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

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

BEFORE:

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

PRESENTERS:

David Hauch, Long-Term Care Coordinator, CUPE;
Candace Rennick, Secretary-Treasurer of CUPE;
Debra Maxfield, Chair, Provincial Healthcare Workers' Coordinating Committee, CUPE;
Andrew Ward, Long-Term Care Policy Researcher, CUPE;
Jackie Esmonde, In-House Legal Counsel, CUPE.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;

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

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Let me, first of all, thank you for meeting with us. Let me just sort of tell you where we're coming from.

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

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

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

So from our perspective, any

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

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

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

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

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

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

My name is Candace Rennick. I am the

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

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

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

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

throughout this process.

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

(TECHNICAL INTERRUPTION)

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

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

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

All right. Go ahead, Candace.

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

You're on mute, by the way.

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

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

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

So if we truly are going to make space

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

Before --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I stop you there for a minute?

CANDACE RENNICK: Yes, you can.

COMMISSIONER FRANK MARROCCO (CHAIR): The way the order in council was drawn, it seems to vest control over confidentiality outside of the commission. We have requested that that be changed.

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

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

CANDACE RENNICK: Understood.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

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

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

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

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

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

JACKIE ESMONDE: Okay.

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

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

a "guided discussion" with a group of workers.

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

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

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

JACKIE ESMONDE: Yes.

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

JACKIE ESMONDE: Perfect.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

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

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

So this recommendation was also

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

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

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

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

understaffed.

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

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

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

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

the demand that's there.

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

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

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

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

So I think a lot of these pieces

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CANDACE RENNICK: I mean, I think --

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

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

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

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

CANDACE RENNICK: Absolutely. And I

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

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

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

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

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

DAVID HAUCH: I will just --

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

CANDACE RENNICK: Yes.

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

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

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

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

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

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

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

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

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

of this.

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

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

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

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

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

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

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

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

COMMISSIONER COKE: We're on fire today.

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

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

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

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

So this new level of classification is

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

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

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

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

COMMISSIONER COKE: Thank you.

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

on this briefly.

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

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

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

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

CANDACE RENNICK: Yes.

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

CANDACE RENNICK: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- who can stay home and forego the money --

CANDACE RENNICK: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- or come to work and get paid. And if you stay home, there's a suspicion that you're not really sick?

CANDACE RENNICK: Yeah, exactly.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

specifically, the N95 mask issue.

But I'm sorry. Go ahead, please.

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

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

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

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

DAVID HAUCH: And I think it's

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

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

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

COMMISSIONER COKE: Okay. Thank you.

CANDACE RENNICK: Thank you.

Dave, go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In terms of our interactions with the

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

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

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

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

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

When they hear where work refusals have

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

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

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

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

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

DAVID HAUCH: I believe they are, yes.

COMMISSIONER COKE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

But not -- it's not your --

DAVID HAUCH: No.

COMMISSIONER COKE: They're probably OPSEU?

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Excuse me --

DAVID HAUCH: Yeah.

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

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

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

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

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

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

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

There are also very clear and valid

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. I haven't considered it, but I probably would have thought that it was the local -- that it was the medical health issues -- the local medical officer. But in any event, it's a debate people can have. Somebody has to be responsible.

DAVID HAUCH: Yeah, yeah. Absolutely.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Yeah.

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

long-term care homes.

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

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

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

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

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

DEBRA MAXFIELD: Yes, I believe so.

Dave, do you want to answer this?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and more modern facilities, particularly in areas with ventilation.

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

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

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

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

addressed by the order.

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

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

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

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

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

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

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

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

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

And our members are the ones who have

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

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

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

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

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

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

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

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

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

Jackie?

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

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

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

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

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

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

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

JACKIE ESMONDE: -- linking that to --

COMMISSIONER FRANK MARROCCO (CHAIR):

The staffing crisis.

JACKIE ESMONDE: Yeah, so in that sense.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and a part of their workplace.

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

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

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

Sorry to cut you off, Candace.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What was discovered, though, was that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And that's my final point.

Candace?

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

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

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

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

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

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

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

COMMISSIONER COKE: Yeah, thank you.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

COMMISSIONER KITTS: Thank you.

COMMISSIONER COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye, everybody.

JACKIE ESMONDE: Thank you so much.

-- Adjourned at 3:50 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, CSR, 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 8th day of October, 2020.

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