Long Term Care Covid-19 Commission Mtg.

Panel Session with Dr. Doris Grinspun
on Friday, November 20, 2020

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7 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14 --- Held via Zoom, with all participants attending
15 remotely, on the 20th day of November, 2020,
16 10:00 a.m. to 11:38 a.m.
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19 BEFORE:
20
21 The Honourable Frank N. Marrocco, Lead Commissioner
22 Angela Coke, Commissioner
23 Dr. Jack Kitts, Commissioner
24
25

1 PRESENTERS:
2
3 Doris Grinspun, RNAO CEO
4 Miranda Ferrier, Ontario Personal Support Workers
5 Association - President,
6 Samir K. Sinha, MD, DPhil, FRCPC, AGSF
7 Irmajean Bajnok, PhD, MScN, BScN, RN
8 Ian Dasilva, Human Resources Director for the
9 Canadian Support Workers Association and Human
10 Resource Director for the Ontario Personal Support
11 Workers
12
13 PARTICIPANTS:
14
15 Alison Drummond, Assistant Deputy Minister,
16 Long-Term Care Commission Secretariat
17 Ida Bianchi, Counsel, Long-Term Care Commission
18 Secretariat
19 Sanjay Bahal, Team Lead for Operations, LTCC
20 Derek Lett, Policy Director, Long-Term Care
21 Commission Secretariat
22 John Callaghan, Gowling LLP
23
24 ALSO PRESENT:
25 Janet Belma, Stenographer/Transcriptionist

1 I N D E X
2
3 **The following list of undertakings, advisements
4 and refusals is meant as a guide only for the
5 assistance of counsel and no other purpose**
6
7 INDEX OF UNDERTAKINGS
8 The questions/requests undertaken are noted by U/T
9 and appear on the following pages: 77, 83, 86
10
11 INDEX OF ADVISEMENTS
12 The questions/requests taken under advisement are
13 noted by U/A and appear on the following pages:
14 None
15
16 INDEX OF REFUSALS
17 The questions/requests refused are noted by R/F and
18 appear on the following pages: None
19
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1 -- Upon commencing at 10:00 a.m.
2 DORIS GRINSPUN: Good morning,
3 Commissioner and everybody.
4 IRMAJEAN BAJNOK: Oh, there's Doris.
5 COMMISSIONER JACK KITTS: Good morning,
6 Doris.
7 DORIS GRINSPUN: Commissioner, you have
8 me so impressed with that letter, the strength of
9 the letter, the timing of the letter, and the --
10 everything, so thank you.
11 Still, though, I met with the Premier
12 in person and by phone -- and in person and by
13 phone, and what we hear is that we will not know
14 anything 'til end of December, so not much is
15 changing in reality for the seniors. They are
16 dying in larger numbers. We need you to push
17 again. We don't seem to make -- to make the impact
18 that they need, not us, but they.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Well, you know, let me just start. I think -- and
21 then we can get right to it.
22 First of all, I'm Frank Marrocco,
23 Commissioner Dr. Jack Kitts, and
24 Commissioner Angela Coke. We've met, I think,
25 virtually everybody before, maybe not everybody,

1 but almost everybody. So I'll dispense with a lot
2 of the formalities.
3 We're trying to get a little bit of a
4 better understanding of what a properly staffed
5 long-term care facility should look like. We've
6 already encouraged the Government in terms of the
7 staffing study, but we wanted to understand a
8 little better the acuity levels of the patients
9 and -- the residents, and then we wanted to try to
10 just understand what is required today as opposed
11 to what was required 20 years ago. You all know
12 the issues, so I'm not going to get into it much
13 further than that.
14 In terms of starting, I guess we could
15 start anywhere, but, I mean, how would -- how do
16 you think it would be correct to describe the
17 acuity level of the people that are typically
18 resident, and from that, what kind of staffing do
19 you need to deal with it?
20 If that's -- if that's okay with
21 everybody, I go -- it's got to start somewhere, so
22 that's where I would propose to start.
23 DORIS GRINSPUN: So --
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Dr. Sinha.

1 SAMIR SINHA: Yes, so perhaps I can --
2 I can just start. I mean, I think we -- a lot of
3 us know this information, and I can -- and also,
4 I'll just say something generally, and then I
5 welcome Doris and Ian and our teams to do -- but,
6 you know, this has actually been really
7 well-documented and very clearly in Ontario
8 because, for example, in long-term care, we've been
9 using the interRAI Assessment Systems, and I know
10 from the presentations I've seen, you've actually
11 been able to, you know, get some links in with the
12 Ministry and CIHI, for example, just to show the
13 difference between a resident, say, in 2012, for
14 example, versus a resident today.
15 And so in that sense, it's quite
16 well-documented, for example, and you've seen
17 that -- those figures, for example, that, you know,
18 the typical resident today is more likely to have
19 dementia and more likely to have urinary
20 incontinence, more mobility issues, and that.
21 So in that sense, we actually know
22 that, Number 1, the care needs are much more
23 difficult to manage especially when you say it's
24 not just that more people have dementia, but if
25 they have dementia, there's more behavioural

1 issues, and that takes time to manage.
2 If there's more urinary incontinence or
3 fecal incontinence, for example, then that just
4 takes a lot more time to manage because, you know,
5 as my nursing and personal support worker
6 colleagues will say, it's not just that they have a
7 condition like heart disease, it's just that now
8 it's about toileting routines. It's about -- it's
9 all of those sorts of things.
10 If there's more physical limitations --
11 and one thing, when I was helping to do the
12 physiotherapy reforms in long-term care back in
13 2013, I think, or '14 at this time now, we were
14 realizing that the way physiotherapy was being
15 developed, it wasn't allowing people to work within
16 their scope of practice and actually identify, you
17 know, kind of, when people have more functional
18 limitations, there's a -- more of a need for
19 rehabilitation.
20 So I think -- so it's not -- so it's
21 the idea that the types of conditions have made the
22 levels of care increase in terms of more time that
23 needs to be spent, but the other thing in the
24 interRAI Instruments that happen is we have
25 something called a CHESS Scale. And the

1 CHESS Scale is one that talks about medical
2 instability and acuity. And it really shows, you
3 know, that level of instability and acuity has been
4 arising. So again, then not only informing that
5 this is the type of skill mix we'll need to
6 actually do the day-to-day care, but then this is
7 the type of clinical expertise you actually need.
8 And so when we think about the role of
9 the primary care provider, whether that be a nurse
10 practitioner or a physician, for example, you know,
11 for example, who can actually be providing that
12 oversight and that care in the home, what does that
13 also look like, for example, in terms of making
14 sure that one is present more than once a week, for
15 example, one can more acutely respond to those
16 clinical needs that might be there; and how do you
17 make sure that that support is in place so that a
18 home is not likely in that situation where we have
19 the saying called when in doubt ship out as opposed
20 to how do we actually create a model that actually
21 works.
22 And I think one of the biggest
23 challenges that I'll say as a physician, and then
24 I'll -- and then I'll shut up is that when -- and I
25 think you've heard about this about the challenges

1 that we have with the current Medical Director
2 Model -- there are no requirements. You know,
3 like, I think right now I believe -- and I could be
4 wrong, and my colleagues will I -- hopefully
5 correct me -- I think the only thing I know about
6 in the staffing requirements or legislation, it
7 might say there needs to be at least one RN in the
8 building. And then it might even say that there
9 has to be a medical director. Maybe it says that.
10 I think it does say that, but I don't think it
11 actually tells you what they need to do, what the
12 roles and responsibilities, the expectations are.
13 And I think the key is, unless you
14 actually outline -- you know, and it's not about --
15 I -- and I think we have to be very careful about
16 saying, you need 'X' number of PSWs. You need 'X'
17 number of RPNs, 'X' number of RNs, NPs, but I think
18 if we actually say, especially at that higher
19 level, if you will, of care where we say this is
20 the type of care that needs to be provided, and
21 then realizing by geography there might not be a
22 physician available; it really needs to be an NP,
23 an NP with 'X' support, whatever the case is, then
24 I think we, then, start understanding how do we
25 actually meet those needs knowing that every

1 geographical -- they have so many geographical and
2 supply issues that we sometimes get in a bear trap,
3 if you will, when you start saying, well, it has to
4 only be a physician, or it only has to be 'X', 'Y',
5 and 'Z'; and then an area says, well, what do we do
6 when we don't have that? So that's, kind of, my
7 view on acuity, and how that's evolved.
8 But we have really good data that
9 actually helps us understand that, and I think it
10 really can start a really good conversation about
11 the right skill mix and, I think, the medical -- or
12 I don't want to say medical, but I want to say the
13 clinical oversight that needs to be provided to
14 help people age in place or get the acute care they
15 need onsite or with the extra support of additional
16 resources. So I'll stop there.
17 DORIS GRINSPUN: If I may build from
18 that, Commissioners, all of them. I know -- I know
19 you, Jack. How are you?
20 COMMISSIONER JACK KITTS: Good, Doris.
21 DORIS GRINSPUN: And now I see the
22 third commissioner is there.
23 I believe you know what's needed,
24 Commissioner, and I'm sorry to be distressed. I
25 believe you heard from families. You heard from

1 other associations. I believe that it's time to
2 start the conversations that Samir is alluding is
3 over. I believe that the Government knows what's
4 needed. The Minister of Long-Term Care has
5 healthcare background. She practiced 'til about
6 seven years ago. She ought to know that this would
7 have been a tragedy.
8 So I am less patient, and I am sorry
9 that -- continue to be less patient and will be
10 increasingly so -- doing so in the media and with
11 families.
12 I believe that the only area where I
13 will completely defer from Samir, in addition that
14 it's not a conversation anymore, these actions, is
15 the role of NPs. NPs are not there instead or when
16 there are no physicians. The only homes that have
17 in place 60 of them are performing better because
18 that's their job. It's not their second. That is
19 not their tertiary. It's not a job on the side.
20 It's not income on the side. It's their job
21 full-time in the home, and they have produced
22 results that are significantly better in hospitals,
23 in primary care, and in long-term care. The
24 problem is that there are only 60.
25 They're only -- I will move again to

