

Long-Term Care COVID-19 Commission Meeting

Dietitian Network
on Tuesday, March 30, 2021



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 30th day of
March, 2021, 9:00 a.m. to 10:30 a.m.

1 BEFORE:

2 The Honourable Frank N. Marrocco, Commission Chair

3 Angela Coke, Commissioner

4 Dr. Jack Kitts, Commissioner

5

6 PRESENTERS:

7 DIETITIAN NETWORK

8 Stacey Scaman, RD, Corporate Dietitian, Seasons

9 Care Dietitian Network

10 Carol Donovan, RD, President, Seasons Care

11 Dietitian Network

12 Julie Cavaliere, RD, Director of Long Term Care

13 Systems, Sienna Senior Living

14

15 PARTICIPANTS:

16 Alison Drummond, Assistant Deputy Minister,

17 Long-Term Care Commission Secretariat

18 Ida Bianchi, Senior Legal Counsel, Long-Term Care

19 Commission Secretariat

20 Derek Lett, Policy Director, Long-Term Care

21 Commission Secretariat

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

23 Care Commission Secretariat

24 Alain Daoust, Team Lead, Long-Term Care Commission

25 Secretariat

1 Adriana Diaz Choconta, Senior Policy Analyst,
2 Long-Term Care Commission Secretariat
3 Angeline Hawthorn, Senior Policy Analyst, Long-Term
4 Care Commission Secretariat
5 Rose Bianchini, Senior Policy Analyst, Long-Term
6 Care Commission Secretariat
7 Lynn Mahoney, Counsel, Gowling WLG
8 Peter Gross, Counsel, Gowling WLG

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11 ALSO PRESENT:

12 Deana Santedicola, Stenographer/Transcriptionist

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1 -- Upon commencing at 9:00 a.m.

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3 LYNN MAHONEY: So this morning we have
4 the Registered Dietitians here. They are Julie,
5 Carol and Stacey are all here, and they have a
6 presentation to you.

7 Myself and Alison and Dawn and Alain
8 had met with them, and we thought that the message
9 and the information that they had conveyed to us
10 was important, and although, as is the case, we
11 transmit all information to you, we thought it
12 would be helpful for you to hear from them and for
13 there to be a transcript posted as well of what
14 they had to say.

15 So over to you, Commissioner Marrocco.

16 COMMISSION CHAIR FRANK MARROCCO: Well,
17 thank you for coming. We are certainly very
18 interested in what you have to say. I am Frank
19 Marrocco, and also Commissioner Dr. Jack Kitts and
20 Commissioner Angela Coke.

21 As Ms. Mahoney said, there is a
22 transcript and we'll post it on the website. If
23 you don't mind, we'll ask questions as we go along
24 so that we don't have to go back.

25 We are very much coming to the end of

1 our inquiries and we are in the process of writing,
2 so your presentation seemed to us to be important
3 and so we asked you to come in.

4 And we are ready to go when you are, so
5 go ahead.

6 STACEY SCAMAN: Great, thank you.

7 We are very excited and honoured to be
8 here to share our experiences during COVID. We
9 have lots of expertise behind us all, and we speak
10 for Dietitians as a whole.

11 So we hope to really communicate that
12 message of what COVID was like, what it was like
13 before and what our recommendations would be moving
14 forward for our residents in long-term care.

15 So just so you know a little bit about
16 us, my name is Stacey Scaman. I am a Registered
17 Dietitian and I have been in long-term care for
18 just under 13 years. Currently my role is
19 Corporate Dietitian, and so I support many homes
20 and many management teams within long-term care and
21 many Dietitians.

22 Carol?

23 CAROL DONOVAN: Hi, I am Carol Donovan.
24 I have been in long-term care for about 25 years.
25 I have been a Dietitian for 37. A fabulous

1 profession and I have enjoyed it very much.

2 I too am a consulting Dietitian. I
3 have my own company called Seasons Care, and we
4 provide dietitian and food service expertise to
5 long-term care homes across Canada, and in Ontario
6 we provide services to both not-for-profit and
7 for-profit.

8 And currently, I am the Chair of the
9 Board of Dietitians of Canada, so I am very
10 pro-Dietitian.

11 STACEY SCAMAN: Julie?

12 JULIE CAVALIERE: Yes, and I am Julie
13 Cavaliere. Currently I am the Director of Long
14 Term Care Systems for Sienna Senior Living. It is
15 one of the bigger chains, private senior housing
16 chains across Canada, both retirement and long-term
17 care.

18 I have been a Dietitian since 1999. I
19 am the nutrition expert on the Ontario Long-Term
20 Care Geriatric Review Committee. I also sit on and
21 am a newly elected member of the Board of Directors
22 for Dietitians of Canada. And my experience in
23 long-term care is not just in the clinical
24 dietitian side, but also the food services side as
25 well.

1 STACEY SCAMAN: Awesome. So I am just
2 going to open up the PowerPoint so we can follow
3 along and I can help guide the conversation.

4 So now let's see if I can do this
5 quickly.

6 COMMISSION CHAIR FRANK MARROCCO: We
7 can see it.

8 STACEY SCAMAN: Perfect. Okay, thanks
9 for letting me know. Sometimes you never know.

10 So what we are going to cover today is
11 kind of just a brief review of what we do in
12 long-term care as Registered Dietitians, the care
13 that we provide, both the status of past, where we
14 are right now and pre-pandemic and where we see
15 ourselves going in the future, and we want to share
16 some of those lessons that we have learned and what
17 we think would be really helpful moving forward in
18 the future.

19 Okay, so let's go. Go ahead, Carol.

20 CAROL DONOVAN: Yes, I just wanted to
21 introduce our profession to you. We are part of
22 the Allied Health Professionals Act, and we are
23 experts in nutritional care and food service in
24 long-term care.

25 Our goal, our job when we go into

1 long-term care is to assess, plan and implement and
2 evaluate the nutrition plans and hydration plans
3 for the seniors that we service.

4 So one of the guides that we follow is
5 the Ministry of Health legislation, and so we not
6 only provide the nutritional care but we also
7 review the menus and provide clinical care and
8 consultation to other staff.

9 We are governed and licensed by the
10 College of Dietitians of Ontario, and we are
11 supported by our association, Dietitians of Canada.

12 One of our biggest goals, of course, is
13 to prevent risk. We mitigate risk for residents in
14 long-term care and make sure they have a solid
15 foundation of nutrition and hydration.

16 And so that is what we do in long-term
17 care. We are not just people that plan to put a
18 tray in front of a resident and hope they eat. We
19 are a lot more than that. We want to ensure and we
20 work hard to make sure that their needs are met in
21 every way they can be.

22 Now, according to the Act right now,
23 Dietitians are mandated for 30 minutes per resident
24 per day, and so in a 120-bed home, we get 60 hours
25 a month. Not a lot of time.

1 We are contracted by organizations such
2 as Seasons Care, my company, or with chains like
3 Sienna or Revera. And one of our other consultants
4 that have worked on this project with us is Tara
5 Pfab from Revera. So we have got a good
6 cross-section of people that are working together
7 to bring you this message.

8 Long-term care homes can hire
9 Dietitians independently. They can go through a
10 company like mine. Julie would hire her staff.
11 Some are hired as contractors, and some are hired
12 as employees.

13 But very few Dietitians work just in
14 one home, because the hours are so small. So if
15 you have only got 60 hours, you are probably going
16 to pick up one or two or three contracts to give
17 yourselves a full-time equivalent.

18 Now, when we get into remote homes in
19 the north, we really have difficulty getting
20 Dietitians on-site. We have been very creative, 25
21 years of being creative, to find those homes the
22 support. We offer remote, but often they want
23 somebody on-site, so we end up sometimes even
24 flying somebody in to provide that service.

25 So what we provide at present is based

1 on the Ministry regulations.

2 COMMISSION CHAIR FRANK MARROCCO: Are
3 they wired up north so that you could do it
4 remotely? And I am assuming in the question that
5 there are some services that could be provided
6 remotely.

7 CAROL DONOVAN: Yes, we are. We are in
8 a good position where we can provide the service
9 remotely, but the legislation basically says
10 on-site. So there are owners that say, you know,
11 we want you on-site. They will not allow the
12 remote. And even when we have reached out to the
13 Ministry about that, they can be very strict in
14 their rules.

15 So there is sometimes some homes that
16 go without service, which is disappointing.

17 COMMISSION CHAIR FRANK MARROCCO: Okay.

18 CAROL DONOVAN: Okay, the next slide,
19 Stacey.

20 So just a little -- we don't want to
21 get into too much history. We are actually right
22 now the Dietitians of Canada is working on a
23 project to give you the history of our profession,
24 so it is going to be really interesting. But there
25 were a lot of people even before us, a lot of

1 Dietitians that really advocated for Dietitians to
2 be in long-term care.

3 So in 1998 Dietitians were mandated for
4 15 minutes per resident per day on-site, and they
5 fought very hard for that. So we are really
6 grateful for the work that they did.

7 So another 12 years later, again, after
8 a lot of strong advocacy, we were increased to 30
9 minutes per resident per day on-site and that was a
10 coup for us.

