of the things that we want to  
13 make sure is that every home has an adequate supply  
14 of PPE and that every worker has access to it, the  
15 PPE that they need to perform their job safely.  
16 And that, in our view, is inclusive of the N95  
17 mask.

18 I will say there is a really important  
19 distinction between supply and access. And what we  
20 saw over and over again in homes during the first  
21 wave of COVID was, you know, homes that would tell  
22 us that we have supply on hand -- "don't worry, we  
23 have enough PPE available," but it's locked in the  
24 back room, and it's not accessible to the staff  
25 that need it.

1                   And so there is a real challenge,  
2 especially when we hear from politicians, about the  
3 fact that homes have all of the supply that they  
4 need, and they have all of the PPE in the home.

5                   That may well be true, but having it in  
6 the building and having it in the hands of the  
7 staff that need it are two very different things.

8                   And what we encountered in a lot of  
9 cases -- and I know some of this is driven by  
10 supply issues, but the supply was very strictly  
11 rationed, especially at the outset.

12                   And so you would only get one mask for  
13 your shift, and if that became soiled, you had to  
14 go and ask for another one. But that meant that  
15 you had to find the supervisor. And often, you  
16 couldn't find a supervisor on the floor. In some  
17 of our homes, we actually had supervisors who were  
18 doing their jobs by phone calling in and not  
19 actually in the facility.

20                   And so, you know, when you're already  
21 working short, when you're already stretched to the  
22 limit, having to go and find an RN to be able to  
23 get another mask -- because, while you were  
24 changing a resident, they ended up coughing, and it  
25 got moist from the fluid that came from the

1 resident -- you know, it dramatically hampered  
2 people's ability to do their job safely.

3 I will say, as well, you know, things  
4 did improve slowly as we went through the first  
5 wave. But the lack of clear guidance and direction  
6 about how to handle outbreaks in homes and  
7 especially how to handle doing that work safely was  
8 huge.

9 You know, if you take, as an example,  
10 Directive 3 and look at the sort of time line that  
11 we can trace in the various changes to that  
12 directive, the first iteration of that directive  
13 was three pages long, and now, the most recent  
14 version is 11 pages long.

15 And it goes into great detail about the  
16 various different steps that need to be taken to be  
17 able to assess outbreaks in homes, to be able to  
18 manage outbreaks in homes. I think if we had had  
19 those 11 pages on Day 1, if there had been clear  
20 direction on how to handle these things, so much of  
21 this could have been prevented by cutting through  
22 that extreme confusion.

23 In a number of cases, prior to the  
24 implementation of the universal masking directive,  
25 we heard time and again from a number of homes that

1 they didn't want staff wearing masks because they  
2 didn't want to upset the residents and that having  
3 people going around the home wearing PPE would  
4 upset residents.

5 I, personally, would think that the  
6 risk of getting COVID would have upset the  
7 residents more. But, you know, at the end of the  
8 day, that's not an isolated case. We heard that  
9 over and over again in the initial stages.

10 We also have numerous examples of homes  
11 where PPE that was provided was inadequate --  
12 surgical masks that were marked as not being for  
13 medical use; homemade cloth masks were being used  
14 instead of surgical masks; gowns that wouldn't  
15 close properly.

16 I think one thing that was quite  
17 troubling in the midst of things was a number of  
18 homes that started requesting that staff save their  
19 masks when they would go on break and in between  
20 shifts. And they would be given Ziploc bags to  
21 take the mask off and put into the bag when they  
22 take their break and then take it back out and put  
23 it back on again.

24 And for anyone who has training in the  
25 donning and doffing of PPE, that is just crazy

1 because there are all sorts of ways that that  
2 becomes another source of transmission and actually  
3 makes things less safe than having no mask at all.

4 So, you know, those things were really  
5 troubling to us, and we tried raising these points  
6 a number of times both at the home level and with  
7 the Ministry of Labour. And I will be honest with  
8 you, our experiences there were quite frustrating.  
9 And I'm going to get into those in a little bit  
10 more detail.

11 COMMISSIONER FRANK MARROCCO (CHAIR): I  
12 don't want to take you out of it, so if you're  
13 going to get to it, just tell me. But I was  
14 curious -- I was going to ask you what was the  
15 reaction of the Ministry of Labour? I assume  
16 people complained, and what was the reaction  
17 with --

18 DAVID HAUCH: I will absolutely get to  
19 that in just one second.

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 That's fine.

22 DAVID HAUCH: Yeah. I do want to touch  
23 on the notion of N95s because I think this has been  
24 a major source of contention and conflict at the  
25 frontline level all the way up the chain. And, you

1 know, we had, in numerous cases, employees who were  
2 bringing their own N95s in from home to bring them  
3 into work because that's what made them feel safer  
4 in the moment.

5           There was actually a study out from  
6 OHCOW, the Occupational Health Clinics for Ontario  
7 Workers, that also -- it's talking about not just  
8 the physical safety aspects of having adequate PPE  
9 and the perception of having adequate PPE but also  
10 the impact that that has on the mental health of  
11 the staff as they're working in the home.