1 the issue of skill mix. You have our model.
2 That's been there. It has been consensus across
3 this country, more or less, that what we need is
4 more of everything, more RNs, more RPNs, more PSWs
5 because what you need is the knowledge, judgment,
6 and skills, not only the skills to toilet, not only
7 the skills to feed; you need, actually, the
8 knowledge to ensure that people with dementia don't
9 deteriorate more. You need the knowledge of
10 pressure injuries to apply evidence-based practice
11 and understand the evidence of guidelines, and we
12 are working with 120 of these homes in our
13 best-practice guideline programs, and their falls
14 have decreased; their pressure injuries have
15 decreased, and it's because they have, you know,
16 the evidence there. So you need two things: The
17 skill mix and the ability to work with evidence,
18 and for that, you need all of the above.
19 The NPs which we don't include in the
20 four working hours are a different phenomenon, and
21 you can -- they ought to be, first of all, in any
22 single home, there are no attending physician, and
23 they're not in every single home.
24 But if I were to bring you one of the
25 colleagues that call me two nights ago and that is

1 afraid of going in the media, but you will see that
2 in my blog, hopefully, next week, she was sent to a
3 home. In that home, there was not a single person
4 that belonged to that home, was a person that had
5 been two days in that home, that had worked 16
6 hours. Now she needed to stay 18 hours because no
7 one came to replace her. She couldn't find the
8 physician, so that's where I'm going with this
9 piece. Everywhere -- she couldn't find. Finally,
10 she understood he was busy. It's not that he
11 disappeared. He was busy in some other workplace
12 because they don't work in the home.
13 And finally, she got an NP who gave her
14 a -- they were starting to give the medications.
15 Palliative care, we are talking the -- one -- two
16 of the residents were dying. One was dying as --
17 as at the moment and was dying without any support
18 of medications because she couldn't prescribe.
19 So we need NPs for 120 residents
20 everywhere. I will turn the conversation of Samir
21 a bit around. I heard Samir with great degree of
22 pain, I must say, the transcripts where you allude
23 that NPs come to you because they don't know
24 enough. Maybe that was 20 years ago. Today, they
25 know a lot, and they're well, well prepared.

1 And they were -- they were medical
2 directors during the pandemic under the emergency
3 orders, so the question is, why are they not now
4 permanently medical directors?
5 So I would shift the conversation
6 completely around. What we ask 15 years ago, the
7 same four hours, is what we are asking today
8 because we are pragmatic, not because that's what's
9 needed. It's needed five, and everybody knows
10 that, but no one will give five, so we are saying
11 four but four worked hours.
12 And in the combination that we said in
13 our model, 48 minutes of an RN care, direct care;
14 and if that's too much in 24 hours, well, we may as
15 [sic] not talk, then, what seniors need or their
16 complexity or any of that; 60 minutes of an RPN,
17 and 132 minutes of PSWs, which is up from what we
18 are now.
19 And if that's, again, too much, then
20 I'm not sure it's the same that we spoke with
21 Kathleen Wynne, the same that we spoke with
22 Dr. McGuinty, and this all started in the time of
23 Premier Harris, to tell you the truth, when they
24 increase in -- in gaps started more and more and
25 more and more.

1 So I said yesterday to Effie and to her
2 team, this Government, the current one, has the bad
3 luck that they got COVID handed to them in a -- in
4 a -- you know, in the midst of their term. It's
5 bad luck for all of us but, also, especially for
6 the Government that needs to deal with that, and I
7 absolutely say that with seriousness.
8 They also got the good luck that they
9 can make a difference for once, and I said to the
10 Premier when we met in person a few days ago, my
11 patience is fading. My belief on him is fading. I
12 truly, truly for once believed -- I believed
13 Kathleen, too, but I was -- she was more towards
14 the end of the term, and she didn't have COVID in
15 her plate.
16 But I believed the Premier when he said
17 that he was going to fix this problem. The time
18 for conversations is over. If the -- if they --
19 if Marilyn is going to bring a report end of
20 October [sic] which is late by seven months --
21 IRMAJEAN BAJNOK: December. That is
22 December.
23 DORIS GRINSPUN: -- by seven months --
24 yeah, sorry, end of December, it's late by seven
25 months, then she needs to bring the timelines, the

1 skill mix, the funding, and the hiring directions.
2 We are not going to play the game of more
3 conversations. That's so over.
4 We are already over 300 additional
5 residents lost. I'm not saying all of them would
6 not have lost, but 50% of them would not have lost
7 because that's all you see [indecipherable]. And
8 even in OECD was an issue of challenges with
9 staffing. We all know that from the reports from
10 OECD.
11 So, you know, but 50% here, right here,
12 we are losing simply because of political
13 negligence and stakeholders that delay things,
14 stakeholders that say we cannot get the people.
15 Yes, we can. We have them at RNAO, and we have
16 proven that to the Government, not only RNs, RNs,
17 RPNs, PSWs, and NPs; and RNAO will not play that
18 game. No, we'll not play the game of the
19 Government of delaying all of associations or
20 individuals that want to continue conversations and
21 delay.
22 And then is -- there is the issue of
23 the Extendicare, the Sienna, and the Chartwell of
24 the world, that they are part of the delaying
25 because what they want is basically less and less

1 and less, not more, because their first priority,
2 legally -- legally, their fiduciary responsibility
3 is to shareholders. That's Number 1. Number 2 --
4 and Samir knows because he consults with one of
5 them as is in the transcript.
6 So everybody knows that, so it's all
7 open now. It's all open. You will hear the same
8 from any nurse. It's all -- anybody knows what's
9 needed. What we need is action and timelines and
10 funding. And so skill mix and evidence both, both
11 go together because skill mix without the capacity
12 to deliver good practice will not help. The
13 capacity to deliver good practice without the right
14 skill mix, it helps but to a certain extent, right?
15 That's -- we have proven in our -- in our
16 best-practice spotlight (phonetic) organizations.
17 Every single home should be
18 implementing evidence-based practice today, and
19 they don't need 20 years of school for that because
20 we have told the PSWs also in the homes that were
21 involved. So we have told the PSWs they're doing
22 much better work there. The RPNs oversee that also
23 in their -- in their capacity, and then RNs have
24 that tiny bit now, which is -- I think that I heard
25 from a nurse that calculated that yesterday. I

1 don't know if it's five minutes a day or whatever
2 it is -- enough [indecipherable], right?
3 COMMISSIONER JACK KITTS: Can I just --
4 can I just ask a question? I agree that you've got
5 to get the skill mix right otherwise it's not going
6 to work.
7 We've heard from Dr. Sinha. We've
8 heard from you, Doris, and I want to hear from
9 Miranda as well, but I'd like to get a consensus
10 amongst the three of you on what is the
11 prototypical patient and then have a conversation
12 and go through the list of potential or possible
13 workers, workers that -- and see what their roles
14 are in meeting the needs of these patients -- or,
15 sorry, residents.
16 And we keep mixing up because it
17 sounds, in many respects, that, you know, a decade
18 ago, as you mentioned, Dr. Sinha, was a very
19 different patient -- or, sorry -- a very different
20 resident. And we're struggling with the fact that
21 it's -- these are people now who can't be at home,
22 can no longer survive at home with home care, and
23 I'll get you to comment on that, Dr. Sinha.
24 But we did -- we did hear that ten
25 years ago, a decade or two ago, patients in -- or

1 residents in long-term care homes were fairly
2 independent, could go out, do things; and then
3 Home First or Aging At Home, part of the strategies
4 you were a part of, Dr. Sinha, looks like it worked
5 extremely well. And CIHI told us when they were
6 here that, you know, numbers like 20 to 30% of
7 residents shouldn't be in long-term care homes a
8 decade or two ago. It's down to 8% in Ontario, and
9 I'd like -- I'd like to get you to comment on that
10 and how much further we can go.
11 But residents in long-term care homes
12 today are there because they have failed the
13 Home First or Aging At Home, and so, therefore,
14 they're more acute. And if we're wrong on that,
15 then we're not going to get the skill mix right.
16 So I'd like to hear from the three of
17 you what you think the acuity is, whether there are
18 more patients than residents and whether there's
19 a -- the appropriate people are in the long-term
20 care homes, or what are the alternatives, so I'll
21 open that.
22 DORIS GRINSPUN: But there -- but there
23 is a mistake on what you're saying in the sense
24 that if they were patients like in the hospitals,
25 you will have only RNs and RPNs. This is the wrong

1 conversation again.
2 They are different than 20 years ago,
3 but ten years ago, they were acute. We are -- have
4 been training and staffing for a long time, not
5 just during COVID.
6 COMMISSIONER JACK KITTS: Okay. So
7 that's why I'm asking, what is the right skill mix
8 for them because they're neither hospital nor home?
9 SAMIR SINHA: Yeah.
10 DORIS GRINSPUN: So we gave the skill
11 mix, so I will let Samir and Miranda -- because we
12 gave the skill mix with very solid explanation
13 already many times in writing.
14 SAMIR SINHA: Yeah. Miranda, would you
15 like to go --
16 IRMAJEAN BAJNOK: Just before Samir
17 starts, you know, I do want to make a comment
18 related to what Dr. Grinspun said that the bottom
19 line is we do believe we can direct homes about how
20 many staff they should have. And I think, Samir,
21 you made the comment that we can't direct homes.
22 We can. It's imperative. We need to, and that's
23 what we're saying with the skill mix, and I'm not
24 sure what more you need in terms of the skill mix.
25 There needs to be PSWs, absolutely, but

1 they are there wandering in the woods without some
2 registered regulated staff in RPNs and RNs. So I'm
3 not quite sure what the mystery is.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Well, let me just ask a question. One of the
6 things that has -- concerns me is that if you are a
7 private operator of a home and you employ more
8 qualified staff and you succeed in reducing the
9 acuity level or -- of the -- of the people, the
10 residents, this can affect your funding in a
11 negative way, as from what I've heard, and money --
12 DORIS GRINSPUN: Let me --
13 [indecipherable] --
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 No. No. Just a minute. Just a minute. Money
16 influences behaviour, and so I'm -- I'm not sure we
17 really -- I think I just need some help with that
18 because I -- it seems to me there's a disincentive
19 in the system for the very improvements that you're
20 suggesting, and I don't know -- if that's wrong,
21 then I need to be disabused of that because it's
22 affecting my thinking.
23 DORIS GRINSPUN: You know,
24 Commissioner, you are right. You are right also,
25 and I spoke yesterday with Effie and with all of