11 But again, now we are almost 12 years
12 from that and we have seen no increase in 12 years
13 but we have seen an increase in the needs of the
14 residents that are entering into long-term care;
15 and even into the retirement home sector, which we
16 service as well, their needs are much greater than
17 they were in 2010.

18 COMMISSION CHAIR FRANK MARROCCO: And
19 does the fact that their needs are greater affect
20 the time that you have to spend? Intuitively, a
21 person would think that is so, but until you say
22 it, the fact that I may think so isn't worth very
23 much.

24 CAROL DONOVAN: Yes, and definitely, we
25 definitely end up spending more time on the people

1 with a higher need, but then that doesn't give us
2 as much time for the people that might not have as
3 great a need but do have needs. For example, tube
4 feeds, we have a lot of people that are on tube
5 feeds, and they take a lot of time to prepare and
6 make sure that that person is doing well and then
7 it is an ongoing monitoring with them.

8 So we do have systems in place to
9 ensure that everybody is seen within those 30
10 minutes. So we do do quarterly assessments so that
11 we make sure that nobody was left out.

12 But there are some people that we
13 definitely are spending more time on. And 30
14 minutes, we are running very hard. It is not -- it
15 is a very difficult job to get good results out of.
16 We take care of wounds. If people are losing
17 weight, they are not eating, there is so many other
18 things, and the other Dietitians are going to tell
19 you about a few of the little -- the things that
20 are our time-zappers.

21 COMMISSION CHAIR FRANK MARROCCO: So as
22 the physical condition of the residents becomes
23 more serious or more complex, the amount of time
24 you as a Dietitian have to spend figuring out how
25 to feed them and what to feed them and all the

1 things that you do - and I don't want to
2 encapsulate what you do in those two phrases - that
3 amount of time should increase; is that the idea?

4 CAROL DONOVAN: It should, but it
5 doesn't.

6 COMMISSION CHAIR FRANK MARROCCO:
7 Right.

8 CAROL DONOVAN: We do it within the 30
9 minutes. We are not allowed any extra time. That
10 is all we are allotted, and so we make it work but
11 it could be better.

12 COMMISSION CHAIR FRANK MARROCCO: It
13 increased from 1998 to 2010. Did it increase for
14 that reason, or did it increase for different
15 reasons back then, do you know?

16 CAROL DONOVAN: Yes, at that point in
17 time, that is when we brought in MDS and the RAI
18 system as well, so that caused us to have an
19 increase in time because they wanted to start
20 gathering data. And the other reasons were just
21 advocacy that we needed more time.

22 COMMISSION CHAIR FRANK MARROCCO: Okay,
23 thanks.

24 COMMISSIONER JACK KITTS: Can I just
25 follow up on that?

1 CAROL DONOVAN: Sure.

2 COMMISSIONER JACK KITTS: So to me it
3 seems highly prescriptive.

4 CAROL DONOVAN: Yes.

5 COMMISSIONER JACK KITTS: And I am kind
6 of thinking with most health professionals, you get
7 your judgment as to who needs more than 30 minutes
8 and who needs less than 30 minutes. Does that
9 count or do you have to spend 30 minutes --

10 CAROL DONOVAN: No.

11 COMMISSIONER JACK KITTS: That doesn't
12 count.

13 CAROL DONOVAN: It doesn't count, no.
14 There is no increase in hours.

15 COMMISSIONER JACK KITTS: And you --

16 JULIE CAVALIERE: But I think how I
17 understand your question, what you are saying is if
18 one person doesn't need the time, that they are low
19 risk, do we still spend the 30 minutes, if I
20 understood correctly. And the answer is no. The
21 Dietitian spends their time on the highest risk.
22 We actually have lots of mechanisms in place to
23 assess for a low, moderate and high risk. Those at
24 high risk get more than 30 minutes, and those at
25 low risk, we have to rely on the nursing staff or,

1 you know, other staff to send a referral or let us
2 know through the communication channels that, you
3 know, something has changed, that their status has
4 changed, perhaps through MDS or some other channel.

5 But those that need more than 30
6 minutes will get it. It is just that we don't get
7 more time for them. We have to sort of have this
8 hierarchy system of risk.

9 COMMISSIONER JACK KITTS: And is there
10 any -- it just doesn't really make that much sense
11 to me, so I hope I am not missing something. But
12 if you have 120 residents and you get 30 minutes
13 with each, each day, could you just multiply 30
14 times 120 and spend it with who you need to spend
15 it with and not with those who don't need it?

16 JULIE CAVALIERE: Yes, that is what is
17 done.

18 COMMISSIONER JACK KITTS: Okay.

19 JULIE CAVALIERE: So the ones at high
20 risk do get the time. The ones at low risk, they
21 won't get Dietitian time unless they are referred
22 to us.

23 COMMISSIONER JACK KITTS: Okay, but you
24 get paid for that many hours, okay.

25 And the second thing is do you think

1 that the pandemic has sort of opened the doors to
2 perhaps innovative things like virtual Dietitian
3 care? Do you think that there is an advantage
4 there, or do you think it is going to be strictly
5 on-site?

6 CAROL DONOVAN: I think as we go along,
7 you will see that on-site is preferred, and we can
8 give our rationale for that. We have gotten
9 through the last year using a lot of virtual
10 services, but it is not -- that is where we found
11 the problems.

12 COMMISSIONER JACK KITTS: Okay, thank
13 you.

14 CAROL DONOVAN: Thank you.

15 And just to finish up with the
16 legislation, as well we do receive our funding for
17 food through the Ministry of Health and we get a
18 raw food cost.

19 Unfortunately, there is not enough
20 money to always meet what is recommended by
21 Canada's Food Guide. And in 1993, the raw food
22 cost was \$4.26, and here we are this many years
23 later at \$9.54 per day. That is to provide three
24 meals, three snacks, two choices at each meal of
25 the entree, the dessert, the vegetable. We also

1 have to do all our tube feeding. If the person
2 needs some Ensure or a supplement or special food
3 because they perhaps have a cultural need, all
4 those things are included in that cost, even
5 vitamins and minerals at times.

6 So that is well used money, and it is
7 used up and often our budgets go over.

8 COMMISSION CHAIR FRANK MARROCCO: But
9 do I understand you to say that the \$9.54 is per
10 resident per meal?

11 CAROL DONOVAN: Per day.

12 COMMISSION CHAIR FRANK MARROCCO: Per
13 day, per resident per day would not be sufficient
14 -- that is not sufficient to permit you to feed
15 them in accordance with the Canada Food Guide?

16 CAROL DONOVAN: That's correct.

17 COMMISSION CHAIR FRANK MARROCCO: So
18 they get less than the Food Guide says a Canadian
19 should get?

20 CAROL DONOVAN: Well, we do our best to
21 get it as close as we can. We set up our menus to
22 meet Canada's Food Guide, but it is very, very
23 difficult and we don't always have -- well, another
24 thing we are going to just share with you shortly
25 is the shortage of Food Service Workers that we

1 have. You hear a lot about PSWs, Personal Support
2 Workers, but Food Service Workers are also similar
3 to PSWs but their focus is on food, and we don't
4 have enough of them to make things from scratch.

5 So we work very creatively with
6 suppliers, and that is what Dietitians do. We meet
7 that Canada's Food Guide, but sometimes our budget
8 will be over, and that is a cost to the
9 municipality or to the owners or whatever.

10 That is not adequate money to provide
11 what is expected, and it has not been increased
12 adequately. You know, if you do the percentages on
13 that, we are not getting much a year. And as soon
14 as the price of the raw food cost goes up, you'll
15 notice that the suppliers increase their cost, so
16 we never get ahead.

17 COMMISSION CHAIR FRANK MARROCCO: Dr.
18 Kitts.

19 COMMISSIONER JACK KITTS: We have heard
20 about the raw food envelope from the beginning, and
21 it has intrigued me as to what "raw food" actually
22 means. Can you tell me in a meal what proportion
23 of the meal is deemed to be paid for by the raw
24 food envelope and how much of the other envelopes
25 cover the rest of the food?

1 CAROL DONOVAN: I think, Julie, you
2 probably could answer that best.

3 JULIE CAVALIERE: Yeah, I mean, the
4 envelope is called "raw food". Any food or fluid,
5 supplement or tube feed related to the resident's
6 intake is part of the raw food envelope.

7 The only thing that perhaps can come
8 out of another envelope is if, you know, there is a
9 program and they are making muffins that day, well,
10 then the muffin mix will come out of that program
11 envelope or the apple sauce with the medication
12 will come out of the nursing envelope. But every
13 other food, fluid, supplement, tube feeding,
14 cultural food, special event meal will come out of
15 the raw food envelope.

16 COMMISSIONER JACK KITTS: So it is
17 \$9.54 per resident per day?

18 JULIE CAVALIERE: Yes.

19 COMMISSIONER JACK KITTS: For pretty
20 much all the food they eat?

21 JULIE CAVALIERE: Correct.

22 COMMISSIONER JACK KITTS: Wow, okay.

23 JULIE CAVALIERE: Yes.

24 STACEY SCAMAN: And too if I can add in
25 is we have a lot of much more involved families now

1 that request a lot of specialty items. So items
2 like gluten-free, I am not sure if you are familiar
3 but they are very costly. So we have a lot of
4 special diets coming in, and the cost of those
5 items, because we cannot buy them in bulk because
6 there is not enough, are quite costly.