12           And, you know, we already were  
13 operating in an environment of extreme fear. And  
14 then to have numerous news stories, both Canadian  
15 and international, in scope that are talking about  
16 the possible airborne nature of the virus and  
17 knowing that there is PPE available in the form of  
18 N95s for better protection that is not being made  
19 available because, in the eyes of the directives,  
20 they were set out, and in the eyes of the  
21 government, this wasn't an airborne virus --

22           We contend that it is. We think that  
23 the science is certainly not -- it's not a settled  
24 matter by any stretch of the imagination. And, you  
25 know, health and safety is rooted in the notion of

1 the precautionary principle. That is a fundamental  
2 tenet of how health and safety should work.

3 And, you know, it's quite troubling to  
4 us, not only the fact that the PPE stockpile and  
5 the inventory that was created after SARS to deal  
6 with exactly this type of situation was left to  
7 expire and then be destroyed prior to this  
8 happening, you know, it was very clearly found by  
9 Justice Campbell in the report that they issued  
10 after SARS that --

11 I'm just going to read you a quote  
12 really quickly.

13 "If the Commission has one  
14 single take-home message, it is the  
15 precautionary principle that safety  
16 comes first, that reasonable efforts  
17 to reduce risk need not await  
18 scientific proof. Ontario needs to  
19 enshrine this principle and enforce  
20 it throughout our entire health  
21 system."

22 That was a very clear, I think, very  
23 unambiguous recommendation from the Commission that  
24 looked into what happened during SARS. And it's  
25 baffled us from the outset of this pandemic how



1 when you don't have clear science, when there are  
2 mixed views -- to put it as generously as possible,  
3 mixed views as to whether or not this is an  
4 airborne virus --

5 We should err on the side of caution,  
6 and we should provide staff and workers with the  
7 highest level of protection possible and reasonable  
8 in the circumstance.

9 You know, N95s are, like, commonly  
10 stocked in the homes, just not in the numbers that  
11 we would have needed. People are annually  
12 fit-tested for these masks. It's not a significant  
13 departure out of the realm of possibilities that  
14 people would have access to these.

15 And, you know, when we have 2,700 staff  
16 members and healthcare workers in long-term care  
17 who have contracted COVID up to this point, clearly  
18 something in the way in which they were being  
19 protected on the front line and PPE that's being  
20 used -- clearly something there wasn't lining up.

21 I will say the recent revisions to  
22 Directive 5 are absolutely welcome. You know, we  
23 think that the fact that now -- in a home in  
24 outbreak, if a staff member feels that they need an  
25 N95 when dealing with a confirmed or suspect case

1 of COVID that they are to be provided one. That  
2 should have been in place from Day 1, and I think  
3 it is quite frustrating to us that it took numerous  
4 grievances and a judicial review filed on by  
5 numerous unions of the directive itself to bring  
6 the government to the table and to actually lead to  
7 that revision that we saw this week.

8 I think we heralded that as very good  
9 news for our members working on the front lines in  
10 the second wave, but it should have come much  
11 sooner.

12 CANDACE RENNICK: And if I could just  
13 add to that -- sorry, Dave -- you know, obviously  
14 in the recent victory that we got around the access  
15 to the masks, we weren't successful in, you know,  
16 the airborne issue.

17 But it is important to know that  
18 countries like Vietnam, for example, who do treat  
19 this virus like it's airborne -- and China, for  
20 that matter -- Vietnam has lost no workers and no  
21 residents in long-term care facilities. And China,  
22 relative to their population, a very small number  
23 compared to us. And so they are treating it like  
24 it's airborne, and I don't think that can go  
25 ignored.

1                   DAVID HAUCH: I think the other thing  
2 that we need to be clear on is to ensure that every  
3 home is providing hands-on training to all workers  
4 on infection control and as well as the proper wear  
5 and use of PPE.

6                   That is incredibly true not just for  
7 staff that are working in the homes but also for  
8 visitors at -- the homes are now, you know, more  
9 open to visitors coming in. We need to make sure  
10 that people understand these principles and will  
11 adhere to these principals when they're in the  
12 home.

13                   And, you know, we also have numerous  
14 examples of where that training that's taken place  
15 has been showing a 15-minute video to a new hire  
16 when they've walked in off the street. And then  
17 when they get onto the floor and they try and use  
18 proper donning and doffing techniques as outlined  
19 in that video, they're told by their supervisor on  
20 the floor that "that's not how we do things here."

21                   And, you know, you don't need to have  
22 a -- you don't need to change your mask if you're  
23 going in between residents. Yeah, I'll leave it at  
24 that.

25                   In terms of our interactions with the

1 Ministry and what that looks like, it's important  
2 to say -- we need to ensure that workers are able  
3 to exercise their fundamental rights under the  
4 Health and Safety Act. And I think paramount to  
5 that, it's the right to refuse.

6 So it was reported by the Star in  
7 April, at that point, the 200 work refusals that  
8 were COVID related that had been submitted, not a  
9 single one of them was upheld by the Ministry.

10 In our experience, when we've had these  
11 conversations, it's been a very, very frustrating  
12 experience that leads staff to not want to do it  
13 again.