1 them that right now if you do better, if you
2 have -- start to have less pressure injuries, less
3 falls, they next year yank the money from you
4 because your CMI goes down, but that's not what we
5 are talking.
6 The Government is saying they will
7 change the funding. They also said they will send
8 a funding formula, so if you put a decent -- a
9 decent, not a good, a decent, which is what we
10 propose, staffing formula that will be bring safety
11 and quality of life, then they will fund to that
12 staffing model.
13 If private operators want to make
14 profits, they can make it on haircuts. They can
15 make it on -- I don't know what else, but not on
16 the basic staffing that these people need and
17 deserve.
18 IRMAJEAN BAJNOK: And maybe reduce
19 their profit -- [indecipherable] quite big.
20 SAMIR SINHA: Can I get -- can I -- can
21 I get -- yeah.
22 DORIS GRINSPUN: [Indecipherable]
23 was --
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 The other -- the other part of this was the

1 reference to regulated versus unregulated persons
2 in the home. As I understand it, PSWs are not
3 regulated. Is that right or wrong?
4 MIRANDA FERRIER: That is right.
5 That's correct.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Yeah, now, I don't -- you know, I don't understand
8 how, in terms of the quality of care, you can have
9 an unregulated -- and I don't mean to disparage
10 personal support workers. That's not what I'm
11 saying, but I don't understand how you can have an
12 unregulated group of people --
13 MIRANDA FERRIER: No.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 -- providing care to vulnerable members of the
16 public.
17 SAMIR SINHA: Paramedics are not
18 regulated either.
19 DORIS GRINSPUN: And then it is a
20 physician --
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 If they're not regulated, there are no --
23 DORIS GRINSPUN: -- physician
24 assistant, that's called --
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 If they're -- if they're unregulated, there are no
2 consequences.
3 MIRANDA FERRIER: Exactly.
4 IRMAJEAN BAJNOK: Well, there are.
5 MIRANDA FERRIER: Exactly.
6 SAMIR SINHA: Let's let Miranda speak
7 here. And then I'll go --
8 MIRANDA FERRIER: Thank you very much.
9 SAMIR SINHA: And then I'll go after
10 you, Miranda.
11 MIRANDA FERRIER: I appreciate that.
12 So I just want to answer a couple of the questions
13 that you guys were going on about talking about the
14 acuity of what type of residents are in long-term
15 care homes and what we're hearing from our
16 membership.
17 And, of course, when I worked in
18 long-term care myself, we're seeing a lot more
19 mental health components in long-term care
20 facilities now. So it's not just the typical, you
21 know, Mr. and Mrs. Smith that have dementia or
22 Alzheimer's or Parkinson's or Huntington's, et
23 cetera.
24 What we're seeing now is more of a
25 mental health component, so we have people with,

1 you know, schizophrenia, bipolar affiliated with
2 dementia, so it's far more complex cognitive issues
3 for our residents in long-term care.
4 We're also seeing a lot of mobility
5 issues, [indecipherable] mobility issues, not just,
6 you know, a sit-to-stand lift. Now we need a full
7 HoyerLift in order to, you know, assist these
8 individuals.
9 When we're talking about more NPs or
10 doctors or nurses in long-term care, I mean, as my
11 colleagues know, I've always been keen for more
12 nurses in long-term care facilities.
13 I'll answer the one question that Samir
14 had about, you know, like, you're supposed to have
15 an RN on site at all times in a long-term care
16 facility. That is true. You are supposed to have
17 an RN on site at all times.
18 But I'm telling you right now that lots
19 of the operators don't. A lot of times on the
20 overnight, they have an on-call nurse that may or
21 may not be available when you actually need that
22 individual, so that's a -- that's a main core
23 issue.
24 When speaking about, you know, care for
25 our loved ones in long-term care, we really need to

1 look at the ground up. PSWs are caring for their
2 activities of daily living, so if they're -- you
3 know, if they're not being toileted -- and I, to be
4 perfectly honest, right now, it's great if we have
5 a plan of care for toileting or BM or, you know,
6 et cetera. They don't have the time to do that.
7 So if someone has to be, you know, on a
8 toileting regime every day, good luck actually
9 having the staff available in order to do that,
10 right? So it's all great on paper, but what's
11 actually happening on the front line is a
12 completely different matter.
13 You know, I was speaking as well with
14 Effie and her team at the Ministry of Long-Term
15 Care on Wednesday, and one of the things that we
16 mentioned was I think that in order to know how
17 many staff we need, the perfect, kind of,
18 collaboration of different, you know, professionals
19 in healthcare, we have to look at ratios because
20 then we will know exactly how many PSWs we need in
21 order to give them this -- you know, let's talk
22 about the four hours of care that's been promised
23 over the course of the next four years.
24 Well, if you do -- let's say, give an
25 example: 1 to 8 ratio, so, like, one personal

1 support worker because that's what I talk in -- I
2 don't tread -- so one PSW to eight residents,
3 that's -- I believe that was -- and Ian can attest
4 this -- having 32 or 36 hours of care a day, which
5 makes no sense, that would need to be given.
6 So we'd need a lower ratio. Believe it
7 or not, they were open to that concept. Once you
8 know how many PSWs you need in the home, then you
9 can look at how many nurses, et cetera, and so on
10 and so forth.
11 It has to -- I think we need to start
12 viewing this from the ground up as opposed to the
13 top down because the job that the PSW does is
14 physical. Yes, it can be dirty, but it's a very
15 vital job in long-term care, and they know their
16 residents the best. So let's look from the ground
17 up. I think that way, we can build a better team.
18 IAN DASILVA: And if I can support --
19 IRMAJEAN BAJNOK: I think we have to
20 look from the [indecipherable] up --
21 IAN DASILVA: If I can support that,
22 Miranda -- Miranda, we also are looking at
23 patient-support-centred care, and that's really the
24 trend that we're moving to in Canada.
25 Sorry, Irmajean. I'm just going to

1 interject here.
2 IRMAJEAN BAJNOK: Okay.
3 IAN DASILVA: The patients -- we've
4 really got to be looking at patient-focused care.
5 We hear a lot about --
6 MIRANDA FERRIER: Exactly.
7 IAN DASILVA: -- RNs, RPNO [sic], we
8 need more money; we need more money; we need more
9 money.
10 I think we need to reverse this
11 conversation and say we've got to look at patient
12 care, and to answer Dr. Samir's question --
13 Dr. Samir's question -- sorry -- how are we not --
14 or how are we allowing such a majority of our
15 healthcare in long-term care to be delivered by
16 people who have no governing or regulatory body
17 without any public protections? This is the
18 fundamental lacking piece.
19 All of these discussions will continue
20 on and on and on. We'll have the same debate in
21 ten years until you can guarantee some sort of
22 professional status for the frontline healthcare
23 workers. We are literally resting the entire
24 healthcare model on the shoulders of PSWs who have
25 no regulatory or voice in government.

1 And we do meet with Ford regularly. We
2 meet with these people too. We believe he's going
3 to change it, but the fundamental truth -- and I
4 know Miranda will agree -- you need to start there.
5 MIRANDA FERRIER: Yes.
6 IAN DASILVA: Because that is who deals
7 with the patient. You start with the patient
8 first, then the PSW. The nurses will, of course,
9 follow them.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Irmajean, you wanted to say something. Or,
12 Irmajean, I think you were cut off. You were
13 trying --
14 IRMAJEAN BAJNOK: Oh, yes. Well, I
15 wanted to make two points. Number 1, some of this
16 discussion centers around, there's not enough
17 nurses. That is not the case. You make long-term
18 care a good work environment, and you will have the
19 staff. There are registered nurses and registered
20 practical nurses who do want to work in long-term
21 care.
22 The other thing I think we really need
23 to be aware of is, absolutely, nurses in all ways
24 have been caring for residents in long-term care.
25 And if you want to spend six months figuring out

1 some ratios, moving to regulating people, let's
2 first get some basics in place so people stop dying
3 and the whole sector collapses.
4 The other piece is let's remember
5 employers have a responsibility. Not everyone is
6 regulated. Employers are responsible for setting
7 descriptions for job positions, doing performance
8 review, and making sure staff are competent in
9 their work, so we can't regulate the entire world.
10 That's what the -- that's not what this is about.
11 This is about safe care.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 But you -- I understand that, and I understand that
14 staff -- that owners have a responsibility for
15 their employees and how their employees behave. I
16 get that.
17 But they also -- they're conflicted a
18 bit because if you have a working situation and
19 it's working and there doesn't seem to be anybody
20 complaining about anything, there might be a
21 tendency to think that everything's okay.
22 I would have thought that, in addition
23 to the responsibilities that an owner has for their
24 employees, that there's a public oversight issue
25 that needs to be addressed. It just helps keep

1 everybody on the straight and narrow.
2 If I employ a registered nurse, then as
3 the employer, I have a responsibility for that to
4 make sure that that nurse is behaving properly, but
5 so does the College of Nurses have an interest in
6 how that nurse is behaving.
7 SAMIR SINHA: M-hm.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 So I am having a lot of difficulty with the idea
10 that you have -- it seems to me you have two
11 problems: You have an unregulated group of people
12 who are quite essential, and you have a situation
13 where the -- there's no proper inspections of
14 what -- to -- so you know what's going on in
15 these -- in these homes.
16 I'm not talking about a response to a
17 fall or a claim -- an allegation of assault. I'm
18 just talking about overall inspections. It seems
19 to me it's essential.
20 DORIS GRINSPUN: So that -- so I had my
21 hand, but somehow --
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 I'm sorry. I didn't mean to ignore you, Doris. I
24 was -- I'm sorry.
25 DORIS GRINSPUN: That's okay. I

1 just --
2 COMMISSIONER FRANK MARROCCO (CHAIR): I
3 was -- I was wrapped up -- I was wrapped up
4 listening to myself, so I'm sorry about that.
5 DORIS GRINSPUN: No worries. So you're
6 right, but the inspections are needed all the time,
7 and that's why you need the 48 minutes of an RN.
8 That's exactly why you need that. Regulated,
9 unregulated is -- will not solve you the issue.
10 They have six months' education. They can work
11 within that context of six months' education which
12 is for the basic ADLs which is absolutely
13 essential, necessary, and needs to be done well and
14 with compassion.
15 But they do not have the expertise nor
16 should they be expected, right? They don't have a
17 unique body of knowledge. Regulated professions
18 have a unique body of knowledge, right?
19 So to me, absolutely, keep going the
20 discussion. That will be a much larger discussion
21 than us using here, the time to regulated, not
22 regulated. As Samir said, paramedics are not
23 regulated. I can also tell you physician
24 assistants are not regulated, and there are a
25 gazillion others not regulated.