7 So that in our homes that have some of
8 those requests really struggle with their budget,
9 and we foresee that only increasing as we continue.

10 JULIE CAVALIERE: Yes, and the
11 religious-based foods that we get, like for
12 example, kosher food or halal food, you know, as
13 our population changes and ages, we see more and
14 more cultural foods that we require and those cost
15 more. Similar to a gluten-free, it is kind of like
16 an item that is not, you know, part of our regular
17 supply chain. We have to go to specialty shops and
18 boutiques to purchase some of the products. And
19 especially because we can't buy it in bulk, that we
20 might only have one resident or five residents, and
21 so those costs increase as well when we can't buy
22 in volume.

23 STACEY SCAMAN: And I think too --

24 COMMISSION CHAIR FRANK MARROCCO:

25 Commissioner Coke.

1 STACEY SCAMAN: Oh, I'm sorry, go
2 ahead.

3 COMMISSIONER ANGELA COKE: It's all
4 right, if you want to finish that point, I am
5 asking something else.

6 STACEY SCAMAN: And I think what
7 happens in our homes, and you know, it is
8 unfortunate, is when we get these extra items or
9 when the budget goes up because we are trying to,
10 you know, make Canada's Good Guide, et cetera, one
11 of the things, you know, is obviously we get very
12 creative, but what usually suffers is the food
13 quality, so you know, lower cuts of beef, right,
14 lower vegetables, frozen versus fresh.

15 So we are really unfortunately having
16 to move away from that good quality food to more
17 economic type foods, and that is never as nice on a
18 plate of food and never as well received as it
19 could be if the quality was better.

20 So sorry about that, go ahead.

21 COMMISSIONER ANGELA COKE: Okay, my
22 question is you had mentioned that there is a
23 shortage of Food Service Workers, and I just want
24 to understand what is driving that? Is it a pay
25 issue or working conditions? Or what is the

1 shortage a result of?

2 CAROL DONOVAN: Well, the shortage is
3 something we identified pre-pandemic, and we did
4 have the opportunity to speak about it at a panel.
5 We are having a really hard time finding people
6 that are qualified.

7 The Ministry put in the regulations
8 back in 2010 that anybody working in the kitchens
9 had to have their Food Service Worker
10 Certification. Now, that takes time to get. There
11 is no fast-tracking method to get that. We have
12 been out to the colleges. We have tried recruiting
13 in all different ways to get more Food Service
14 Workers.

15 So we have had a shortage. And yes,
16 the reason is sometimes it is the pay, and it is a
17 very hard job. You work non-stop. You barely get
18 your breaks. And you could make that same amount
19 of money perhaps at Tim Horton's or at McDonald's
20 or at Walmart with half the stress. So people are
21 tending to go that way.

22 The colleges are not able to put out
23 the Food Service Workers in the quantity that we
24 need, so we are constantly short on Food Service
25 Workers, and that was pre-pandemic as well.

1 COMMISSIONER ANGELA COKE: Okay, thank
2 you.

3 LYNN MAHONEY: And I assume, Carol,
4 that you are going to talk to us about the impact
5 that the pandemic had on the availability of Food
6 Service Workers and the impact that that therefore
7 had on the residents.

8 CAROL DONOVAN: Absolutely, yes.

9 LYNN MAHONEY: Okay, thank you.

10 CAROL DONOVAN: Thank you.

11 Okay, we'll move on to the next slide.

12 So just again, when we are talking
13 about pre-pandemic and that we were -- one thing
14 that the group of us, and that is why we are here
15 today, we have been proactive and, as Julie
16 mentioned too and Stacey, we are looking to the
17 future and looking for the population that is
18 coming. We have been analyzing statistics and we
19 see very complex needs coming, even more complex
20 needs coming into long-term care and more people
21 that are aware of what their nutritional needs are
22 and are going to have extra demands that we are
23 trying to prepare ourselves now to be ready for.

24 So some of the regulations that we are
25 currently working on with the Ministry of Health,

1 as you can imagine, which are 12 years old are out
2 of date. So we would like to be able to contribute
3 to updating them. And we have been working with
4 the Ministry and with the nursing profession on
5 updating the skin and wound regulations, so that is
6 currently in the works. But everything takes a
7 long time.

8 The other problem we often faced
9 pre-pandemic, and still to this day, of course, is
10 interpretation of regulations. I think it was back
11 I don't know if it was 2010, but quite a few years
12 ago the Ministry put in an RQI program. It is
13 their quality program where they had set
14 guidelines, set questionnaires, set things they
15 were looking for. We were all trained in it. They
16 were all trained. And what we are finding -- and
17 that was to get rid of any subjective evaluation
18 from the Ministry of Health. It worked for awhile.

19 Now we are back to subjective
20 interpretation when Ministry compliance comes in,
21 and you can be cited on something in one home and
22 not cited in the other.

23 So it is not apples to apples anymore.
24 It has become subjective again.

25 COMMISSION CHAIR FRANK MARROCCO: Is

1 there any place at the Ministry where you can go
2 and ask for an interpretation? And by that I mean
3 get a written interpretation or a written response
4 to your questions so that at least it is clear what
5 the Ministry's view is of how the regulations
6 should be applied?

7 CAROL DONOVAN: Other than the
8 regulations themselves, when we do have an
9 inspection or the Ministry comes in on a complaint,
10 we do get a written report as to their
11 interpretation. But again, from one home to the
12 other, it might be an issue to one compliance
13 advisor and not to the other.

14 COMMISSION CHAIR FRANK MARROCCO: Yes,
15 one inspector would interpret the requirement one
16 way and another inspector interprets it another
17 way.

18 CAROL DONOVAN: Yes.

19 COMMISSION CHAIR FRANK MARROCCO: Okay.

20 CAROL DONOVAN: And that was supposed
21 to be levelled out some years ago with the new
22 inspection protocols that they put in place, but it
23 hasn't been. And so that definitely needs to be
24 looked at.

25 The other thing too within the

1 regulations, our staffing models are in there, and
2 again, as we have told you, it is not enough to
3 support the complex needs of our residents.

4 So we talked about the Food Service
5 Workers. That is the qualification we need. Just
6 like a Personal Support Worker, they have about the
7 same education requirements and we are not turning
8 out enough in colleges. People are not interested
9 in that job, and it is difficult to find people
10 that are qualified.

11 And we have got --

12 COMMISSION CHAIR FRANK MARROCCO: But
13 the Food Service Worker, are they regulated?

14 CAROL DONOVAN: No.

15 COMMISSION CHAIR FRANK MARROCCO: Okay.

16 CAROL DONOVAN: No, not yet. And they
17 are just like a PSW. It is an expectation that you
18 have them, but it is not a regulated profession
19 yet.

20 COMMISSION CHAIR FRANK MARROCCO: Yes,
21 Commissioner Kitts. You are on mute, Jack.

22 COMMISSIONER JACK KITTS: My apologies.

23 Just building on Commissioner Coke's
24 question about why insufficient staffing, so you
25 have said now that it is really they are not

1 producing enough of these workers. Are you saying
2 then that basically the salary and the working
3 conditions would be on a par with a hospital, which
4 I imagine would be your biggest competition. So it
5 really is there is just not enough of them; is that
6 correct?

7 CAROL DONOVAN: There is not enough of
8 them, and in the regulations there is a formula to
9 calculate how many hours you get of the Food
10 Service Worker, and it is not enough for us to get
11 the job done.

12 COMMISSIONER JACK KITTS: Okay.

13 JULIE CAVALIERE: Sorry, if I could
14 just mention, the salaries are not on par with
15 hospitals.

16 CAROL DONOVAN: Right.

17 JULIE CAVALIERE: They are more on par
18 with Tim Horton's or like a food service
19 establishment, but the working conditions is like a
20 hospital. So you know, they need to understand
21 therapeutic diets and how to work, you know, with
22 elderly, sick patients, sick residents, people with
23 dementia.

24 But you know, at Tim Horton's or
25 whatever -- and I mean, I am not saying that those

1 jobs aren't difficult. Those are also fast-paced.
2 But the pay is very similar to that, and we lose a
3 lot of cooks and Food Service Workers to retail
4 type jobs. And if a hospital job comes up, well,
5 we have definitely lost them because they pay
6 significantly more.

7 COMMISSIONER JACK KITTS: Okay, thank
8 you.

9 CAROL DONOVAN: The other legislation
10 we have is for our Nutrition Managers, and they are
11 the people -- they have an association that governs
12 them. They are not a regulated profession either.
13 But in the legislation, we have to have them by a
14 certain formula, again, based on the occupation of
15 the home or the population of the home. And the
16 Nutrition Managers in some homes, in a smaller
17 home, you might have somebody part-time, so you
18 don't even have management there full-time.

19 So that is a big issue. And a lot of
20 independent homeowners are starting to look at that
21 and try and find a way to get those Nutrition
22 Managers on-site every day by giving them extra
23 work, but the work is still there every day but
24 they are not. So that calculation needs to be
25 looked at.