14 So work refusals themselves are -- they  
15 put staff in a very awkward position because it  
16 is -- you're taking -- it's an individual right,  
17 and so it means someone putting their neck out to  
18 say that they're going to refuse this work.

19 And inherently in doing that, that  
20 means that they are taking themselves off the  
21 floor, and they're putting someone else in -- like,  
22 it's -- where they're already working short,  
23 they're putting their colleagues in an even more  
24 awkward position.

25 When they hear where work refusals have

1 happened, they've resulted in no findings by the  
2 Ministry. At a certain point, when it comes to the  
3 work refusal process, our members just gave up with  
4 that being a recourse that they had available to  
5 them.

6 We did find another way to be able to  
7 raise things through the complaint process with the  
8 Ministry. But in some cases, it took days, if not  
9 weeks, to hear back from the inspectors.

10 The vast majority of inspections were  
11 done by telephone. And how you can investigate the  
12 safety in a workplace without being in the  
13 workplace --

14 And you also have to think about the  
15 psychological message that that sends to members  
16 when, you know, they're being told "oh, it's okay.  
17 Everything that's happening here is perfectly  
18 safe," but the inspector from the Ministry isn't  
19 going to come into the home; they're going to phone  
20 in.

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 Is the inspector part of a bargaining unit?

23 DAVID HAUCH: I believe they are, yes.

24 COMMISSIONER COKE: Yeah.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 But not -- it's not your --

2 DAVID HAUCH: No.

3 COMMISSIONER COKE: They're probably  
4 OPSEU?

5 DAVID HAUCH: Exactly, yeah. And  
6 believe me, I want to be clear in this. Those  
7 folks are also incredibly overworked and, you know,  
8 overstretched as it is. There aren't enough  
9 inspectors to begin with.

10 I do certainly sympathize with the very  
11 difficult position that they ended up being put in.  
12 But I think overall, we ended up with a real lack  
13 of accountability for enforcement of health and  
14 safety protections for workers in the course of the  
15 first wave.

16 And that took a few different types of  
17 examples, but you know, you have a real lack of  
18 clarity as to who's role it is to enforce  
19 directives. We've heard a number of times from  
20 various folks from the Ministry that it's not their  
21 role to enforce the directives from the chief  
22 medical officer of health.

23 And we failed to understand how that  
24 could be possible when there are very clear and  
25 real health and safety implications to our members

1 and those pieces are not being followed. At the  
2 same time, we would have Public Health saying that  
3 they're not in our area of workplace disputes, and  
4 so --

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 Excuse me --

7 DAVID HAUCH: Yeah.

8 COMMISSIONER FRANK MARROCCO (CHAIR):  
9 That's what I was just about to ask you. So the  
10 local medical officer of health -- if you go to the  
11 local medical officer of health, they say it's a  
12 work-related issue? What do they say?

13 DAVID HAUCH: They'll give us their  
14 interpretation of how the various directives apply,  
15 and they'll say that, when it comes to workplace  
16 matters, that that's the purview of the Ministry of  
17 Labour. And then on the other hand, we would have  
18 the Ministry of Labour telling us that the  
19 directives are a Public Health matter.

20 And so when we have a home that's not  
21 following the directives, we're left in this very  
22 frustrating infinite loop trying to figure out how  
23 to get those enforced. And that doesn't even begin  
24 to scratch the surface of the challenge that comes  
25 with --

1           You know, just because this is what the  
2 directive is from Public Health doesn't necessarily  
3 mean that that meets the standard of a  
4 precautionary principle and the obligation under  
5 the Health and Safety Act for an employer to take  
6 every precaution reasonable for the protection of a  
7 worker.

8           And so there are places where it very  
9 reasonably could mean that there need to be further  
10 protections taken than what are called for in the  
11 directives. But when we went up with that kind of  
12 circular loop in terms of accountability and  
13 enforcement, it becomes next to impossible to  
14 actually find a place to actually have that  
15 conversation in the first place.

16           COMMISSIONER FRANK MARROCCO (CHAIR):  
17 Did you have a view about which one of them it  
18 should be that makes the order or does it?

19           DAVID HAUCH: Yeah. I would say when  
20 it comes to fundamental issues of health and --  
21 well, I think both, to answer your question. But I  
22 think, fundamentally, when it comes to issues of  
23 health and safety in the workplace, that is the  
24 role of the Ministry of Labour to enforce.

25           There are also very clear and valid



1 Public Health concerns that Public Health should  
2 also be enforcing. But, you know, at the end of  
3 the day, I think, at best, there should be a dual  
4 responsibility rather than a lack of clarity as to  
5 where the responsibility lies.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Yeah. I haven't considered it, but I probably  
8 would have thought that it was the local -- that it  
9 was the medical health issues -- the local medical  
10 officer. But in any event, it's a debate people  
11 can have. Somebody has to be responsible.

12 DAVID HAUCH: Yeah, yeah. Absolutely.

13 JACKIE ESMONDE: If I could just jump  
14 in, I mean, I would say what Public Health does and  
15 what the Occupational Health and Safety Act  
16 requires are not necessarily the same thing. And  
17 it's the occupational health and safety  
18 requirements in the workplace that need to be  
19 enforced.