1 What is needed is, as you said, the
2 ongoing supervision and assessment. Supervision is
3 not just to look at charts. What assessment was
4 missing, as it happens now, is being there present,
5 and you cannot do that if you don't have those 48
6 minutes of RN and the 60 minutes of an RPN. You
7 simply cannot do that, and that's why it's not
8 being done. That's why we're moving to these
9 models that are completely panic -- punitive.
10 That's all they do, right?
11 And let me tell you, these visits that
12 we do now with inspections, we'll go to hospitals,
13 they will find 20,000 things, too, because if you
14 dig enough in the charts, you will find something,
15 period. All of us will find something.
16 What you need is a more positive
17 approach to ongoing supervision, ongoing looking at
18 what are the clinical needs, and ongoing
19 intervention. And then, yes, the PSWs, of course
20 we need them there to do the ongoing ADL so people
21 are not all the time in bed, so people are turned
22 the way they need to be turned, so people get the
23 time to be helped for the sip of water -- they --
24 the conversation of one minute, the -- et cetera,
25 et cetera, which now they are completely deprived

1 and not just during COVID, before COVID too.
2 IAN DASILVA: I'm sorry, Mr. Marrocco,
3 but I do have to disagree with Ms. Grinspun on this
4 issue. You cannot compare the PSW to a physician
5 assistant, like --
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Well, don't be sorry. That's why we created the
8 Panel.
9 IAN DASILVA: Like, you can't -- you
10 can't compare a PSW to a paramedic or a physician
11 assistant --
12 DORIS GRINSPUN: No, I don't --
13 IAN DASILVA: Now, should they be
14 regulated? Absolutely. But the PSW provordes
15 [sic] a much more comprehensive role and a much
16 more continual role in healthcare than a paramedic
17 does even than the physician assistant does.
18 They're right with the patient daily.
19 To say that the PSW simply can be
20 delegated and that that's enough public protection,
21 I really -- I think we're really past that now, and
22 I'm a little -- I think we really need to start
23 looking a little bit more seriously at this.
24 We can no longer attract people to the
25 field because it doesn't have title protection.

1 You can't guarantee that once you've gone to school
2 for this, you're going to keep that job. So --
3 MIRANDA FERRIER: Yeah.
4 IAN DASILVA: -- we can't keep people
5 in the field. The idea saying that, oh, there's
6 plenty of them out there and that they're just
7 waiting to come in, we know that's not true.
8 That's not correct. You need to put out a title
9 regulation for the frontline healthcare worker. It
10 is a necessary -- and you need to protect the
11 public. To say that you don't want to have that or
12 it's not needed runs contrary to public interest.
13 I'm sorry. I'm sorry --
14 SAMIR SINHA: Can I get --
15 DORIS GRINSPUN: Commissioner, would
16 you mind introducing us. I --
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Just a second. Doctor -- Doctor --
19 DORIS GRINSPUN: -- don't know all the
20 Panel is. Would you mind introducing us? I never
21 met Mr. DaSilva. Would love to know --
22 IAN DASILVA: We met -- we met a year
23 ago, Ms. Grinspun.
24 DORIS GRINSPUN: Well, I don't recall.
25 I'm sorry.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 No, but Mr. DaSilva, if you want to explain to
3 Dr. Grinspun what your role is with the --
4 IAN DASILVA: I'm the Human Resources
5 Director for the Canadian Support Workers
6 Association and the Human Resource Director for the
7 Ontario Personal Support Workers Association.
8 DORIS GRINSPUN: You are the person
9 that is setting the agency for regulation, then; is
10 that correct?
11 IAN DESILVA: We are the ones
12 advocating for self-regulation; that's correct.
13 Yeah.
14 DORIS GRINSPUN: But I -- you are
15 already setting an agency. Okay. I understand.
16 IAN DESILVA: That's correct. Yes.
17 DORIS GRINSPUN: I understand. So --
18 IAN DESILVA: So we do -- we believe
19 our position is very familiar.
20 DORIS GRINSPUN: Yeah.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Okay.
23 IAN DASILVA: Yeah, and we -- you're
24 familiar with us, Ms. Grinspun.
25 DORIS GRINSPUN: No. Now I

1 understand --
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 This is sounding like a political debate, so --
4 I couldn't --
5 MIRANDA FERRIER: [Indecipherable].
6 COMMISSIONER FRANK MARROCCO (CHAIR): I
7 had no idea -- I was -- I would have put my gown
8 on.
9 SAMIR SINHA: This is why --
10 IAN DESILVA: It's a very contentious
11 issue in Ontario right now, the [indecipherable] --
12 SAMIR SINHA: This is why I wanted a
13 frontline seat. Okay. So let's -- so there's been
14 a lot of comments to my comments, but again, you
15 know, I've been researching this as well for a long
16 time, and I just wanted to -- I just wanted to,
17 kind of, string together a few things because I
18 think it's helpful to make sure that we have the
19 right facts, Number 1.
20 So Number 1 in terms of the comments
21 earlier about CIHI's recent report, the 2020 Report
22 saying about 8% of Ontario residents, you know,
23 could -- you know, long-term care entries could
24 have probably been avoided, right?
25 You have to realize that I've -- I work

1 with -- I've been working with CIHI on these two
2 reports. The latest report that they did used a
3 different methodology from the 2017 report which,
4 again, talked about 11 to 30% of residents actually
5 entering a long-term care home.
6 So the methodologies are different, but
7 the point is it's about 8 to 30% of people entering
8 into our long-term care homes currently are people
9 that we think we could have actually supported at
10 home.
11 And that, again, goes to the idea of,
12 like, what do these residents have; what are their
13 actual needs, and why aren't they being well
14 supported at home?
15 So, for example, 10% of the residents
16 entering into a long-term care home in Ontario
17 right now have dementia with very light-care needs,
18 right? They actually don't need bathing. They
19 don't need dressing. They don't need to have an RN
20 there 24 hours supervising their care. They're
21 people who could be supported at home if we had the
22 right supports in place in the community. And
23 there are other examples of that when you start
24 looking at the overall CIHI data, saying that there
25 are a lot of people who are being prematurely

1 institutionalised currently, you know, from that
2 perspective.
3 So I just wanted to make sure that we
4 understand because it's not the notion that people
5 end up in long-term care because they can't be
6 supported in home. It's because we actually
7 haven't organized our system well enough in the
8 community for a lot of these same issues that we're
9 talking about, a lack of staffing, a lack of
10 services and support, a lack of coordination in
11 that way.
12 So we just released a White Paper
13 yesterday, our National Institute on Ageing, that
14 actually looked at the entire Ontario situation,
15 that actually talked about what do these people
16 look like; what are their needs? And I put that in
17 the chat box there so that we could understand,
18 again, that it's not just a matter of having a list
19 of diagnoses. It's actually having a list of care
20 needs which in many respects could actually be
21 supported in the home, in some cases, but of
22 course, when you do, ultimately, need to be in a
23 long-term care home, what does that actual need
24 look like?
25 And I think, to a certain extent, you

1 know, I think we've already heard from my
2 colleagues, for example, that it's not just having
3 dementia, but it's -- or having incontinence, but
4 it's that care that's actually needed and that
5 support. And frankly, when you just have a lack of
6 time to do that care, I think, as Miranda was
7 saying, then the challenge is is that, you know,
8 the care just doesn't get done, and then people
9 deteriorate.
10 So in terms of the -- I agree with you,
11 and I hope we can just -- but I don't want to use
12 titles like Doctor, this and that, Justice,
13 whatever. I would just ask if we can all go by
14 first names because that's what I see, if that's
15 okay with everybody.
16 But, Frank, to your -- to your question
17 about the funding issues in terms of how do we
18 actually fund right now, again, we have a care --
19 we have a funding envelope that goes to a home.
20 Obviously, you have your personal care funding
21 envelope that funds the largely PSW, and, you know,
22 kind of, RN and RPN time, for example, that goes.
23 But, again, funding doesn't actually --
24 is -- funding's not necessarily based on quality.
25 It's based on us saying, for example, right now,

1 here's the standard care envelope. You know, it
2 will be adjusted up and down based on the
3 complexity. And you're right. If the complexity
4 lowers, you get less funding, so there is a
5 disincentive there.
6 You know, if you actually have
7 everybody bedbound and actually everybody looking
8 horrible, and frankly, we've had issues where homes
9 have gained their MCI scores to try and get more
10 funding, you know, that comes along with it; well,
11 that doesn't drive quality as you -- as you just
12 noticed.
13 So one good thing the Commission might
14 want to look at is what was actually being proposed
15 in the U.S. under Medicare where they were actually
16 looking at a program called the Interact II
17 Model -- and Interact -- and the idea was that it
18 was the notion that you're actually going to start
19 funding homes also based on quality.
20 So what are bad markers of quality, for
21 example? It could be the -- like, it could be
22 those markers that you actually do get through the
23 interRAI Assessments where you can actually see,
24 you know, high rates of antipsychotic use, for
25 example; high rates of restraint use, for example.