1 Registered Dietitians, of course we are
2 run off our feet and we could use more time.

3 And the legislation also talks about
4 Certified Cooks, and you have to have a Certified
5 Cook in each home for a certain number of hours.
6 The issue with that is that some of the Certified
7 Cooks we are getting are not trained in long-term
8 care. They don't know how to texture modify. They
9 are chefs that have been in the restaurant
10 profession, and so we have to work very hard to get
11 them on board.

12 And there is a lot of homes in this
13 province that don't have the Certified Cook yet,
14 after all these years. That has been since 2010,
15 and they still don't have a Certified Cook, that
16 they grandfathered in somebody else. So the
17 quality, you are not going to get the best quality
18 unless you have that Certified Cook on-site.

19 So we have people cooking that aren't
20 qualified. We are short on Food Service Workers to
21 provide the food to the residents. The Nutrition
22 Managers are short and the Dietitians are short.
23 So all of the people that provide food service
24 could be increased, the hours could be increased
25 and well used.

1 And I know we are going to talk about
2 this later, but one of the things that we want to
3 talk to you about is if you increase Food Service
4 Worker hours, we can take some of the load off the
5 PSWs, and so the girls will talk about that in a
6 minute.

7 So you know, pre-pandemic, when you are
8 short food service hours, that might be where you
9 take away from cleaning time. You might not get
10 your ovens cleaned that week, or different things.
11 We have often had to go into our cleaning and, you
12 know, perhaps our IPAC wasn't as good as possible
13 because we were short so many hours or short so
14 many staff. And so we really need to look at that.

15 Meal production, and again, I alluded
16 to this earlier, we might get a raw food cost
17 increase but we don't have extra staff to help us
18 prepare fresh food from scratch. And so we have to
19 have quite a balance and quite a -- it is quite a
20 scale of balance to try and put a good quality menu
21 out.

22 And we run into a lot of trouble in
23 food service in the Schedule C homes. They have
24 large common dining spaces. They are old, with
25 small kitchens. We don't have room for storage.

1 They are quite antiquated, so it is hard work
2 putting out good meals in a Schedule C home, but we
3 do our best.

4 COMMISSION CHAIR FRANK MARROCCO: So
5 what you are saying is not enough money for food
6 and the cooking facilities are not appropriate for
7 the work that you have to do.

8 CAROL DONOVAN: That's correct, yeah,
9 yes. And I have had the opportunity to be in the
10 best homes in the province and the worst homes, and
11 it is incredible what the Food Service Workers and
12 the Nutrition Managers do, some of them working out
13 of very small spaces, very cramped, and not
14 necessarily built for proper sanitation. There is
15 a lot of re-working of the system that needs to be
16 done.

17 LYNN MAHONEY: And can I --

18 COMMISSIONER JACK KITTS: And the --

19 LYNN MAHONEY: Sorry.

20 COMMISSIONER JACK KITTS: Sorry, does
21 the \$9.54 a day, does that get topped up by homes
22 or do families say that we'll pay more if we can
23 get some fresh fruit? Is the \$9.54 rigid or is it
24 topped up?

25 JULIE CAVALIERE: It is not topped up

1 by the funding envelopes. It is topped up by the
2 organization itself. So we often go over \$5.54.
3 It is common to go over \$5.54.

4 CAROL DONOVAN: \$9.54.

5 JULIE CAVALIERE: Sorry, right, \$9.54,
6 yeah. No, it is often topped up, but you know, it
7 comes out of the budget of the organization. It is
8 not topped up by any other envelope.

9 COMMISSIONER JACK KITTS: Okay.

10 JULIE CAVALIERE: Well, I guess you
11 could shift from the other accommodations envelope
12 into raw food, but that is where it comes from. It
13 is not a top-up of the raw food envelope.

14 COMMISSIONER JACK KITTS: Right, but I
15 have to believe in the tame that it has gone from
16 \$4.00 or \$5.00 to 9-something, and even from there
17 to now, the cost of food has probably gone up
18 exponentially in everybody else's household except
19 in long-term care.

20 JULIE CAVALIERE: Every year we get
21 reports from our buying groups on, you know, the
22 percentage of inflation for, you know, recently it
23 has been pork. And with COVID and all of the
24 issues that have occurred in the beef industry, I
25 mean, those prices are considerably higher, but

1 there is no change to the raw food budget
2 accordingly.

3 COMMISSION CHAIR FRANK MARROCCO: Well,
4 it doesn't seem to me it is hard for anyone who
5 wants to understand it, that all they have to do is
6 imagine that they are feeding themselves on \$9.54 a
7 day. If that is all they can spend on raw food for
8 the day, and I think the problem becomes obvious.
9 In any event...

10 CAROL DONOVAN: In the past -- and,
11 sorry, Julie, just in the past, we had an
12 opportunity that if somebody was a special needs,
13 for example, or a tube feed, there was a way to
14 apply for special funding from the Ministry, but
15 that was taken away a few years ago.

16 So things like tube feeds and
17 supplements and high needs were folded into the raw
18 food cost; whereas in the past, and I am talking
19 quite a few years ago, we did have that opportunity
20 to apply for extra funding from the Ministry, but
21 that is long gone.

22 COMMISSION CHAIR FRANK MARROCCO: All
23 right.

24 JULIE CAVALIERE: Okay, so I'll
25 continue.

1 So we'll speak on the present, and when
2 we say "present", like during COVID, because we are
3 still navigating through COVID, and remember that
4 long-term care homes were designed for communal,
5 congregate dining. We were never set up for tray
6 service. You know, if perhaps there was a flu
7 outbreak, you might have five residents in a room
8 with a tray. We never had a full unit and/or a
9 full long-term care home with tray service, so we
10 were not set up or built for that.

11 But in a day's notice, if we went into
12 outbreak, we were now all locked in, you know, into
13 the lockdown, if you will, that nobody could come
14 in, nobody could leave. Residents were all in
15 their rooms. And we weren't set up like a hospital
16 for a belt line and tray service and the supplies
17 and things needed to make that happen and to keep
18 food warm and at the proper temperature, transport
19 carts, the staffing that is required for that type
20 of service versus a dining room service which you
21 do need more people.

22 So we did get the Canadian Armed Forces
23 report. It was released on May 29th, and it did
24 identify some nutrition care concerns. And so the
25 three nutrition care concerns that, you know,

1 really stood out to us was that the identification
2 of high-risk residents were overlooked, and that
3 increased the risk of malnutrition and dehydration
4 and choking and that kind of thing.

5 And you know, when we went to
6 single-site work, and I believe that directive came
7 in early April, the first week of April, well, that
8 pretty well wiped out a third of the staff within
9 the first week. And then further to that, as we
10 went along and had to try and relieve staff, then
11 infection took some of our staff away because they
12 got infected and staff that had small children that
13 were now not in school or elderly parents that they
14 had to take care of.

15 So we were really looking at a very
16 bleak work force, just the number of bodies,
17 including the Dietitians, that were not in the
18 home.

19 And because of privacy laws, we weren't
20 having the risk level, you know, above the bed or
21 at the table or what diets they were on. Because
22 of privacy laws, you know, those were kept in iPads
23 or books, you know, care plans, and the staff would
24 use reports. So when staff are gone and there is
25 no way to identify if a resident required a special

1 feeding, you know, extra time or something, and
2 they were all in their rooms, it really did provide
3 an increased level of risk, including malnutrition
4 and dehydration.

5 And so --

6 COMMISSION CHAIR FRANK MARROCCO: Do
7 you think people died as a result of malnutrition
8 and dehydration? They might have been sick with
9 COVID, but they might have died from the other?

10 JULIE CAVALIERE: Yes. Yes. There was
11 a sheer lack of people at the onset. It took
12 months to gain enough people through agency staff,
13 recruitment of new staff. It took months.

14 And so there was a period of time
15 where, you know -- and remember, they are not
16 congregate dining anymore, so you couldn't see
17 everybody all at once and whether they were eating
18 or not. You did have to don and doff your PPE for
19 every room and go check on them. In the meantime,
20 the food may have been sitting there or may not
21 have arrived yet. People that needed help may have
22 needed extra help.

23 And you will see through the
24 presentation, it is not just whether they had COVID
25 or not or whether they had an infection that caused

1 them to not eat. Well, they weren't seeing their
2 families. They were isolated. They couldn't come
3 out. People that needed a little bit of help now
4 maybe needed a lot of help, and we had less people.
5 There was just less bodies, period, of all types,
6 PSWs, Food Service Workers, Dietitians, you name
7 it. And whoever was there, it was all hands on
8 deck, double shifts, whatever we could get, which
9 puts them at risk for catching COVID, because the
10 fatigue and the donning and doffing of PPE and all,
11 you know, the new -- it was a very new way of
12 working and an environment we have never had to
13 work in before. And I spoke about that tray
14 service. Many of the Food Service Workers and PSWs
15 never had to work in a tray line before and never
16 knew how to work that system, and had to learn that
17 with a very skeleton staff.

18 So the second point, and I believe that
19 we just sort of like explored the staff shortages
20 and the infection and isolation, the unintentional
21 weight loss, and yes, that was a very unfortunate
22 consequence of many things. We felt it the most
23 when the single-site work order went into place and
24 we lost staff almost immediately.