20 So if you ask me, I think the Ministry  
21 had quite a responsibility to -- and not -- and  
22 couldn't just slough that off on the Public Health  
23 in these situations.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Okay. Yeah.

1                   DAVID HAUCH: I think the other things  
2 that I want to touch on here is the vital  
3 importance of clear communication, and so I'm going  
4 to talk about that in two different aspects.

5                   But, you know, at a local level, one of  
6 the those other inherent rights within the Health  
7 and Safety Act is the right to participate for  
8 workers in the workplace, both in the  
9 identification of hazards and through their health  
10 and safety apparatus in how to address and mitigate  
11 the risks of those hazards.

12                   And, you know, it was like pulling  
13 teeth to get basic things like pandemic and  
14 outbreak plans from employers when this started to  
15 understand what they were operating under.

16                   You know, there was a requirement to  
17 report supply of PPE to the government. We began  
18 asking for homes to provide us with, you know,  
19 knowledge of what those supplies were because,  
20 across numerous directives, there was an obligation  
21 on the parties to be good stewards of PPE and  
22 supply. And we can't be a party to that  
23 conversation if we don't have any of that  
24 information. We don't know if there are supply  
25 issues.

1                   And what we got back in a frustratingly  
2 high number of cases were simple statements from  
3 employers that they are adhering to all the  
4 requirements under the Health and Safety Act, and  
5 that was the end of the conversation.

6                   So, you know, from a workplace  
7 perspective, you know, staff have real legitimate  
8 fears and concerns. And they try and raise those  
9 fears and concerns with the employer, and that's  
10 the response that they get back.

11                   And so, you know, it was extremely  
12 frustrating to perpetually have an ongoing -- this  
13 lack of communication about anything that was  
14 happening in the home. So I will say that did get  
15 better as time goes on, but it's far from perfect  
16 or what it should be.

17                   I think that lack of clear and  
18 consistent communication also extends across all  
19 the various levels of government and the various  
20 levels of authority in the health system. I think  
21 you're actually seeing a pretty perfect example of  
22 the challenges with that right now as we look at  
23 decisions that people are making with what to do  
24 this weekend where you have the premier and various  
25 medical officers of health and various communities

1 saying to folks that they need to, you know,  
2 celebrate Thanksgiving limited to their own  
3 individual household. But at the same time, if I  
4 gather with my extended family in a bar, that's  
5 still allowed and that's okay.

6 And how you can reconcile those two  
7 pieces when you have -- when the rules don't match  
8 with what people are saying and when you have  
9 people at various different levels of leadership  
10 saying different things, over all, it leads to mass  
11 confusion.

12 And at a certain point, people throw up  
13 their hands, and they just don't follow anything.  
14 And I really do think that's what we're seeing  
15 manifested large scale right now in society. And  
16 that does have an effect that trickles down into  
17 the workplace and is a significant issue.

18 COMMISSIONER FRANK MARROCCO (CHAIR):  
19 Okay.

20 DAVID HAUCH: I think I've covered off  
21 most of my points in there, so unless there are any  
22 questions, I'll turn it over to Debra.

23 DEBRA MAXFIELD: Thank you. So we need  
24 to provide free, regular, consistent COVID-19  
25 testing for everyone living, working, or visiting

1 long-term care homes.

2           There needs to be a priority for all  
3 healthcare workers and more efficient forms of  
4 testing and processing the results. I can tell  
5 you, working in long-term care myself, it's very  
6 unpleasant and very uncomfortable, and it's not a  
7 very nice experience at all.

8           Any opportunities for testing to be  
9 less invasive, a faster way, would certainly be  
10 appreciated like a mouth rinse, that test that was  
11 developed in BC for school-aged children.

12           Currently visitors only needing to  
13 attest to having tested negative in the last two  
14 weeks is becoming more challenging given the  
15 demands of the testing system and so visitors are  
16 entering the home without meeting the testing  
17 requirement guidelines.

18           COMMISSIONER FRANK MARROCCO (CHAIR): I  
19 wanted to ask about that because it was suggested  
20 in one of the other presentations that basically  
21 the province has, in effect, common geared all of  
22 them -- testing facilities, whether they're private  
23 or -- tying them up in one form or another.

24           Is that your understanding, that the  
25 testing capability has been totally taken over?

1 DEBRA MAXFIELD: Yes, I believe so.

2 Dave, do you want to answer this?

3 DAVID HAUCH: Well, and we see, in a  
4 number of cases, the testing -- the surveillance  
5 testing that's happening in homes is being  
6 conducted by employers at this point. They are  
7 still able to get those tests back.

8 Our bigger concern is around visitors  
9 and the capacity for people visiting homes to be  
10 able to get the tests required to be able to make  
11 the attestation that they have to make to be able  
12 to come in and visit their loved ones.

13 And, you know, we recognize fully the  
14 balance that needs to be struck between, you know,  
15 the safety but also the mental well-being of the  
16 residents themselves and being able to have visits  
17 from their loved ones. But we need to make sure  
18 that we are able to do it in a way that is safe.

19 And, you know, at this point now, it  
20 takes -- I'm in Hamilton. It takes five days to be  
21 able to get an appointment for a COVID test and  
22 then almost a week to be able to get the result  
23 back.