1 You can also look at acute care transfers, ED
2 transfers. You can look at hospitalization rates,
3 et cetera, because funding was actually going to
4 follow or funding would be determined in a
5 mechanism that homes that weren't performing well
6 on these quality measures, that would actually
7 impact that funding because all of a sudden then,
8 you have a funding care envelope that hopefully is
9 reasonable, and then you're actually staffing, or
10 you're making sure that you have a skill mix that
11 can better respond to what the clinical needs are
12 of the residents there.
13 There is no incentive to do that right
14 now, and I think it really is more about, I've got
15 money. I'm just going to hire whoever I can to get
16 the job done in that care envelope.
17 And frankly, I think what really drives
18 a lot of this is, frankly, who's available to hire
19 around the corner. And I think that really drives
20 that issue as well. I'm glad my PSW friends are
21 nodding, I think, in approval from this.
22 So then I want to go to the point about
23 -- Doris had mentioned, for example, that, you
24 know, who -- like, what was my comments about NPs
25 coming to me. Yes, we don't actually have

1 representation here from the nursing -- Nurse
2 Practitioners' Association of Ontario because, yes,
3 I know -- I know you represent them, too, Doris,
4 but they also have their --
5 DORIS GRINSPUN: But the majority of
6 them, Samir, you are -- you are mistaken. The
7 majority, 1,700 NPs are members of RNAO compared to
8 420 of -- so please -- please get --
9 SAMIR SINHA: Right. Right. Fair
10 enough. Exactly, but I -- but I would also say, in
11 terms of where did this conversation happen, well
12 when the Government basically said, we're going to
13 put in NPs a few years ago, great; I said, that's
14 fantastic; we need more advanced skill
15 practitioners especially when, in many cases, you
16 can't find medical directors, or you can actually
17 have that -- we do need more people with the skills
18 to provide care and oversight.
19 I don't think it needs to be an
20 either/or situation, and if I -- if I was -- if
21 that's, kind of, what was interpreted in my results
22 about, you know, you only need NPs when you don't
23 have doctors, no. It's -- the point is you need to
24 have that skill in place. And in some cases, for
25 example, if you don't have a physician, for

1 example, well, and -- but you do have NPs, great,
2 you can have that. But again, whatever model
3 you're actually creating, you need to make sure
4 that you have enough of the right skill in place.
5 And the challenge I had is when the
6 Province announced the NP Program, for example, it
7 was the NP Association of Ontario, not the RNAO,
8 but the NPAO Association of Ontario that came to me
9 and basically said, okay, we have a problem here.
10 And I was advocating behind the scenes because here
11 is the challenge in Ontario: When -- if you're in
12 NP training, right, and I -- and I am on the Board
13 of Ryerson University which has the largest school
14 of nursing in Canada and has an NP training program
15 as does U of T, everywhere else, you will realize
16 that unlike the U.S., NP training, there's actually
17 a geriatric NP training stream. There is no
18 training -- the geriatric NP training stream. You
19 either do pediatric, or you do adult NP care.
20 But I can tell you the NPs that I work
21 with through our program in geriatrics at Sinai,
22 when we hire an NP, we have to put them through a
23 training program so that they can feel very
24 comfortable doing the level of geriatric care we
25 want them to be doing and support them. We have

1 very great NPS, but we -- they often tell us, or
2 they've come to us saying, we haven't been given
3 the training and the skills that we need.
4 We also see this -- like, and I
5 think -- and I'll ask Miranda and Ian to comment on
6 this, but even for our personal support workers,
7 depending on where they're getting their training
8 and how they're getting their training, right,
9 it's -- sometimes it's not necessarily -- you're
10 taught how to bathe someone, but how do you bathe
11 someone who has aggressive behaviours and is going
12 to do that?
13 And so I think, partly, it comes down
14 to (a) the educational mix. And this is not about
15 an NP, a PSW, an RN issue. The doctors who are
16 working in these training, they're not getting
17 skills in geriatric training or skills. They're
18 not necessarily doing, say, a medical director
19 training course and so on, so you've got maybe a
20 physician, a medical director in a home who may not
21 appreciate the skills and the needs of the
22 patients -- or the residents who are there, and
23 then may be working with other providers who also
24 don't have the right training and support.
25 And I think -- and I think the key --

1 the bottom line is we've got to make sure that
2 whatever education that we are putting in -- or --
3 that it actually has to make sure that folks are
4 feeling well-supported and qualified to doing the
5 training because you can have the mix of whatever
6 types of people you want in a home, but if they
7 don't actually know how to work within their scope
8 of practice for that particular patient population,
9 then we're just deluding ourselves that we can
10 actually achieve quality care.
11 So the final thing I just wanted to say
12 was I think that -- I think (a) if we just say --
13 like, I think back to the point is, right; you
14 know, you can say right now that, you know, you
15 have to have 'X' number of PSWs or 'X' number of
16 NPs or 'X' number of RNs or 'X' number of doctors
17 or whatever the case is. The problem is it's the
18 reality across Ontario, we've got some communities
19 where you don't have one or you don't have the
20 other or you have too many of everything, right?
21 And so the question is, I think where
22 we defeat -- and this is why the Province has gone
23 to this role where they say, just have one RN;
24 hopefully have a medical director, and then you
25 figure out the rest in your care envelope.

1 I don't think that's the right
2 approach, but I also think that we can put
3 ourselves in danger if we say this is the one
4 formula you need to have. You need to have, you
5 know, for -- if you have a hundred patients, you
6 need to have, you know, ten personal support
7 workers; you have to have three RPNs; you have to
8 have one RPN, one NP that -- what happens if you
9 don't have one or the other, for example?
10 And I think this is where, again, we
11 need to think about ratios or formulas or
12 recommendations to say, if you don't have any -- if
13 you don't have enough 'X' -- like, RPNs to do a
14 certain role or RNs, you know, what is that
15 balancing measure so that you -- so that homes
16 actually know what they should be working for, and
17 then you can tie that funding overall to quality
18 based on what we think that group, whatever that
19 mix is, can actually deliver. So I'll stop there.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 All right. Irmajean, you were -- you were trying
22 to get a word in before. What did you want to say?
23 IRMAJEAN BAJNOK: Well, there were a
24 couple of things. One, I do want us to go back to
25 that basic care guarantee, and I think if you

1 listen to what the RNAO has been saying and others
2 who agree with this, the base is gone. It's
3 dropped. We need to set that base, and then, okay,
4 Samir, and the others around the table, we add
5 those pieces for quality. But without that basic,
6 it's not going to happen.
7 And I am just a little bit concerned
8 about this point that we need regulation because
9 PSWs aren't providing safe care; they're not
10 providing competent care. That isn't true.
11 Right now, we don't have enough of
12 anyone. We don't have enough PSWs. We don't have
13 enough registered nurses, registered practical
14 nurses, NPs for the whole team to work together to
15 ensure the safe care. Regulation isn't going to
16 help if nothing happens to that basic foundation of
17 what care should look like.
18 And, you know, to me, this really is
19 getting to look like a rabbit hole that, okay, so
20 do you regulate someone with a body of knowledge
21 that's six months -- so what do you do? Do you
22 increase it? Well, you know, and then you've
23 got -- you do have registered nurses and registered
24 practical nurses. They are there. They are giving
25 care for older persons in their curriculum. And

1 there are many ways that registered nurses and
2 registered practical nurses do get additional
3 education to care for older persons.
4 But again, if you're spread so thin,
5 nothing will help. So get the basic in place, and
6 then we can add for that quality, for that
7 excellence, but right now, safe basic is what we
8 need to focus on.
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Do you not -- would -- if you were -- if we're --
11 you're relying on a registered nurse or a
12 registered practical nurse in a supervisory
13 capacity, do they not have a bit of a problem in
14 the sense that they're employed by the corporation
15 that's running the home and accountable not only --
16 they're, kind of, accountable to the corporation
17 and the corporation's policies? If they're the
18 only person you're relying on for supervision, does
19 that -- are they in kind of a conflict?
20 IRMAJEAN BAJNOK: Well, it's no
21 different than registered nurses working with any
22 other staff. You work together as a team. You do
23 the assessments. You work to make sure that the
24 individual can carry out those aspects of care for
25 which they do have the education.

1 And every registered nurse is
2 employed -- not every, but the majority are
3 employed by some organization. And that really,
4 then, is the basis of you providing ethical
5 practice.
6 And sometimes we find that many of the
7 care operators would prefer not to have the
8 registered nurse who can oversee and can see where
9 some of the shortcuts are being taken and how
10 quality is eroding. And we do hear that, that
11 nurses are challenged when they see things that
12 operators would prefer they not see.
13 So we do need the team. We do need the
14 education base, and we do need to make sure that
15 the RN is providing the care that they're qualified
16 to do, and the PSW is providing the care they're
17 qualified to do, regulated or not. If you don't
18 have enough of them and they don't have the
19 knowledge base, they can't give the full spectrum
20 of care.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 No, and I appreciate that, that regulating them
23 doesn't address the problems you've mentioned, but
24 do you not feel that there's -- that they -- there
25 needs to be a public accountability for their

1 behaviour the same way that there's a public
2 accountability for the doctor's behaviour and for
3 the nurse's behaviour? Why would -- why would one
4 group -- why would they be exempt from that?
5 IRMAJEAN BAJNOK: Well --
6 IAN DESILVA: Miranda, would you like
7 to address that?
8 Miranda -- I think Ms. Ferrier would be
9 the best -- someone could look at that one.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Just hold on. No. Wait a minute.
12 DORIS GRINSPUN: [Indecipherable] not,
13 quite frankly.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 I was asking Irmajean because I was just trying to
16 follow up on what you were saying.
17 DORIS GRINSPUN: And I want to go
18 after.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Certainly. Certainly, Doris. I would -- I
21 wouldn't dream of not doing that. I promise I
22 will. But --
23 IRMAJEAN BAJNOK: Well, again I get
24 back to this question and say, why are you asking
25 this question? I have not had a lot of evidence in

1 this whole pandemic, and the -- you know, havoc
2 gets wreaked in long-term care. I have not heard
3 people say that PSWs are just making a mess of it.
4 In fact, it's the contrary -- that -- and I think
5 in situations where you have that team, where you
6 have registered staff being able to assess what are
7 some of those needs and then working closely with
8 the PSW so that the care they're delivering is
9 based on what they are prepared to do.
10 Right now, if there are issues, it's
11 because the PSW is, in fact, there within, as
12 Miranda already said, cases where there isn't even
13 a registered nurse. And that does -- relieves the
14 PSW from the stress, the anxiety, the fact that
15 they want to run away from a long-term care home --
16 as you say, you're not finding them because they
17 feel they're in it by themselves. Again,
18 regulation will not help that.
19 I think they are responsible people,
20 and the -- I'm not certain that regulation will
21 help in this situation. Get the basic care there,
22 and then we can look at what else do we need to get
23 the quality that -- and excellence.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Doris. Doris.