25 And then we did talk about the lack of

1 dietary manager support. If there is a Nutrition
2 Manager, Carol spoke that they are on a limited
3 amount of hours, but if that dietary manager, the
4 person that operationalizes the food service went
5 away, whether for COVID or other reasons, there was
6 virtually nobody to look after the logistics of
7 getting food to people. That person was
8 essentially eliminated from the long-term care
9 homes, and the Dietitian, although they are
10 qualified, well, now they are on a single-site
11 order and were not there, definitely were not there
12 full-time and not there to assist in the logistics.

13 So Dietitians were deemed essential,
14 but because of the single-site work order, they
15 couldn't go to their multiple sites and assist with
16 some of those food service logistical things, as
17 well as the clinical issues that were coming to
18 pass.

19 So I mean, we did cover the best we
20 could using, you know, these four methods:

21 Remotely, which is virtual access only,
22 and you know, and that becomes very difficult.
23 When you are working remotely, you rely heavily on
24 the staff that is there and they were already
25 taxed. And so getting somebody to tell you whether

1 somebody ate or drink and who is eating or drinking
2 and whose wound is getting worse and whose tube
3 feed is stable and who isn't, I mean, that was --
4 in some places, it was virtually impossible to get
5 somebody on the other end of the phone, and so
6 working remotely becomes very difficult.

7 COMMISSION CHAIR FRANK MARROCCO: Just
8 so it is clear on the transcript, did you say "two
9 feeds"?

10 JULIE CAVALIERE: Tube, yeah, the tube
11 feeds, enteral feeding.

12 COMMISSION CHAIR FRANK MARROCCO: Tube
13 feeds.

14 JULIE CAVALIERE: Uhm-hmm.

15 COMMISSION CHAIR FRANK MARROCCO: I
16 see, that means that the person has to be fed using
17 a tube?

18 JULIE CAVALIERE: Correct.

19 COMMISSION CHAIR FRANK MARROCCO: Yes,
20 and that takes longer?

21 JULIE CAVALIERE: Well, and you also
22 cannot assess them if you are not there in person
23 to see, you know, tolerance. Is somebody telling
24 you, are they tolerating it well. Is the weight --
25 are they maintaining their weight? Because if they

1 are not, they are not getting enough.

2 You know, so getting somebody on the
3 other end of the phone becomes critical in all
4 situations, including enteral feeds.

5 COMMISSION CHAIR FRANK MARROCCO: Okay.

6 JULIE CAVALIERE: There is a hybrid
7 model where the Dietitian would only go in if there
8 is a crisis. So because of the single-site work,
9 they were in one place, and in the other places
10 that they provided service, it was, you know,
11 somebody is in sort of a critical state and can you
12 please come and assess this one person or these two
13 or three people that aren't eating or drinking or
14 perhaps not swallowing well or their condition has
15 changed.

16 And then the ones that were on-site,
17 and they would virtually, you know, cover
18 everything that they needed to cover and more if
19 they were on-site, leaving the other two homes
20 either virtual, remote work or, a fourth option, no
21 coverage at all. Some rural homes, as we mentioned
22 at the beginning, didn't have any, some remote
23 locations, and/or if there were very large
24 outbreaks, the Dietitian was on-site at a very
25 large location more than full-time and so they

1 could not provide coverage to the other homes
2 remotely.

3 Okay, and so when we look at what the
4 largest clinical risks are during this time and
5 during COVID, dehydration was one of the biggest
6 things that we saw. I mean, I know I work as a
7 Corporate Dietitian, if you will. I mean, I have
8 many hats, but you know, I was called into even
9 some of our retirement homes because residents were
10 dying of dehydration. They just were not drinking.
11 The fluids were put there, but there was nobody to
12 give it to them. There was no special cups that
13 were coming up that they needed perhaps if they had
14 mobility issues. This was in long-term care as
15 well as retirement homes.

16 And the risk of dehydration, I mean,
17 although it was identified, you can bring as many
18 fluids as you want to the room, but if you don't
19 have people to actually assist them in consuming
20 them, often -- I mean, we can't, you know, provide
21 a litre of fluid at one time and leave. It has got
22 to be throughout the day. I mean, that is how we
23 hydrate people properly.

24 And we did eventually, when the Doctors
25 were able to come in and the Nurse Practitioners,

1 we were able to do hypodermoclysis. And the
2 Dietitians were heavily involved with, you know,
3 identifying those with dehydration so that the docs
4 could do hypodermoclysis. And that didn't happen
5 right away. There weren't docs coming in either,
6 and so that became difficult.

7 STACEY SCAMAN: And if I could just
8 intervene, Julie, we actually had one of the worst
9 homes hit in outbreak, and the physician had said
10 that these people are not dying of COVID, that they
11 are dying of dehydration.

12 So in one home -- and I think I shared
13 the personal stories of the Dietitians. There were
14 three. There was many more, but we really got a
15 cross-section of what it was like to work remotely
16 and what the difference was when we were on-site.
17 And in this particular home, and in several more of
18 them, as Julie alluded to, we had to use means of
19 hydration that were never used before. So
20 hypodermoclysis was never ever used, but these
21 people could not drink orally enough to keep them
22 hydrated.

23 So when the physicians couldn't be in,
24 our Dietitians were texting the physicians and
25 saying that these people are at risk, because she

1 is physically there to see that. It wasn't put on
2 the nurses who were already overworked. She could
3 go from resident to resident and identify risk,
4 communicate with the physician, and get those
5 interventions proactively, or at least as
6 proactively as we were able to.

7 And that is scary because we know that
8 dehydration is the first thing, and if dehydration
9 goes, you know, that it doesn't really matter what
10 infection they get, it is going to be dire straits
11 for them.

12 And then that led into dysphagia,
13 right, and so dysphagia came part and parcel. We
14 had seen a huge spike in dysphagia and swallowing
15 difficulties when COVID hit. And so people who
16 normally were on regular sometimes at breakfast,
17 and by suppertime they couldn't swallow, right, or
18 they were not awake enough to do that. So the need
19 for swallowing assessments was through the roof,
20 and when we didn't have a Dietitian on-site, no one
21 could do that.

22 So you know, if the Dietitian was
23 trying to do that remotely, it is, again, trying to
24 find staff to grab an iPad and to go let us see
25 them, which just didn't happen. So diets were

1 switched, you know, and downgraded whenever able,
2 which was scary. With the Dietitian on-site, they
3 were constantly triaging. They were walking around
4 the rooms, walking around dining rooms, talking
5 with staff, so they were able to triage and
6 identify risks much more appropriately and do the
7 swallowing assessments as able. So that made a
8 huge difference.

9 And then as you can imagine,
10 significant weight loss is just a given, right.
11 People aren't eating and drinking, and so that
12 happens automatically. So we are losing a lot of
13 muscle mass, and we are having a lot of protein
14 malnutrition, et cetera, occur.

15 And I think the biggest one is number
16 4, and I know, Lynn, we talked about that at length
17 in our first discussion, that you know, as we have
18 been saying, that ongoing message of staffing. So
19 as Julie said, when it hit, when certain things
20 happened, we dropped right down to let's say 30
21 percent of people, so we had nobody. So you can
22 imagine that if you put some food in front of
23 someone and then you get help on a good day when
24 they were awake and aware, and when COVID hits and
25 they decline and there is no one to even try and

1 put a spoon in their mouth, they are not eating,
2 right. They are not -- the people that required
3 encouragement, in the Ministry regulations it is
4 two per resident, so two support staff, PSWs, to
5 feed a resident -- or, sorry, two residents per one
6 PSW. So when we were in our rooms, right, that one
7 PSW has to go room to room to room to residents
8 that require more assistance than they ever did.
9 Before it might have been 50 percent required help.
10 Now it was all of the residents that required help,
11 so we could not meet that.

12 Even in the dining rooms when we are at
13 a distance, we can't meet that anymore. We need
14 two staff for where we only needed one before, and
15 we are already short.

16 LYNN MAHONEY: So, Stacey, is it fair
17 to say that if you had been involved or consulted
18 about some pandemic planning, you would have been
19 able to foresee these issues because they are basic
20 resident needs, quite frankly, of hydration and
21 nutrition? And is it the case that this would have
22 been readily apparent if there had been any
23 involvement of Dietitians or others with respect to
24 pandemic planning as to the effect that a pandemic
25 would have had on long-term care residents?

1 STACEY SCAMAN: Oh, a hundred percent.
2 A hundred percent. We knew exactly what was going
3 to happen, and we tried to advocate the best we
4 could.

5 I know at Seasons Care for the homes
6 that we managed, and I know Julie did the same for
7 hers and so did Tara, that we started putting out
8 resources, very practical, that here is what you do
9 the second COVID hits; here is how you can
10 streamline staff; here is how you cut back on this;
11 here is how you address hydration.

12 So we started re-working the systems as
13 individual groups, where it should have come from
14 an umbrella. If the Ministry came and consulted
15 and we were at the table, we could say, Okay, here
16 is some general tools that we can all agree on, and
17 we put these out to the homes to help them right
18 away.