24 And by that point, you're pushing right  
25 up against the edge of that 14-day window that

1 you're supposed to be able to have in the  
2 attestation before you have to go and repeat that  
3 cycle all over again. That clearly can't be -- the  
4 whole notion of the visitation and the way  
5 visitation is structured and doing it safely relies  
6 on the ability for people to make -- to have the  
7 effect on them to make these attestations. And  
8 we're getting to a point where we honestly don't  
9 know how that's possible for visitors to be able to  
10 do.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 But if the testing capability is basically  
13 exhausted and it's taking that long, then you need  
14 some kind of technological change. You need a  
15 different kind of test.

16 I've read different things about these,  
17 but is it your impression that there's a reluctance  
18 to resort to other technology, or is it just  
19 technology, really, hasn't arrived yet?

20 DAVID HAUCH: I'll be honest, we're  
21 heading outside of, I think, our sphere of  
22 knowledge to be able to answer that.

23 COMMISSIONER FRANK MARROCCO (CHAIR): I  
24 know. It's outside our terms of reference too, but  
25 I thought I'd ask anyhow.

1           DAVID HAUCH: But I will say from a  
2 speculative point of view, I think we also need to  
3 be mindful of the challenges we see south of the  
4 border with, you know, the technology that was used  
5 by the White House to test individuals going into  
6 and out of the Oval Office that clearly did not  
7 serve the function that it was supposed to serve.

8           So how you start that balance? Like, I  
9 recognize it's a very real challenge. And yeah, I  
10 leave that to higher pay grades to figure --

11           COMMISSIONER FRANK MARROCCO (CHAIR):  
12 Well, sorry, Ms. Maxfield. We interrupted you in  
13 the middle of it.

14           DEBRA MAXFIELD: That's okay. The  
15 other thing is to ensure that all visitations occur  
16 only when the homes are able and appropriately --  
17 can safely manage. The current rules stipulate  
18 that homes can monitor visits for -- safely and  
19 inherence to distancing requirements, but it's not  
20 required, right?

21           So my next point would be facilitate  
22 the transfer of COVID-positive residents from  
23 long-term care to hospitals where it is better --  
24 more appropriate treatment -- you know, hospitals  
25 that have better resources, higher staffing levels,



1 and more modern facilities, particularly in areas  
2 with ventilation.

3 In numerous cases during the first  
4 wave, we had homes that were completely overwhelmed  
5 while hospitals had access capability and could  
6 have provided the needed treatment to our residents  
7 to help save their lives.

8 And then back to the single-site  
9 restriction, to be amended for all full-time hours  
10 for impacted employees to mitigate economical  
11 losses suffered by staff who were prevented from  
12 working two or three locations.

13 You know, again, we recognize the  
14 important health and safety requirements behind  
15 this order, but the impact that it had on our  
16 members has been substantial.

17 In contrast, BC's single-site order  
18 also came with measures to promote full-time work  
19 with standardized wages for staff. While our  
20 members were prevented from working in multiple  
21 sites temporarily, agency staff were able to work  
22 in multiple locations without the requirement of  
23 self-isolation to self-isolate. Not only this was  
24 not fair to our members but increased the risk of  
25 viral transmission that was supposed to be

1 addressed by the order.

2           DAVID HAUCH: And sorry, just going to  
3 add one point. With respect to the contrast with  
4 BC, I think it is very clear that -- what you see  
5 in how the single-site provision was implemented in  
6 the two provinces, you can see a very different  
7 approach on the part of government to the impact  
8 that those orders would have.

9           In Ontario, the single-site restriction  
10 purely just says that someone cannot work in two  
11 long-term care homes, retirement homes, health  
12 service providers at the same time. So they have  
13 to pick one, consequences began.

14           At the end of the day, we do recognize  
15 that, you know, employers did have additional  
16 funding that was flowed to them by the government.  
17 And one of the things that that could be used for  
18 was to increase hours from part-time hours to  
19 full-time hours to help compensate them for the  
20 loss. But they suffered by not having that second  
21 job, but there is nothing requiring that to take  
22 place.

23           And so in practical reality, then,  
24 you're leaving it to individual operators and  
25 providers to make that decision to do that. And in

1 some cases -- and I think largely driven by just  
2 necessity and need for hours, they did do that, but  
3 that has not been a universal experience.

4 And when you look at the way -- I think  
5 the BC example is a perfect way of being able to  
6 show how it is possible to make the same kind of  
7 public policy decision while also recognizing the  
8 economic impact that's going to be faced by the  
9 people impacted by that order.

10 Because in BC they put mechanisms in  
11 place to compensate people up to 1.3 FTEs for the  
12 hours that they've lost and also, you know, rose  
13 everyone to the high watermark in terms of wages.

14 And recognizing that the regulatory  
15 frameworks and how the systems are set up are  
16 different in both provinces, that was, maybe,  
17 easier for them to do in the way that their system  
18 is set up.

19 I think it is really clear that the  
20 government made a conscious choice in BC to take a  
21 really important health and safety public health  
22 policy directive but also consider what that does  
23 to staff on the ground, and that second piece of  
24 the analysis was just missing in Ontario.