1 DORIS GRINSPUN: So, Commissioner, and
2 everybody, I'm quite fascinated that we focus so
3 much on the public accountability, and yet the
4 Government just took away the public accountability
5 of the operators and organizations that are
6 actually providing the services to the seniors and
7 where families are in anguish because, actually,
8 they cannot close the cycle of suffering that
9 they're having.
10 So I am -- I am quite disturbed that
11 you are speaking so much about the public
12 accountability, and maybe in your report, you also
13 will comment in the public accountability of
14 allowing nursing homes not to be sued because
15 that's what the regulator -- that's, if there are
16 challenges, they discipline the health
17 professional, so if there are challenges, they
18 should discipline the nursing homes. But that was
19 washing their hands, right? Because that's to
20 support, of course, the big chains that it is a
21 political issue, and you are quite right.
22 But if we are going to deal with
23 regulation, we are going to go back at the
24 regulation of nursing homes and the ability of
25 families to get answers that they need and deserve.

1 I want to get back to the skill mix
2 because the issue of regulation or not regulation
3 has many added agendas that we have become recently
4 aware, but you know what? Let it take its course,
5 and it will go wherever it needs to go, and that's
6 why I was asking Mr. DaSilva if he was overseeing
7 that agency that is being set up, but that's a
8 different story.
9 I want to go back to the basics for
10 these residents that continue to die today,
11 meanwhile that we continue to have conversations.
12 What they need now is action. RNAO is fully aware
13 that there is enough RNs, RPNs, PSWs, and NPs to
14 deliver the care for at least 3.5 worked hours at
15 this point because we have the data bases and
16 because we deployed -- we deployed thousands of
17 them to the homes during the first round, during
18 the -- through -- via nurse. So the people are
19 there, so they -- they -- if you hear from anybody
20 we don't have enough people, we do.
21 If you don't have a basic, you will
22 continue to have poor care. If we don't have a
23 basic, you will continue to have poor care.
24 If we cannot say that we need
25 48 minutes in a day, 24 hours, of RN care that

1 brings that level of expertise and 60 minutes of
2 RPN care, then we may as well go home and put PSWs
3 only, and more and more will quit, and more and
4 more will feel disheartened because they're calling
5 us. They're calling Miranda. They're calling us
6 as well.
7 If we want to use all kinds of
8 triangulation about nurse practitioners, let me
9 tell you, RNAO represents, to be very clear, the
10 great majority of nurse practitioners. We had
11 [indecipherable] as twice a week with the 60 that
12 work in nursing homes throughout the pandemic. We
13 heard their cries, not because they didn't know
14 what to do. In fact, they are experts in the
15 field, but because they didn't have enough hands,
16 boots, whatever you want to call them, in the homes
17 at the time, not of PSWs, not RNs, not for RPNs,
18 not of anything. And they were working 16 to 18
19 hours on site there. So it goes back to the same,
20 and it's not during COVID only.
21 First of all, we better be prepared
22 that new generations and governments will have two
23 pandemics a year of different types, different
24 types, pandemics or epidemics, of different types.
25 We have the flu every year. We have other issues

1 every year. We have the -- you know, just look in
2 the back -- in the last ten years. COVID went
3 by -- as a pandemic, but epidemics, we have all the
4 time, and serious issues we have all the time.
5 So -- and the residents that come are even, without
6 those issues, very compromised.
7 So if we believe that six months of
8 education -- I would say move to one year of
9 education at the very least before we even start to
10 talk about something else, more serious problems of
11 education, and then we can start the conversation
12 of what else is needed.
13 But at this rate, with six months of
14 education and having only PSWs and even not enough
15 of them, you know, I fail to understand how it will
16 go, but you have our formula. You have the
17 evidence behind the formula. It's well based. It
18 has been for many years. We are not the only ones
19 supporting that, and we're not supporting it for
20 RNAO because let me tell you, one NP for 120
21 residents or, you know, 48 minutes of an RN in
22 nursing homes is not going to make RNAO richer or
23 less richer.
24 It may add if they regulate, but if --
25 it will not hear -- you know, our bulk of our

1 nurses are inside in hospitals and in-home care, so
2 it's not about that. It's about what the residents
3 need. So we don't have a secondary or tertiary
4 agenda but agenda of the residents, and that's
5 where we will continue to speak.
6 MIRANDA FERRIER: Can I cut in now?
7 Are we --
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Yes, go ahead, Miranda.
10 MIRANDA FERRIER: Just for the record,
11 we do agree with the majority of what the RNAO
12 stands for and what they're trying to put in place
13 with this base of care in long-term care.
14 We obviously don't see eye to eye when
15 it comes to the regulation of personal support
16 workers, but I welcome the opportunity to change
17 Doris's mind at any point.
18 DORIS GRINSPUN: And when we can talk
19 about that if you [indecipherable] --
20 MIRANDA FERRIER: Absolutely.
21 DORIS GRINSPUN: -- year education, we
22 used to have the nursing assistant with the year
23 education.
24 MIRANDA FERRIER: Yeah.
25 DORIS GRINSPUN: And we suffered when

1 we lost that, you know?
2 MIRANDA FERRIER: No. I know. I know,
3 but PSW has different links. If we can agree on
4 one curriculum for the personal support worker,
5 that would be fantastic. We have the PSW and
6 Community College.
7 Like, Samir, that's playing right to
8 what you were saying. The education that is
9 required for a PSW in long-term care in order to
10 bathe an aggressive resident or deal with
11 aggressive residents, that is not taught in -- both
12 in career and Board of Education Courses. It is
13 taught in the Community College course.
14 So I'm a Community College graduate for
15 the PSW program, and we were given a very huge
16 overview of aggressive dementias, how to protect
17 yourself, how to protect your resident, your
18 residents' rights, et cetera, et cetera.
19 Now, to say that there's an abundance
20 of PSWs and nurses in the Province of Ontario, that
21 is true. There is an abundance of personal support
22 workers. There's a ton of them, but they don't
23 want to work in the sectors. They don't want to
24 work as PSWs. That's just the plain truth.
25 The reason why we're pushing for a

1 professional recognition or professional title,
2 title protection for the PSW is because,
3 unfortunately for the PSWs, we now have another
4 level of worker coming up behind the personal
5 support worker, and we're not regulated.
6 It's one thing to have RN, RPN, and
7 then PSW, cool. But now we've got a resident
8 support aide. We've got supportive care providers.
9 We got home-support workers. We have all these
10 other objectives and other, you know, entities that
11 are popping up, and they're stating, well, the PSW,
12 or the RSA can do this, or the -- you know, the
13 supportive care provider can do that.
14 Well, until the PSW is a protected
15 title and we protect that profession, I can't tell
16 you how many PSWs leave the field because of the
17 fact that they don't feel professional respect
18 because they don't have that badge.
19 When I went to -- I was at Mohawk
20 College with McMaster University and did my PSW. I
21 saw so many nursing students with Nurse across
22 their butt on their jogging pants and wearing their
23 sweaters with pride. That doesn't happen for the
24 PSW.
25 Now, since the Association's creation

1 within the last six years, we're seeing more of
2 that, but there has to be that type of pride.
3 And, Frank, and to speak into what
4 you're saying about, you know, the accountability
5 factor in long-term care homes, I completely agree.
6 Right now, a PSW can abuse or be accused of abuse
7 in a long-term care facility. It can be
8 happenstance. They don't have enough proof. Well,
9 that PSW picks up, goes down the street to the next
10 long-term care facility, and bada-bing bada-boom,
11 doesn't use that reference from the past long-term
12 care facility and gets hired in the next one, and
13 the cycle of abuse continues. I've been talking
14 about this for over a decade. This has been our
15 reality.
16 So I think, you know, something along
17 the lines of we -- it's not -- and it's eight
18 months, by the way. It's, like, eight to ten
19 months for the PSW and Community College. The
20 Career College is in Board of Education. You can
21 see where I'm going with that. This is not where
22 the PSW program needs to be.
23 I think that's pretty much what I
24 wanted to say, but I just -- we were speaking with
25 the Ministry of Long-Term Care the other day,

1 obviously, as were our colleagues, and, you know,
2 one of the things we said was there needs to be
3 oversight accountability in long-term care
4 facilities through our association. We can do
5 that.
6 So just like with the other
7 professional associations, we have liability
8 insurance. We have that oversight factor to ensure
9 they are who they say they are. They wear a badge.
10 They have the proper education. That might be a
11 place to start.
12 So we need to start somewhere where we
13 can make it a profession of choice where people
14 want to come in and be personal support workers and
15 move on from there. That's my piece.
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Dr. Kitts.
18 COMMISSIONER JACK KITTS: Yeah, I
19 just -- I just want to summarize so that I -- to
20 see if I understood. It's been a tremendous
21 debate, but sometimes a little hard to follow.
22 So in terms of the residents in the
23 long-term care homes, there is more appropriateness
24 today than there was ten years ago helped by the
25 Home First and Aging in Home program, but it hasn't

1 maximized yet. There is still room to keep people
2 out of long-term care and at home longer, and that
3 will require more resources of investment in home
4 and community care.
5 So while the acuity level is up, it is
6 not at the level of hospital or subacute care. It
7 still is the type of care that we've been
8 providing. However, we need to look at the skill
9 mix because of the change in resident acuity.
10 SAMIR SINHA: Agreed.
11 COMMISSIONER JACK KITTS: So what I've
12 heard is that PSWs are the base -- the basis. They
13 provide the activities of daily living, the heavy
14 lifting, the feeding, all of those ADLs. And so
15 start there and then move up to the RPN, look at
16 that base, look at RNs, base it on the patient
17 acuity; nurse practitioners fill an important role,
18 and then there's the medical director. Those are
19 the components of it.
20 The challenge is that sometimes it's
21 difficult to get medical directors. They're not
22 in-house. Nurse practitioners can be, and -- and
23 in -- during the pandemic, did fulfill the role of
24 medical directors by a special Act. So that's a --
25 that's an opportunity to look at roles and

1 responsibilities in order to improve care at best
2 cost. I think that's --
3 So the key -- and here's the key issue
4 I see is that all of you, PSWs, nurses, MDs have
5 said that long-term care homes don't get the
6 respect that the rest of the health system seems to
7 get, and, therefore, people who work there feel
8 like somehow second-class caregivers.
9 And so -- and it's hard -- it's hard to
10 find -- there are PSWs and nurses and doctors out
11 there, but it's hard to get them to work in
12 long-term care homes. And what we've heard over
13 the last few months is the lack of respect and not
14 feeling valued is really important, and the work
15 environment --
16 IAN DESILVA: Very much.
17 COMMISSIONER JACK KITTS: -- is also
18 critical in that it's often short-staffed. You're
19 working more shifts. You're working overtime.
20 You're caring for more patients than you can
21 possibly handle, and at the same time, now your --
22 the system is looking at lower -- less-skilled,
23 lower-cost workers to actually replace you because
24 you're not there.
25 MIRANDA FERRIER: Yes.