19 The resources that all of us put out
20 were so appreciated by the home, because it wasn't
21 the Ministry regs anymore. It was keeping our
22 residents alive, and how can we do that with what
23 we are left with.

24 So a seat at that table is vital for
25 future care, absolutely.

1 COMMISSION CHAIR FRANK MARROCCO: This
2 situation I guess can lead to the false impression
3 that COVID is fatal to the long-term care residents
4 to a greater degree than it is fatal to others, but
5 in order to make that conclusion - and correct me
6 if I'm wrong - you have to factor out the people
7 who died because of dehydration, because of
8 swallowing difficulties, because they weren't fed
9 properly. You have to get those people out of that
10 statistic before you can accurately predict or
11 state how fatal COVID was to long-term care
12 residents.

13 STACEY SCAMAN: Absolutely.
14 Absolutely. And we heard from a lot of families
15 too in terms of the fear, and we have, fortunately,
16 in long-term care we have a lot of families that
17 come in and help feed, a lot that visit and come
18 feed their families. And so when they couldn't
19 come in, they were very worried about and for due
20 reason, because when they didn't come in, they
21 weren't being fed, right. We didn't have enough.

22 So that was a huge hindrance as well,
23 and those families really felt that there was a
24 component of that that led to the death of a loved
25 one, right. And we know that. Like, you know, we

1 know in hospital care and long-term care and in
2 community, if someone is not strong with a
3 nutrition and hydration foundation, they are at
4 risk for a whole load of complications. So when
5 you are dealing with such an at risk population,
6 nutrition and hydration foundation is vital.

7 So without us being there,
8 unfortunately, the eyes and ears go to nursing
9 care, identifying nursing risk. And those are
10 completely legit, don't get me wrong, but the
11 problem is that we miss the boat on the proper care
12 that they need just to keep them strong enough to
13 fight the issues with COVID and infection, and that
14 is I think where the ball was dropped, not
15 intentionally, but again, identifying risk but
16 forgetting this big one.

17 You know, and when we look at even
18 number 5 for palliative care, a huge part of our
19 job is supporting families and residents at end of
20 life, a huge part. We value that role of empathy
21 and being able to support families going through
22 such a horrible time. And when they couldn't be
23 there and we weren't on-site to tell them how their
24 family is doing, we couldn't put in those comfort
25 measures. We couldn't call them and let them know

1 what is going on. We couldn't explain what
2 nutrition and hydration is at end of life. We
3 couldn't support, and unfortunately, residents died
4 alone. Families are left with so many questions
5 unanswered because we couldn't be there.

6 And we'll talk to you a little bit more
7 as we go about some of the roles on-site that the
8 RD did that was never in our role but we were able
9 to support, and that is important.

10 CAROL DONOVAN: Sorry, I just want to
11 add one thing too, and this is just for
12 clarification.

13 As Dietitians, we rely very heavily on
14 weight to help us determine risk. So there is the
15 visual that we weren't able to get by not being
16 on-site, and then the weights. We weren't always
17 able to -- the Ministry regulations have us getting
18 weights once a month, and we have a re-weigh plan
19 as well if there is a change. And we weren't able
20 to get weights. That was kind of put on the
21 back-burner. That wasn't high priority for nursing
22 staff because they had so much day-to-day, hands-on
23 care to do.

24 So even if we were virtually, we didn't
25 have the statistics, the weights, the labs, the

1 things that we needed to identify risk. So that
2 was a big gap that needs to be addressed going
3 forward.

4 STACEY SCAMAN: Uhm-hmm, yes, there was
5 a lot of information, and food and fluid
6 documentation we'll talk about later as well, and
7 none of that was done.

8 So working virtually in this type of
9 setting we can have conversations, but to do proper
10 assessments of nutrition risk or hydration risk
11 when there is no food and fluid documentation,
12 there is no weights, there is no one to talk to,
13 only what is documented, and we know that was short
14 because people didn't have time. So a lot of
15 limitations for virtual care in our line of work.

16 LYNN MAHONEY: All of which I would
17 assume could have been addressed in advance because
18 you on the fly were able to develop some things to
19 assist on some of these issues, but all of these
20 issues would have been obvious if they had been
21 discussed in advance and measures could have been
22 put into place to try to deal with them.

23 STACEY SCAMAN: Absolutely.
24 Absolutely. I am hoping that is the case moving
25 forward.

1 So when we take a look at Dietitians
2 being on-site and some of the values that we have
3 seen, the clinical support obviously, so as Julie
4 talked at length about, you know, the high-risk
5 resident numbers increased. So normally,
6 Dietitians would do the assessments on high-risk
7 residents and then annuals, et cetera. And let's
8 just say there might have been 30 or 40 percent at
9 high risk on a good day. Now, just about all of
10 them were high risk because all of them were
11 affected, right, not even just the ones that had
12 COVID, but the other ones because food service and
13 support assistance went down for everybody. So we
14 couldn't even keep up, and so those ones that maybe
15 were at moderate are all moving up to high risk.

16 Swallowing assessments, as I alluded
17 to, are cumbersome virtually, almost impossible to
18 do it safely and very challenging. So having a
19 Dietitian on-site, she was in there just doing them
20 one after another in the dining room or as the
21 resident was at their door, right, and we were able
22 to kind of do them just looking at them, but at
23 least we had eyes on the resident.

24 The collaboration between nursing and
25 the doctors, as I said earlier, they were texting

1 and calling back and forth identifying risk.

2 The other thing, we were doing roles
3 that we never did before. Anything we could help
4 with, we were up feeding most of the time, so our
5 role was get up wherever they are and just feed,
6 push fluids, do whatever you can. Some were
7 assisting with, you know, weights when they were
8 being done. We were feeding. We were -- oh, geez,
9 we were doing so many different things.

10 The other big role that we took is that
11 food service support. So I know in two of my homes
12 that were hit hard that the Nutrition Manager got
13 COVID, so there was no one. So again, when that
14 person who is responsible for the flow of food
15 disappears, nursing doesn't have that background,
16 nor do they have the time to focus on that. So you
17 are left with non-certified cooks and food service
18 staff that usually aren't even your own because you
19 had an agency brought in.

20 So no one was controlling that flow of
21 food. So you know, in our homes where the
22 Dietitian was, they almost went in and they took
23 over that role to kind of help and make sure that
24 food was still getting out.

25 They did just about anything that they

1 could. Many of our homes, we couldn't fill the
2 positions fast enough. They were saying as many
3 hours as you can have the Dietitian on-site,
4 because we are multifaceted, so you know, we helped
5 and we ran and helped support the dietary. We were
6 up doing rounds. So we had Dietitians in some
7 homes five, seven days a week for 10, 12 hours a
8 day just to support.

9 Where that came in, as we alluded to
10 before, the single-site directive when that hit
11 really hurt us. As we said before, many of our
12 Dietitians are working at different sites, and so
13 no one wanted someone that was at another location.
14 So for the first time ever and I think in a volume
15 we have never seen, we had to put call-outs to
16 Dietitians in whatever field they are at; if they
17 are not working anywhere, we will train you to get
18 you on-site for the basics, so we had to do
19 fast-track training to get Dietitians in just to
20 focus on triaging.

21 And I think the other value of our
22 on-site that I said in the last slide is the
23 documentation. So Carol said no weights were done.
24 Food and fluid is normally done on every resident
25 for every meal and snack, so normally we would be

1 able to look at computer records of how they are
2 eating. Well, that wasn't done at all. So the
3 Dietitian on-site could at least go around and talk
4 to staff and see what was going on and assess risk
5 without the need for having to look at the
6 documentation.

7 So those are just a handful of the
8 benefits on-site, but the Dietitians did absolutely
9 amazing in supporting all different departments
10 during this time.

11 So some of those other challenges, and
12 I'm not going to kick this one any further because
13 we have talked about it a lot already, but the
14 staff shortages were a priority, right. The
15 reality is we can bring all the food and put it all
16 in front of the rooms and have it be perfect, but
17 if we don't have staff to help feed the resident,
18 it doesn't matter how many meals we provide and how
19 good they are.

20 The social piece really, really had an
21 impact. You can imagine months in your rooms. The
22 residents, some of them said, I would just rather
23 die than go through this. I don't want to eat. I
24 don't get to see my family. I don't get to see
25 people or my table mates. So the social enjoyment

1 of meals really suffered.

2 The logistics we talked about already.

3 And the other challenge, not only the
4 issue with Ministry regulations and different
5 inspectors, but it felt true during COVID as well.
6 So we had Public Health Units giving guidance to
7 the homes in terms of what they do when COVID began
8 or an infection began, but we also had hospitals
9 that were involved.

10 So the difficult part is there was
11 often discrepancies between the direction for IPAC
12 and other procedures, tray service, et cetera,
13 between a Public Health Unit and the hospital
14 giving directions. So homes were confused. Rules
15 were changing sometimes hourly based on what the
16 process should be. So it differed there.

17 And then for change, one home with one
18 Public Health Unit was directed to do one thing,
19 and then another home a little further away that
20 was under another Public Health Unit guidance was
21 told something different.

22 So understandably in chaos and crisis,
23 you know, lines get crossed, but the discrepancy
24 between the directions really made it difficult for
25 our kitchens to run effectively.

