Long-Term Care COVID-19 Commission Meeting

Dietitian Network
on Tuesday, March 30, 2021

77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

neesonsreporting.com | 416.413.7755

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.

BEFORE:
The Honourable Frank N. Marrocco, Commission Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:
DIETITIAN NETWORK
Stacey Scaman, RD, Corporate Dietitian, Seasons Care Dietitian Network
Carol Donovan, RD, President, Seasons Care Dietitian Network
Julie Cavaliere, RD, Director of Long Term Care Systems, Sienna Senior Living

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Senior Legal Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Alain Daoust, Team Lead, Long-Term Care Commission Secretariat

Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angeline Hawthorn, Senior Policy Analyst, Long-Term Care Commission Secretariat
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Gowling WLG
Peter Gross, Counsel, Gowling WLG

ALSO PRESENT:
Deana Santedicola, Stenographer/Transcriptionist

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

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

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

So over to you, Commissioner Marrocco.

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

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

We are very much coming to the end of

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

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

STACEY SCAMAN: Great, thank you.

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

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

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

Carol?

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

profession and I have enjoyed it very much.

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

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

STACEY SCAMAN: Julie?

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: We can see it.

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

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

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

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

Our goal, our job when we go into

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

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

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

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

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

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

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

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

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

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

So what we provide at present is based

on the Ministry regulations.

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Okay.

CAROL DONOVAN: Okay, the next slide, Stacey.

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Right.

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Okay, thanks.

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

CAROL DONOVAN: Sure.

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

CAROL DONOVAN: Yes.

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

CAROL DONOVAN: No.

COMMISSIONER JACK KITTS: That doesn't count.

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

COMMISSIONER JACK KITTS: And you --

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

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

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

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

JULIE CAVALIERE: Yes, that is what is done.

COMMISSIONER JACK KITTS: Okay.

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

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

And the second thing is do you think

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

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

COMMISSIONER JACK KITTS: Okay, thank you.

CAROL DONOVAN: Thank you.

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

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

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

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

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

CAROL DONOVAN: Per day.

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

CAROL DONOVAN: That's correct.

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Dr. Kitts.

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

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

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

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

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

JULIE CAVALIERE: Yes.

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

JULIE CAVALIERE: Correct.

COMMISSIONER JACK KITTS: Wow, okay.

JULIE CAVALIERE: Yes.

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

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

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

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

STACEY SCAMAN: And I think too --

COMMISSION CHAIR FRANK MARROCCO: Commissioner Coke.

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

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

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

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

So sorry about that, go ahead.

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

shortage a result of?

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

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

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

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

COMMISSIONER ANGELA COKE: Okay, thank you.

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

CAROL DONOVAN: Absolutely, yes.

LYNN MAHONEY: Okay, thank you.

CAROL DONOVAN: Thank you.

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Is

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

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

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

CAROL DONOVAN: Yes.

COMMISSION CHAIR FRANK MARROCCO: Okay.

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

The other thing too within the

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

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

And we have got --

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

CAROL DONOVAN: No.

COMMISSION CHAIR FRANK MARROCCO: Okay.

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

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

COMMISSIONER JACK KITTS: My apologies.

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

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

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

COMMISSIONER JACK KITTS: Okay.

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

CAROL DONOVAN: Right.

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

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

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

COMMISSIONER JACK KITTS: Okay, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

LYNN MAHONEY: And can I --

COMMISSIONER JACK KITTS: And the --

LYNN MAHONEY: Sorry.

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

JULIE CAVALIERE: It is not topped up

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

CAROL DONOVAN: $9.54.

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

COMMISSIONER JACK KITTS: Okay.

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

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

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

there is no change to the raw food budget accordingly.

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

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

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

COMMISSION CHAIR FRANK MARROCCO: All right.

JULIE CAVALIERE: Okay, so I'll continue.

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

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

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

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

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

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

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

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

And so --

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

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

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

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

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

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

And then we did talk about the lack of

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Tube feeds.

JULIE CAVALIERE: Uhm-hmm.

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

JULIE CAVALIERE: Correct.

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

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

are not, they are not getting enough.

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

COMMISSION CHAIR FRANK MARROCCO: Okay.

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

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

could not provide coverage to the other homes remotely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and calling back and forth identifying risk.

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

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

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

They did just about anything that they

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

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

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

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

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

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

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

of meals really suffered.

The logistics we talked about already.

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

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

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

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

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

Carol, do you want to explain these?

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

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

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

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

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

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

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

reality of what we went through.

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

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

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

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

and what do we need to do for that.

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

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

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

But the adaptability, collaboration and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Food Service Worker --

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

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

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

COMMISSION CHAIR FRANK MARROCCO:

Right.

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

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

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

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

And so --

COMMISSION CHAIR FRANK MARROCCO:

Commissioner Coke?

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

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

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

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

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

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

So it has been a bit frustrating in

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

COMMISSION CHAIR FRANK MARROCCO: Commissioner Kitts.

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

CAROL DONOVAN: Yes.

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

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

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

COMMISSIONER JACK KITTS: So nursing

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

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

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

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

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

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

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

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

STACEY SCAMAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And focussing for a few moments on

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

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

STACEY SCAMAN: Thank you.

JULIE CAVALIERE: Thank you very much.

CAROL DONOVAN: Thank you.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

-- Adjourned at 10:25 a.m.

REPORTER'S CERTIFICATE

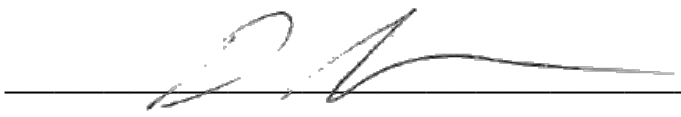
I, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, certify:

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 30th day of March, 2021.



NEESONS, A VERITEXT COMPANY

PER: DEANA SANTEDICOLA, RPR, CRR, CSR

C L A R I F I C A T I O N S

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"

WORD INDEX