1 COMMISSIONER JACK KITTS: Is -- and so
2 in the end, we understand that the acuity is more,
3 but it's not sufficient to bring in the troops, but
4 we also understand that we have to change the
5 environment --
6 MIRANDA FERRIER: Yes.
7 COMMISSIONER JACK KITTS: -- and
8 somehow get these -- I like what you said, Miranda,
9 the healthcare workers that are wearing -- nurses
10 or PSWs or MDs on their backs at school should be
11 doing the same thing if they're working in a
12 long-term care home or anywhere else.
13 MIRANDA FERRIER: Exactly, yeah.
14 Exactly, yes.
15 COMMISSIONER JACK KITTS: So -- and I
16 guess the base is based on ratios or formulae to
17 provide good care and then leave the fine-tuning to
18 the local requirements. Is that -- is that
19 what I -- what we've kind of come to?
20 SAMIR SINHA: I agree with all that,
21 and I just wanted to -- no. I thought that was --
22 yeah, you're a good listener, and you could cut
23 through all of our banter. But, no, I mean, I
24 really do agree.
25 And I just wanted to pick up on that --

1 one of that -- last points about, like, so when we
2 have the workers there because this is what I --
3 like, my PhD was actually called the Sociology of
4 Interprofessional Relations where I looked at all
5 of this whole dynamic between different groups,
6 and, you know, and that fundamental piece that I
7 think that Miranda raised was we actually have the
8 workers out there. Doris and Miranda and others
9 have said, like, we do have the workers. It's
10 just, why do people not want to come in? And that
11 includes MDs, right, you know, in terms of why do
12 physicians not want to come in and, frankly, do a
13 good quality job supporting their other colleagues
14 too, right?
15 And so -- and I think part of that is,
16 you know, I look at a three -- three key issues
17 there. Like, how do you get people to want to come
18 and actually work here because of that lack of
19 respect, and I think you really articulated that
20 well in your letter and hearing that clearly. And
21 I think part of it is just simply wage parity, for
22 example, and it's not so much for the physician
23 side.
24 It's more the idea that, frankly, a
25 lack of respect comes when as an RN or as a PSW,

1 you know, you basically -- you will get -- you will
2 get a pay cut because you work here versus there.
3 And, frankly, that pay cut's even worse if you
4 actually don't even work in a home or an
5 institution when you're working in home care.
6 So you can imagine the conversation
7 we're having about care in a long-term care home,
8 you know, this is a worse conversation out for our
9 community colleagues, you know, who work in
10 everybody's individual home because you take an
11 even greater pay cut.
12 So in countries where you actually
13 have -- or in jurisdictions where you have wage
14 parity, that all of a sudden, it's just -- you
15 know, then you really get down to the other part
16 is, do you actually have enough staff to begin
17 with, and can we make sure these homes are properly
18 staffed?
19 So back to as Doris, you know, was
20 saying, like, if we actually have that basic -- you
21 know, that basic funding envelope that says, well,
22 you can get a basic care guarantee with, you know,
23 a concept of ratios that can be tweaked according
24 to the home's needs -- and with that.
25 But I think within that is that

1 conversation about the education because you could
2 have the right numbers of people on paper, but
3 again, I think as Doris recognized -- and again,
4 this was -- it was recognizing that NP colleagues
5 were being asked to do roles in long-term care,
6 and, you know, and it was -- it was, why was it the
7 Association?
8 I don't think it's -- it should be the
9 role of the Association to help people fill in
10 knowledge gaps. It's a good role of what an
11 association can do, but fundamentally, when -- you
12 know, I helped to rewrite the American Red Cross
13 textbook for nurse assistant training or PSWs
14 because I sit on their advisory council, and it was
15 shocking when I went through their textbook; and I
16 was, like, why are we not talking about skills for
17 working with people with dementia when 70% of these
18 residents have dementia? Why are we missing these
19 things?
20 And so we've made sure we revamped the
21 training programs in the U.S. that train -- the
22 Red Cross trains 40,000 personal support workers,
23 but it's making sure, just as Miranda was saying,
24 that why was her program at Mohawk College teaching
25 her a skill set that others weren't?

1 So it's making sure that if you're an
2 NP, an RN, a physician, a PSW, whatever, you're
3 actually getting the training so that you could
4 work and be successful because, frankly, just
5 being -- when you're working in a home where you
6 don't have enough colleagues or even if you have
7 enough colleagues but you don't necessarily have
8 the skill sets so you can feel successful at the
9 work that you're doing, it helps to understand why
10 the turnover rates in these homes are so high.
11 I think, one, because there's just not
12 enough people, so you get burnt out easily; you're
13 not getting paid, and so you rather go to the
14 Ottawa Hospital where you get a much better
15 paycheque; and then, finally, if you -- when you
16 put staff in -- and I see this with my MD
17 colleagues all the time, it's demoralizing when a
18 patient just keeps hitting you all the time, and
19 you're not actually given the skills to say, how do
20 I actually work with that person and develop a care
21 plan because I've been given these knowledge and
22 skills?
23 We're setting people up for failure
24 when we don't make sure they have the right
25 education; there's not enough of them, and then we

1 tell some people are worth more than others by not
2 achieving wage parity.
3 So -- and I think -- and I think what
4 the -- and I think what B.C. did very well, you
5 know, at the very beginning was because, say, RNs
6 or PSWs, et cetera, are being paid at variable wage
7 rates, they secured the staffing in B.C. by saying,
8 we're going to take the top wage rate and make sure
9 that everyone's getting paid at least the same
10 wage, and we'll secure staff that way.
11 And I think that worked well in
12 addition to also recognizing months ago that they
13 need to recruit a lot more people into long-term
14 care homes because they just had a shortage as
15 opposed to creating these new roles of RSAs and all
16 these other things because, frankly, it's just
17 cheaper to get boots on the ground and at least say
18 you're -- you know, you're staffing the home up.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Doris, you wanted --
21 DORIS GRINSPUN: I just want to make
22 sure that Samir did not get the wrong impression,
23 perhaps, from me because I heard you, Samir, say
24 that the Association, and maybe you were speaking
25 about Miranda and PSWs.

1 But I did not mean that the twice a
2 week that we met with NPs was to fill in their gaps
3 in knowledge. They're experts. What we were doing
4 was helping them develop centralized materials like
5 policies because the homes didn't even have them.
6 So, please, do not -- I read with great
7 pain -- and I say it again -- the transcripts where
8 you said that NPs were coming to you because they
9 didn't know. Maybe that was 20 years ago.
10 SAMIR SINHA: That was actually --
11 like, Doris, please, let me say that, again, I'm
12 going to be lying and I will be disingenuous if I
13 say that all of my colleagues, MDs, NPs, PSWs,
14 everybody has adequate training in geriatric
15 knowledge. We do not mandate this in any school.
16 DORIS GRINSPUN: [Indecipherable] --
17 SAMIR SINHA: So I think it's -- I
18 think it's wrong when we say that everybody are
19 experts. I can tell you right now that --
20 DORIS GRINSPUN: I didn't mean to
21 [indecipherable] -- so please --
22 SAMIR SINHA: -- that I work with many
23 NPs -- yeah.
24 DORIS GRINSPUN: Samir, I did not
25 interrupt you. Please do not interrupt me. Thank

1 you.
2 SAMIR SINHA: Okay.
3 DORIS GRINSPUN: The 60 NPs that work
4 as attending NPs in nursing homes are experts in
5 geriatric care, and you know that, Samir. Please,
6 if you want to meet with them and test them, I will
7 test your doctors, and they will know more.
8 I don't want to have that discussion.
9 I don't know who and when came to you, but the
10 60 NPs did actually training and are experts. And
11 when we met with them twice a week, was to support
12 them on the pain -- on the pain that they couldn't
13 find medical directors, hence why they did the
14 order for medical directors on the pain that they
15 didn't have enough PSWs, RNs, and RPNs to home --
16 to delegate any of the orders that they were
17 putting.
18 They simply did not have people. They
19 were working 16 to 18 hours because that's the
20 beauty of NPs. They are on site all the time, and
21 that's the difference between NPs.
22 So, please, do not -- I do not want to
23 hear from someone else later on again that we heard
24 Samir saying -- we heard Samir saying that twice a
25 week you met to train NPs because they didn't have

1 the knowledge. I want the Commissioners to
2 understand what I am saying. The rest can spin it
3 the way they want.
4 SAMIR SINHA: Fair enough. I --
5 DORIS GRINSPUN: For the records -- for
6 the record, the 60 NPs that are working in nursing
7 homes are experts in their field, experts, and they
8 act as attending NPs because there is no attending
9 physician, and that's why the role was created.
10 Two years ago, this current Government
11 said they were going to provide the money for the
12 additional 15 that McGuinty already promised. That
13 still has not happened, and we need one NP per 120
14 residents if we want to have homes in better care
15 in addition to what we said of the four worked
16 hours of care of RNs, RPNs, and PSWs which we need
17 more of every one of them.
18 SAMIR SINHA: Okay.
19 DORIS GRINSPUN: So I just want to
20 clarify what's the situation with the knowledge of
21 our College because that is--
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Can I --
24 DORIS GRINSPUN: -- it's quite
25 disrespectful.