1 So we are going to show -- and the next
2 two slides are just a few, you know, pictures and
3 that sort of thing to give you a visual, because I
4 think it is really important sometimes to see what
5 we are up against.

6 Carol, do you want to explain these?

7 CAROL DONOVAN: Yeah, just you know, a
8 picture tells a thousand words.

9 So people in the industry were very
10 creative in what they put in place in order to feed
11 people. So we would take activity rooms or dining
12 rooms. The middle picture is we still had people
13 in the dining room but they had Plexiglas between
14 them and the person across from them, so there was
15 still some socialization in that case.

16 But you can see people eating in the
17 hallway. And this is not, you know, for a week.
18 This is a long period of time. Some are still in
19 that situation.

20 And the logistics just did not work for
21 being able to assist people, as we have alluded to.
22 You know, the legislation says that you can oversee
23 two people, that a PSW can sit at a table and
24 oversee two people and feed two people. So if
25 those two people both needed assistance in the

1 first picture, you were in trouble because you
2 certainly had to, you know, use your PPE and figure
3 out the logistics of feeding those two people. If
4 they were in the hallway, how are you going to feed
5 them, and like Julie said, there was the donning
6 and doffing of the PPE.

7 So the next picture shows you -- yes,
8 the next one. The next slide, sorry. Of course,
9 as you know, we got a lot of bad press about food,
10 a lot of negativity, and some of those facts are
11 true. We were never consulted in any way to give
12 any feedback as to what we were doing to manage
13 food service, and so a lot of bad news went out
14 about the food. And we did not dispute it. We did
15 think about writing in to editors and such to
16 dispute it, but it was a reality of what was going
17 on.

18 But there were homes where they put
19 beautiful meals out and did their very best. So
20 there were times when you are short-staffed and you
21 do the best you can. So you might have brought in
22 more purchased products. You might have brought in
23 things that were packaged, you know, in individual
24 packages and things like that. So it is not the
25 care that we would normally provide, but it was the

1 reality of what we went through.

2 JULIE CAVALIERE: So there are many
3 lessons learned from COVID-19 that, you know, will
4 help us in planning and in the way we do work as
5 Dietitians and the advocacy that we do.

6 I mean, the pictures that you saw, that
7 was in a non-outbreak situation, so you know, in a
8 non-outbreak situation and, you know, although
9 still had to be managed, it wasn't as difficult as
10 the isolation and the loneliness that we saw when
11 everybody was in their room. And when there is an
12 outbreak, to this day they are inside their room
13 and not even in the hallway.

14 So you know, taking that into
15 consideration, not only do we have to manage COVID
16 and the PPE and the infection, we have to address
17 the illness, the weight loss, the risk of
18 dehydration, and how do we manage dysphagia and
19 malnutrition.

20 We spoke about the lack of feeding
21 assistance and support at length, and what we need
22 to -- you know, what do we need to do, not just get
23 the food to the resident in a presentable way and
24 that is warm and home-like, but how do we actually
25 provide the assistance and support that they need

1 and what do we need to do for that.

2 We discussed the Dietitians on-site as
3 being a vital -- the Dietitians being on-site as
4 vital to the clinical care, outbreak management and
5 outbreak support. They are the expert in
6 nutrition. They are the ones trained in logistics
7 of procuring food and getting food into the
8 resident. So being on-site becomes vital.

9 The need for increased supervision and
10 logistical support, Dietitians were doing that
11 outside of the clinical work. You know, who gets
12 fed first? What kind of carts do we need? What
13 does tray service look like? Disposables or not
14 disposables? You know, the supply chain, you know,
15 everybody was vying for the exact same products,
16 and when you couldn't get something, they had to
17 make decisions on what kind of nutritional support
18 to get and what kind of supplies and equipment to
19 get to procure food. So Dietitians did provide a
20 lot of that logistical support during the outbreaks
21 and to this day.

22 I mean, I think the single-site work
23 keeps coming up, but the single-site work did
24 hinder the work of the Dietitian.

25 But the adaptability, collaboration and

1 creativity of what we were able to do is absolutely
2 commendable. You know, we have created all sorts
3 of COVID guides. We did have pandemic menus. You
4 know, if you had limited cooks, you know, what
5 would you do. And if you had limited food, you
6 know, choices or limited staff, you know, what
7 would you do.

8 And so the amount of resources that
9 were developed and provided for all Dietitians and
10 for the greater good, they are all out there and
11 there is just some very creative solutions that's
12 available.

13 CAROL DONOVAN: Julie, can I add too
14 that in terms of creativity, and I am not sure if
15 this is a discipline that you have looked at
16 through the Commission, but the activities staff
17 did an incredible job. They really stepped up and
18 often used food in their activities, which took a
19 little bit of a burden off the kitchen and they
20 found ways to make it very pleasant and enjoyable
21 for the residents.

22 And we have tons of pictures and ideas
23 that they did, and so I think they need to be
24 acknowledged, that discipline, because they did an
25 incredible job. And I am sure they have got some

1 feedback as well for the Commission, because they
2 really stepped up. It was delightful to see what
3 they did.

4 STACEY SCAMAN: You know what, if you
5 are ever looking for pictures, they did hydration
6 carts. They wore hula skirts. They did beer
7 sampling. They did whatever they could to really
8 make it fun in such a trying time and really focus
9 on hydration, which we loved. So that was great.

10 So you know, just to kind of wrap the
11 presentation up, and I know we are a little bit
12 over, when we take a look at next steps, I know we
13 have all been very involved in advocacy and pushing
14 for this and we have been very involved in creating
15 practical, easy, like easy to implement
16 interventions throughout the time of COVID, all of
17 us have.

18 And I think as Lynn mentioned earlier,
19 we need a seat at the table. We need to be part of
20 rewriting some of the food, nutrition and dining
21 guidelines and regulations, not only for every day
22 in long-term care that we continue to advocate for,
23 but for, you know, essential service plans.

24 You know, we are not the god of
25 departments, but I think that we absolutely can

1 make a difference if we can be involved proactively
2 for future crisis situations or we know we'll have
3 another pandemic at some point, and if we can have
4 a seat at the table to voice this piece, I think we
5 will fare much better. It would be a waste to
6 throw away the lessons learned thus far and not be
7 able to voice them in the proper revenue.

8 The next thing that we were looking at
9 is to work on the Dietitian hours. We had seen
10 such a good use before COVID and then during COVID
11 absolutely. Looking at one hour per resident per
12 month, and in this time, we cannot only do our
13 clinical but we can help more in the food service
14 portion to take better care of our residents any
15 day, and especially during crisis. It also
16 provides us to allow potentially some more support
17 from the retirement homes because we are seeing a
18 lot more need and support in that area as well.

19 We would love to see the exemption of
20 RDs from single-site work. We are deemed
21 essential. We proved to be. But the single-site
22 work location was a hindrance for us.

23 And then the last request would be the
24 dietary hours. So we have talked at length about
25 the need for a full-time Nutrition Manager.

1 Someone needs to be working through that flow of
2 food full-time.

3 The Food Service Worker --

4 COMMISSION CHAIR FRANK MARROCCO: Can I
5 just ask you this. So the single-site work
6 directive comes into play. Was there any mechanism
7 for getting feedback about the application of the
8 directive? Was there any mechanism for you saying,
9 Look, we should be exempt. We understand why it is
10 there, but we should be exempt because -- was there
11 any mechanism like that?

12 STACEY SCAMAN: We couldn't find an
13 avenue. We all have our connections through
14 Ministry, et cetera, and we all utilized those the
15 best that we could, but it wasn't optional.

16 And the other part too is that every
17 home and chain does it a little bit differently and
18 look at things a little bit differently. So we
19 couldn't reach the powers that be above that. And
20 some homes were very, very strict with that with no
21 flexibility either.

22 COMMISSION CHAIR FRANK MARROCCO:

23 Right.

24 STACEY SCAMAN: And so our hands felt a
25 little bit tied there.

1 But yes, so we talked at length about
2 number 4 already, but that staffing model and those
3 requests are very much a priority as well.

4 So I guess in closing for us is what's
5 next. How can we share what we have learned and
6 share our expertise to help with future regulation
7 changes, you know, the emergency planning, et
8 cetera, so we can better support the nutrition care
9 of our seniors.

10 How do we get to that table. How can
11 we better support the Commission, the Ministry, et
12 cetera, in making some of those necessary changes.

13 And so --

14 COMMISSION CHAIR FRANK MARROCCO:

15 Commissioner Coke?

16 COMMISSIONER ANGELA COKE: Just from
17 the slide before, in terms of increasing hours and
18 on-site presence, what is the labour supply
19 situation in terms of Dietitians? Is that an issue
20 that has to be addressed?

21 CAROL DONOVAN: It is adequate. We
22 have done -- it is very hard work right now, but we
23 are able to staff quite well.

24 And we have quite an outreach for
25 Dietitians. We go to the universities and we go to

1 the internships. We are constantly recruiting.
2 And all of us train, thoroughly train. We have
3 training modules.