25 And our members are the ones who have

1 really felt the brunt of that, and it is  
2 extraordinarily frustrating for them because there  
3 is no way for them to make up --

4 Like, people don't work at two or three  
5 facilities because they like having a different set  
6 of scenery every day. They work at those multiple  
7 jobs out of financial necessity. That's why we see  
8 it even more prevalent in urban centres, especially  
9 in the GTA where the cost of living is so high.

10 And so people still have those bills to  
11 pay, but they don't have the ability to make up the  
12 hours that they've lost, and so we think that needs  
13 to be something that's considered in the overall  
14 mix. Sorry to interrupt.

15 CANDACE RENNICK: Well, if I could just  
16 add one thing there as well, British Columbia not  
17 only supported people's individual financial  
18 situations. It also actually helped the lower-paid  
19 facilities because, inevitably, people are going to  
20 be leaving those lower-paid facilities to go to the  
21 jobs where they're paid the higher amount.

22 So, you know, they didn't see the kind  
23 of mass exits of staff out of those lower-paid  
24 facilities that, arguably, we may have seen in  
25 Ontario and then heavily relied on agency staff.

1                   ANDREW WARD: And just speaking to the  
2 watermarks that were placed for the provinces and  
3 the staffing, the province -- and we acknowledge  
4 that it's a step in the right direction -- did  
5 announce last week the temporary \$3 bump-up.

6                   However, we want to stress to you, the  
7 Commission, that that only pertains to personal  
8 support workers. So there are entire areas of  
9 employment that aren't covered. So all of the  
10 ancillary staff, the nursing staff in these  
11 facilities would not receive these moneys.

12                   And the other thing that speaks to both  
13 Madam Rennick and Mr. Hauch's points is that it's  
14 one thing to receive a \$3 per hour increase, but  
15 when you've had your hours cut in half to 20 hours  
16 from a particular job that you may be relying on in  
17 order to get groceries or pay for programs for your  
18 kids, you're not going to be able to access that,  
19 and that's part of what also exacerbates the  
20 issues, and it also speaks to the tenure of what  
21 we're regarding today.

22                   DEBRA MAXFIELD: So my last point is to  
23 ensure that all residents and workers have free and  
24 timely access to COVID-19 vaccines as soon as  
25 they're available.

1 Jackie?

2 JACKIE ESMONDE: Thank you, Debra. I'm  
3 going to say a few small things about the use of  
4 emergency orders throughout the pandemic.

5 So emergency orders were one of the key  
6 ways that the province dealt with the lack of  
7 preparation in long-term care and the longstanding  
8 staffing crisis.

9 Was there an emergency? Yes. Was it  
10 foreseeable and could have been avoided? Yes.

11 So in a sense, the province kind of  
12 created the circumstances in which it needed to use  
13 emergency orders. But in doing so, they overrode  
14 collective agreements and undermined the legal  
15 rights of CUPE members.

16 COMMISSIONER FRANK MARROCCO (CHAIR):  
17 When do you think it was foreseeable? Like, at  
18 what point in time?

19 JACKIE ESMONDE: I would say you look  
20 back at reports over years that were identifying  
21 there being a staffing crisis --

22 COMMISSIONER FRANK MARROCCO (CHAIR):  
23 Oh, I see.

24 JACKIE ESMONDE: -- linking that to --

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 The staffing crisis.

2 JACKIE ESMONDE: Yeah, so in that  
3 sense.

4 COMMISSIONER FRANK MARROCCO (CHAIR):  
5 Yeah, I understood now.

6 JACKIE ESMONDE: Yeah. And the risks  
7 of a pandemic in long-term care homes, that risk  
8 has been well known for many years. And the  
9 staffing crisis is one of the contributing factors  
10 to that.

11 Making policy decisions, panicked  
12 policy decisions, in the middle of a pandemic is an  
13 irresponsible approach to what was a longstanding  
14 problem. And it can and did lead to unintended  
15 consequences that themselves created to unsafe  
16 situations and allowed the virus to spread.

17 So, for example, employers relied on  
18 the emergency orders to cancel vacations and  
19 unilaterally implement 12-hour shifts. And that  
20 contributed to dangerous burnout for staff for  
21 frontline staff.

22 A problem that's being compounded right  
23 now with -- in the midst of the second wave, the  
24 vacation year is coming to a close with numerous  
25 employees unable to use their vacation allotment.

1 So that burn out, the inability to take that time  
2 that you need to regenerate to be your best self in  
3 the workplace, that's a real problem.

4 The emergency orders also gave  
5 employers more discretion over training  
6 requirements, reduced documentation and reporting  
7 requirements, allow for the use of unqualified  
8 volunteers.

9 And my colleagues have already spoken  
10 about the single-site orders that had, you know,  
11 serious financial consequences. But beyond that  
12 issue, which is serious enough, it also compounded  
13 the staffing issues, particularly for the homes  
14 with the lower wages where you just saw, you know,  
15 staff running from those to the -- if they had to  
16 choose, they would go to the job with the higher  
17 wage.