4 I just want to make one point. And
5 perhaps because I have been in this industry a long
6 time - and if you go to the last slide there,
7 Stacey - when we say a seat at the table, when it
8 came to planning for COVID, people spoke for us.
9 People have always been speaking for us. And we
10 would like to speak for ourselves. Even in other
11 circumstances, people have spoke for the Dietary
12 Departments and for the Dietitians and Nutrition
13 Managers. We would really like to speak for
14 ourselves. And we don't get to the table. We
15 don't get in on the big decision-making. We are a
16 profession that is told what to do, not asked what
17 to do.

18 And we do have the answers. We have
19 the solutions. We have great recommendations for
20 the Ministry of Health on how they can update the
21 regulations and make sure that everybody's care is
22 being met in an adequate way. We know the staffing
23 numbers we need. We know what we need to do to get
24 more Food Service Workers.

25 So it has been a bit frustrating in

1 that we do have the solutions, and as the other
2 Dietitians told you, that we did make tons of
3 resources. We are ready and we have tried to
4 advocate for our profession, but we need to be at
5 the table. We cannot have other people speaking
6 for us as per past practice.

7 COMMISSION CHAIR FRANK MARROCCO:
8 Commissioner Kitts.

9 COMMISSIONER JACK KITTS: Can I just go
10 back to the previous slide again? So you suggest
11 and you recommend that you increase to one hour per
12 resident per month in a Registered Dietitian, and
13 that is from half an hour; is that correct?

14 CAROL DONOVAN: Yes.

15 COMMISSIONER JACK KITTS: And so I
16 guess two questions about the one site per
17 Dietitian, because I think it is different than
18 looking at PSWs and others.

19 So if you went to one site, what would
20 the ratio of Dietitian to residents be? Would you
21 have a number for that?

22 STACEY SCAMAN: So do you mean if it
23 went to one hour and we were put at one site in a
24 situation like this?

25 COMMISSIONER JACK KITTS: So nursing

1 has said, you know, that a nurse practitioner is
2 one nurse practitioner per 150 or 200 residents.
3 Is there a Dietitian-to-resident ratio that you
4 think is reasonable?

5 STACEY SCAMAN: I don't even -- I don't
6 know. When I see what happened during COVID, and
7 that is kind of what I am going back to, is our
8 Dietitians were on ten hours a day, five days a
9 week, just triaging everyone.

10 I don't know, Carol or Julie, if you
11 can speak to kind of a staffing ratio to that,
12 but --

13 JULIE CAVALIERE: Well, in a 120-bed
14 home, if we had one hour per resident per day, it
15 almost makes them full-time, which is what you
16 need. You need that full coverage to do the full
17 gamut of menu work, clinical work, logistical
18 support, and they become part of the leadership
19 team and not a consultant or an add-on, you know, a
20 resource.

21 So at one hour, essentially in a
22 120-bed home, and I am just -- you know, I mean,
23 many homes are around that. There is smaller and
24 there is definitely larger. But it would make them
25 full-time, essentially.

1 COMMISSIONER JACK KITTS: So with the
2 smaller homes, though, you could have, let's say
3 with 60-bed homes, one Dietitian cover both sites.

4 And now my question is the reason for
5 the one site only was for staff who were having
6 close contact with residents not to pass it on.

7 I don't know your work when you are
8 one-to-one with a resident, but I've got to think
9 that you are probably not doing the same as a PSW
10 in terms of your risk. And so your risk to the
11 resident would be much less than other workers; is
12 that correct?

13 STACEY SCAMAN: Yes.

14 JULIE CAVALIERE: It is, but I will
15 say, you know, during COVID, and I had to go in as
16 a clinical Dietitian and you are, you know, feeding
17 or doing a swallowing assessment, I mean, let's
18 face it, they are coughing all over you. You know,
19 yes, we had our full PPE on, you know; however, you
20 do have close contact with residents. It may be
21 not as often as a PSW because some things we can do
22 assessments at the bedside and we are not actively
23 doing something with them, but you know, we are
24 definitely in there, you know, feeding and touching
25 and in close contact.

1 STACEY SCAMAN: Now, in saying that,
2 absolutely, because that was our priority because
3 there was such a shortage in feeding.

4 Now, in some of our homes where there
5 wasn't a Nutrition Manager, for instance, sometimes
6 the Dietitian did keep more proximity from the
7 residents in order to be able to do the other tasks
8 without leading to more risk.

9 So depending on what that home -- and
10 every home was so individual in terms of staffing
11 and how they worked their staff and how many, you
12 know, agency or hospital staff were in to feed. So
13 then it depended on the role they took. So some
14 took more of a food service than a clinical role,
15 and they didn't have the same contact.

16 So we almost went into a home and did
17 the assessment with the team and figured out the
18 best role at that time, if that helps clarify.

19 COMMISSIONER JACK KITTS: Just one last
20 question. Did the availability of PPE have
21 anything to do with your time in the homes?

22 STACEY SCAMAN: I wouldn't say the
23 availability, but just the sheer amount of work it
24 took to don and doff equipment between everyone
25 did.

1 I think Dietitians were worried about
2 that because -- and I don't know, Carol, Julie, you
3 can tell me if you came across any of that, but I
4 know that some homes when there was that shortage
5 wanted to limit any extra staff coming in because
6 they didn't know how much equipment they would
7 have.

8 So that did play a role in some cases.
9 I couldn't tell you how much.

10 COMMISSIONER JACK KITTS: Okay, that is
11 good. Thank you.

12 CAROL DONOVAN: Having been deemed
13 essential but in some cases not allowed on-site,
14 period, and in some cases being allowed on only one
15 site really isn't the definition of essential. So
16 we did do some creative scheduling, and people that
17 worked at two sites, we amalgamated them to one
18 site and then put somebody else in that other site.
19 So we did what we had to do.

20 In terms of PPE, in the beginning there
21 were a few instances where it was a little rocky
22 making sure that everybody got their needs met, but
23 like Stacey said, there might have been some
24 circumstances when we weren't on-site because the
25 PPE wasn't available.

1 So again, you know, in planning, you
2 know, we really need to define what "essential"
3 means. And then there was that situation, like
4 Stacey said, when you went past -- you were
5 essential but you went past doing your own job. So
6 there was a lot of planning and a lot of organizing
7 that we need to do in terms of the next step.

8 And the other thing about Dietitians
9 too is we are a huge network. There is 15,000
10 Dietitians across Canada, plus we also network with
11 the United States. So I know that the brilliance
12 is out there to bring a plan together for the
13 future.

14 And again, I can't emphasize enough how
15 much we need to be part of the planning and not be
16 told what to do. We could have really helped a lot
17 more. And we are doing our very best, as always.
18 And we speak for the Nutrition Managers too. They
19 haven't had a voice at the table either.

20 So I think the big thing now is yes, we
21 can put a pandemic plan in place and have the best
22 systems in place and do the best we can and then
23 we'll see what that looks like next time, but we
24 need to look at what is going to sustain long-term
25 care in the future.

1 And that applies to, you know, you hear
2 a lot in the media about for-profit and
3 not-for-profit. There is problems in both. So
4 just saying, you know, make all long-term care
5 governed by the Ministry, that is not the solution
6 at all. So people say there shouldn't be
7 for-profit. Yeah, there is problems in both areas.
8 So we need to put the key experts at the table to
9 solve the problems going forward. It is crucial.
10 We'll never change unless we all get to the table
11 together.

12 COMMISSION CHAIR FRANK MARROCCO: Well,
13 I think we took that message from what you have
14 said fairly loud and clear, so we have that.

15 I assume that your presentation is
16 complete. I didn't want to -- I know we went over,
17 but it doesn't matter.

18 I wanted to thank you on behalf of the
19 Commission. We are very fortunate that we did get
20 together with you. So much of the discussion
21 centres around public support workers in long-term
22 care that I think there is a risk when you are
23 looking at this to forget about the other pieces of
24 the puzzle that make up a long-term care home.

25 And focussing for a few moments on

1 Dietitians and realizing how what happens to you or
2 what happened to you during COVID expressed itself
3 in terms of the risk that the residents were
4 exposed to is something that probably can't be said
5 often enough.

6 But thank you for taking the time to
7 come and thank you for the presentation, and we
8 will be the beneficiaries of that. So thanks very
9 much.

10 STACEY SCAMAN: Thank you.

11 JULIE CAVALIERE: Thank you very much.

12 CAROL DONOVAN: Thank you.

13 COMMISSIONER JACK KITTS: Thank you.

14 COMMISSIONER ANGELA COKE: Thank you.

15

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17 -- Adjourned at 10:25 a.m.

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1 REPORTER'S CERTIFICATE

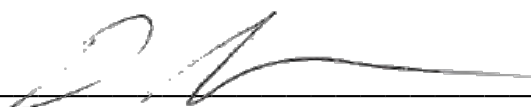
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5 That the foregoing proceedings were
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9 were recorded stenographically by me and were
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11 That the foregoing is a true and
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C L A R I F I C A T I O N S

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Page 31, line 11: "into our cleaning time" not
"into our cleaning"

Page 32, line 14: "in the time" not "in the tame"

Page 43, line 13: "Regular" refers to regular
texture.

Page 52, lines 21-22: "where there was a
Dietitian onsite" not
"where the Dietitian was"

Page 62, lines 11-12: "one hour per resident per
day" not "one hour per
resident per month"

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