18 And although the state of emergency has  
19 been lifted, these orders are now sort of  
20 semipermanent in the sense that there's now the  
21 Reopening Ontario (Flexible Response to COVID-19)  
22 Act which allows these emergency orders to  
23 continue, although the emergency has been lifted.

24 And we say unilateral, reactive orders  
25 by government is no way to deal with a long-term



1 problem. Bill 195 should be repealed in order to  
2 restore workers' collective bargaining rights and  
3 restore collective agreements. And the best way is  
4 to actually work with Labour to solve these  
5 problems.

6 And that's all I have to say about the  
7 emergency orders, so I'll turn it over to you,  
8 Candace, subject to my questions, of course.

9 CANDACE RENNICK: I would just add one  
10 thing to that to say that many homes and employers  
11 actually relied heavily on these emergency orders  
12 by taking away the rights of our members in  
13 situations where that particular home didn't  
14 experience any level of outbreak or COVID cases at  
15 all. And so rather than relying on these emergency  
16 orders out of necessity, it appeared that they were  
17 taking advantage of them.

18 We just have a couple of more points.  
19 I really appreciate the level of engagement with  
20 our presentation, but --

21 DAVID HAUCH: Candace, before you move  
22 on, can I make one more point on the Bill 195?

23 I think it is also really important to  
24 look at this in the bigger picture and in the  
25 context of what it means for staff feeling engaged

1 and a part of their workplace.

2 So they have collective agreements. We  
3 have, you know, over many, many years, built  
4 agreements with employers and built relationships  
5 with employers to be able to address and to work  
6 through a lot of these challenges.

7 And to have the provisions of those  
8 collective agreements basically thrown out the  
9 window in what was originally told to us is a  
10 short-term, two-week measure and then got extended  
11 and then got extended again and now extends  
12 long-term into perpetuity, the level of respect  
13 that that shows in the home to frontline staff  
14 is --

15 Like, people take it very personally,  
16 and, you know, it's just one more hit on top of a  
17 number of other hits that contribute to that sense  
18 of burnout that Jackie had spoken about.

19 Sorry to cut you off, Candace.

20 CANDACE RENNICK: No, not at all. And  
21 we're almost finished. Really appreciate your  
22 patience here with us.

23 We also think that there's a need to  
24 develop comprehensive and ongoing plans and  
25 procedures to prevent and address infection

1 outbreaks in long-term care and to ensure the  
2 implementation of plans and procedures are  
3 regulated, enforced, and fully funded. Many of the  
4 significant issues that arose during the first  
5 wave, particularly at the outset of the pandemic,  
6 resulted in delays and the clear lack of direction.

7           You know, for example, I want to give  
8 some examples of where Ontario fell far behind  
9 other provinces like British Columbia in the  
10 directives being used.

11           So on the issue of the universal  
12 masking, we were 14 days behind British Columbia.

13           On the single-site directive, we were  
14 20 days behind British Columbia.

15           On the setting of the threshold for  
16 declaring outbreaks, at one confirmed case, we were  
17 28 days behind British Columbia.

18           And on the creation of IPAC teams to  
19 deploy and to support long-term care facilities, we  
20 were 40 days behind British Columbia.

21           And because British Columbia acted more  
22 decisively than Ontario, that province was able to  
23 contain the spread of COVID and limit the number of  
24 COVID-related deaths among long-term care residents  
25 to a much, much greater extent.

1 I am going to turn it over to Andrew,  
2 our long-term care researcher, who is going to make  
3 two final points of our presentation.

4 ANDREW WARD: Thank you, Candace. You  
5 may have saved the shortest for last, so I promise  
6 not to be long for two reasons. One is you've  
7 heard some of the points that I'm going to quickly  
8 brisk over; but two, I wanted to leave you all with  
9 some good news.

10 So one of the points that I wanted to  
11 raise deals with developing guidance for  
12 reconfiguration of space and functionality to  
13 address the possibility of future outbreaks, also  
14 to outlook towards surge capacities that apply to  
15 long-term care.

16 Recently, in August, the Canadian  
17 Medical Association Journal released a report  
18 called "COVID-19 and Long-Term Care Facilities:  
19 Does Ownership Matter?"

20 What I found was that a number of  
21 for-profit facilities had more extensive outbreaks  
22 and more deaths than other facilities. So those  
23 would be non-profit or, in the case of Ontario,  
24 also municipally-run long-term care.

25 What was discovered, though, was that

1 regardless of the home type, when a multi-bed  
2 design was added to the model, the for-profit  
3 ownership status dropped like a stone in the water.

4           And the reason for this had to do with  
5 contagion to the point that steps currently are  
6 already being taken to move away from ward rooms  
7 where there would have been more than three  
8 residents in the room.

9           So these would typically -- in most  
10 long-term care facilities that would have that, it  
11 would be a single space, you would have four  
12 residents, and there would be one washroom.

13           The reason why we raise this to your  
14 attention is because the prevalence of shared rooms  
15 has been identified as a significant factor in the  
16 outcomes between BC and Ontario.

17           In British Columbia, only 24 percent of  
18 these types of multiperson rooms exist and Ontario  
19 with 63 percent. And predominantly, you'll see  
20 these types of spaces or spacings in older  
21 long-term care facilities as well as in long-term  
22 care facilities that are found in small-town  
23 Ontario.

24           Now, the last thing that I wanted to  
25 talk to you about -- and I always enjoy talking

1 about these elements of recommendations because we  
2 feel that in order to make the matters whole, an  
3 increase as well as provision of funding needs to  
4 cover the cost and consistent inspections of all  
5 long-term care facilities.

6 The reason why we identify this is very  
7 simple. The long-term care staffing study  
8 recommended this as well. That is, the long-term  
9 care system is set to expand to respond in  
10 increasing demand. What we are currently doing is  
11 not adequate.

12 The home quality inspection program  
13 that is designed at stake for our residents'  
14 well-being by continually inspecting complaints and  
15 incidents within the homes is wanting. We also  
16 want to address staffing shortages in long-term  
17 care which can't happen without additional funding.  
18 We also wanted to point to the fact that an  
19 increased investment will go directly to staffing  
20 by placing the funding in the designated envelopes  
21 which support staffing costs.

22 So there are support services and  
23 personal care envelopes that these moneys can be  
24 provided. We also wanted to flag that these  
25 staffing envelopes -- if they are not using the

1 money for this type of staffing, the money must be  
2 recovered by government.

3           The reason why we speak to all of these  
4 rationale is very simple. When we look at some of  
5 these success stories that we've found in Ontario,  
6 there are two that come to mind.

7           One of them was in Kingston which has  
8 had some of the best outcomes in the province. At  
9 that time, the local medical officer conducted  
10 proactive inspections of infection protection and  
11 control procedures in long-term care homes. And by  
12 so doing, it had an incredible effect on contagion.

13           Another example -- I'm speaking to you  
14 today from Mississauga, but in Grey Bruce, the  
15 region became one of the only areas that hadn't  
16 contacted a deadly case of the virus. Their top  
17 doctor, Dr. Ian Arra of Grey Bruce, tracked seven  
18 outbreaks in long-term care settings, and he said  
19 that in all but one instance, the outbreaks stopped  
20 in one case.

21           What was in the secret sauce with  
22 Dr. Arra? It was very simple. He said that in  
23 long-term care homes, those scheduled calls with  
24 frontline workers, managers, and directors helped  
25 manage the outbreaks. And he concluded by saying

1 that if that redundancy is built in, the ball won't  
2 drop. "Prevention" is the word for Public Health.

3 And it's for these very reasons why we  
4 feel that we need to provide better efficacy for  
5 regular and consistent inspections of all the  
6 long-term care homes.

7 And that's my final point.

8 Candace?

9 CANDACE RENNICK: Thanks, Andrew. So  
10 that really does conclude the presentation that  
11 we've prepared for you folks today. We really  
12 appreciate the opportunity to present to you.

13 We don't envy the task that you have  
14 before you, but we're happy to help support it in  
15 any way that we can, and we'd be happy to answer  
16 any other questions or points of clarification that  
17 you may have of us today.

18 COMMISSIONER FRANK MARROCCO (CHAIR): I  
19 don't think there are any further questions, so I  
20 guess it falls to thank you for the presentation.

21 You do have a website, and would you  
22 mind if there was a link between the website and  
23 our website so that in case your members wonder  
24 what, exactly, we're up to, at least they can find  
25 our website relatively easily?



1                   And we may be back, which I hope you  
2 don't mind, depending on where we are because it  
3 may be helpful to talk to you again.

4                   And we certainly have, Ms. Esmonde, the  
5 one other issue there that we talked about, the  
6 confidentiality issue, which will probably put us  
7 back into each other's company, in any event.

8                   But thank you. Thank you very much for  
9 the presentation. It's very helpful from our  
10 perspective.

11                   COMMISSIONER COKE: Yeah, thank you.

12                   DAVID HAUCH: And thank you very much  
13 for the time. I know we had also tried to focus  
14 what we were talking about today to the sort of  
15 immediate recommendations that you were looking  
16 for.

17                   We absolutely have many thoughts that  
18 we think would be useful to you in the further  
19 phases of your investigation, so we absolutely  
20 welcome any opportunities to be able to come back  
21 and talk to you.

22                   COMMISSIONER FRANK MARROCCO (CHAIR):  
23 Thank you.

24 U/T               CANDACE RENNICK: And we will post the  
25 link, and we have been communicating regularly with

1 our members as things become known to us about your  
2 dealings here and your progress. So thank you.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay. Thank you.

5 COMMISSIONER KITTS: Thank you.

6 COMMISSIONER COKE: Thank you.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Bye, everybody.

9 JACKIE ESMONDE: Thank you so much.

10 -- Adjourned at 3:50 p.m.

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1 REPORTER'S CERTIFICATE

2  
3 I, MCKAYA MCDONALD, CSR, Certified  
4 Shorthand Reporter, certify:

5  
6 That the foregoing proceedings were  
7 taken before me at the time and place therein set  
8 forth;

9  
10 That all remarks made at the time  
11 were recorded stenographically by me and were  
12 thereafter transcribed;

13  
14 That the foregoing is a true and  
15 correct transcript of my shorthand notes so taken.

16  
17  
18 Dated this 8th day of October, 2020.

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