1 SAMIR SINHA: Okay. No. And just I'd
2 just like to respond. So I'd just like to --
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Doctor, if you can just hold on a second.
5 SAMIR SINHA: Sure.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Irmajean's been trying to -- what did you want to
8 say?
9 IRMAJEAN BAJNOK: Oh, I just did want
10 to make it clear that I think you mentioned we've
11 all agreed that we leave this up to the homes to
12 decide how many staff and what areas and what mix.
13 And I certainly don't recall us agreeing.
14 The basic care guarantee is what we're
15 saying is that foundation that does say four hours,
16 worked hours of care, plus the RN care at 48
17 minutes, the RPN care at 60 minutes, the PSW care
18 at 132 minutes. And then we talked about, okay,
19 the -- that will give you the basics.
20 Beyond that, we can start looking at
21 where to add frills for quality, for excellence,
22 and some of the other things we're talking about,
23 but time is of the essence. Let's get that basic
24 in place right now. We're getting close with talk
25 about four direct hours of care. Let's be clear in

1 terms of staff mix and move on, and then we can
2 tinker with what else to do for quality.
3 There just isn't time to be, you know,
4 making huge, huge kinds of system changes other
5 than requiring the four direct hours of care and
6 the staff mix that homes need to be obligated to
7 provide.
8 COMMISSIONER JACK KITTS: Yeah, I'm
9 sorry if I wasn't clear, but that's exactly what I
10 said. I agree with you.
11 IRMAJEAN BAJNOK: Okay.
12 COMMISSIONER JACK KITTS: The tinkering
13 after the base was local.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Dr. Sinha, sorry.
16 SAMIR SINHA: Yeah. No, and I -- and
17 so, thank you, Doris, and thanks for clarifying,
18 you know, the role of -- the RNAO played to support
19 the NPs working in long-term care.
20 So, again, I just want to reiterate the
21 point I'm trying to make is, is that when we don't
22 have foundational education in Ontario for our MDs,
23 our NPs, our RNs, you know, our PSWs to make sure
24 that, on entry to practice, they have the full
25 knowledge and skills to feel comfortable because,

1 again, we can't deny my truth, right?
2 And I want to be very clear on the
3 record, my truth is is that the nursing -- the
4 Nurse Practitioners' Association of Ontario, not
5 your association, came to me with concerns that we
6 were almost setting up NPs, potentially, for fail
7 if we don't necessarily have the right training and
8 expertise coming in and making sure that we can
9 continue to support with continuing education
10 support.
11 I've had these conversations with my
12 colleagues who are PSWs, MDs, and everything. And
13 so I just want to make sure that we're not
14 splitting hairs, but this has been a concern, and
15 I've been approached many times, not 20 years
16 ago -- I've only been in Ontario for the last
17 ten -- but where colleagues who have been saying
18 that we still feel -- and, you know, yes, I think
19 many of our colleagues are experts in many aspects
20 of their care.
21 But not every -- but I think we could
22 do more to make sure on entry to practice training,
23 all of our professionals have the skills so they
24 can feel comfortable to even consider a career in
25 long-term care and feel that when they are in those

1 environments, that they can really work to their
2 scope of practice and feel well supported.
3 Because, as we all know, there are many of us who
4 don't know what we don't know sometimes, and it
5 makes it hard for us to achieve excellent quality
6 of care.
7 So again, I don't -- I don't represent
8 any association of any employees. I'm just -- my
9 truth is is that, again, when I see repeatedly --
10 and this is all in my report back in 2012 and
11 subsequent ones when we're not making sure that
12 people have the right education and skills they
13 need, it's great that if many people feel they are
14 experts, and there are many people who are experts,
15 but there are many people who could be -- you know,
16 who will be more successful when they -- when we
17 make sure that we're setting them up for success.
18 And that's what I was trying to mean, and I just --
19 I just wanted to say that very clearly.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Commissioner Coke.
22 COMMISSIONER ANGELA COKE: So there
23 are, obviously, other players in the mix in terms
24 of other professional folks who come in, you know,
25 allied professionals, therapists. And I'm just

1 curious your thoughts about the mix of those folks
2 and the availability, pharmacist, whoever the other
3 players are -- there are more people in the mix and
4 just curious if you have any thoughts about what
5 should be happening there or not.
6 U/T DORIS GRINSPUN: We -- so from our end,
7 we do, and that's in the document, too, we will
8 send you so that we don't take time here, but
9 absolutely, we do need them. The fact that
10 pharmacies, for example, that was cut recently --
11 the -- just before the pandemic, actually, that has
12 a huge impact on the homes, the relationship with
13 their pharmacist and the -- and availability.
14 But so does, if you look at social
15 workers, if you look at physio, that is
16 tremendously needed to -- for activation,
17 et cetera, so we will send you that.
18 COMMISSIONER ANGELA COKE: Thank you.
19 SAMIR SINHA: And I do think,
20 Commissioner Coke, it's that idea that, for
21 example, from a -- from a therapist standpoint, one
22 of the big things we did to improve the
23 availability of therapists, for example, in
24 long-term care homes is we went from having homes
25 work with direct contractors who were being charged

1 on a per-item basis or a per-thing basis to
2 actually giving a per diem so that the home now
3 actually had its own per diem budget of around $700
4 per year per resident so that that way, they
5 actually had a budget for physiotherapy, and then
6 they could provide physiotherapy, you know, as was
7 appropriate to meeting the needs of the residents.
8 But making sure you have those -- you
9 know, that we're acknowledging the different needs
10 that residents might have whether it be therapies,
11 for example; as Doris mentioned, social work. The
12 pharmacy role, which was very important -- when I
13 worked in long-term care in Baltimore, we had -- we
14 had clear roles and responsibilities where we were
15 expected as a medical director or the NP to work
16 with the pharmacist on a monthly basis to review
17 the medications. Actually, I have a wholesome
18 review to make sure we're doing that.
19 And some provinces like B.C. actually
20 mandate that where it's not mandated in Ontario,
21 that one could do this to make sure that we're not
22 over prescribing and that we're prescribing
23 appropriately.
24 Finally, the other piece is is that the
25 Ministry has been investing now in more community

1 paramedic services and supports for our long-term
2 care homes. The idea that we can provide more 24/7
3 responsiveness, for example, or more acute care
4 level supports that can be brought into the home,
5 so we certainly have nurse-led outreach teams that
6 have -- that are more community in-reach into
7 homes, for example, but they certainly aren't as
8 robust and extensive as we can. And there's some
9 good models where there are joint RN and/or NP and
10 community paramedic models or solely community
11 paramedic models.
12 I think that's, again, to,
13 Commissioner Kitts, speaking about -- speaking
14 about, you know, the acuity and how do you support
15 people to get care in place. For example, it's
16 also looking at the roles of some of those and how
17 they can complement and support homes -- residents
18 to actually receive care on site.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 I just wanted to get --
21 Sorry. Commissioner Coke.
22 COMMISSIONER ANGELA COKE: It's a
23 slightly different question if you wanted to follow
24 onto this topic?
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 No. I was probably changing the subject a little
2 bit myself. Go ahead.
3 COMMISSIONER ANGELA COKE: Yeah, it's
4 just, you know, we can get the right numbers, get
5 the right mix in place, but a lot of what I hear is
6 requirement for better leadership, better
7 collaboration, better teamwork, better work
8 environment that really respects people who can
9 come to work and contribute their best, and how do
10 you become an employer of choice instead of a
11 default, you know what I mean?
12 So, you know, I'm just curious.
13 Everybody has their specific skills and technical
14 expertise to bring to the party, but it is really,
15 you know, who and how are people providing the
16 leadership that makes this a place that people want
17 to come to work. And that is a culture issue. It
18 is about how the team works as a team.
19 Those are softer things, but they're
20 actually the things that are going to make it work
21 or not work. You can have all the numbers in
22 dysfunction. That isn't going to make it work.
23 So I am very interested in how people
24 are -- their leadership skills, their teamwork
25 skills, some of those softer skills that will make

1 the home a more, sort of, robust team to deliver
2 the care that people need.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 And I guess our questions are kind of the same. I
5 just wanted to add that I wanted to get the group's
6 view. It seems to me that if a nurse practitioner
7 can function in the absence of medical staff or in
8 an emergency, then is there any reason why the
9 nurse practitioner can't be functioning in that
10 position all the time?
11 Like, why would -- why would the -- why
12 would they be okay if there's nobody or if there's
13 an emergency but not otherwise okay?
14 So the impression I'm getting is they
15 should be doing it -- they should -- that there's
16 no reason for that.
17 Doris, you want to say something?
18 DORIS GRINSPUN: I want to comment on
19 two things: The previous comment about the --
20 which is hugely important about leadership and the
21 issue of NPs as medical directors, that should be
22 explored.
23 The issue of leadership becomes evident
24 hugely, for example, at the layer of the executive
25 director of a home or whatever title they have in

1 the different homes, depends on above, the director
2 of nursing.
3 And it's very, very clear, and there is
4 good evidence and data for that that in those
5 homes -- and this is something for you to explore
6 with families, by the way, huge time -- in those
7 homes where that person has a healthcare
8 background, they act in a way, way better -- in a
9 way -- in a much better way than when they don't.
10 When they don't, they simply have closed-door
11 policy, and they send them to the director of
12 nursing. When they do, they can converse with the
13 family. And this is in good times, not just now.
14 So this is something that we discuss
15 with Effie when she was the still the PA for
16 Christine, and that really needs to be pursued.
17 And I believe that they're very well aware of that,
18 and that cannot, of course, be achieved overnight
19 because you're not going to change everybody.
20 But it has a different type of backing
21 to respond to issues of families and of residents,
22 right, which is a basic for leadership. Leadership
23 is not an empty word, right? It's skills to bring
24 things together, et cetera, but it's also the
25 content of what is -- are the issues hurting both

1 staff and clients, in this case, residents and
2 their families. So that is something that should
3 be looked and worked with time because --
4 And the second piece on leadership, and
5 it's -- it's -- I mean, I'm sure that you already
6 looked at all the documents that we all gave for
7 the -- for the Wettlaufer Inquiry; all the issues
8 of leadership are mentioned there. Absolutely
9 there needs to be training, and there needs to be
10 ongoing training, both on soft leadership skills
11 but also on less soft leadership skills, say, chart
12 practices, [indecipherable] discrimination
13 practices which is -- which is rampant, rampant in
14 nursing homes with PSWs in particular because many
15 PSWs come from racialized communities.
16 As an aside, and if you're interested,
17 RNAO has a task person that -- that we can talk
18 more at some other point which will be
19 transformative for nursing and for others.
20 U/T On the issue of -- the issue of NPs
21 becoming on permanent basis or being able to become
22 on permanent basis as medical directors, my
23 recommendation from RNAO would be make it -- make
24 it possible by law, not make it mandatory because,
25 again, you wouldn't be able to do it overnight,

1 something like that.
2 But I think that my colleagues in
3 medicine need to make it a choice to actually work
4 full-time in nursing homes, and it's not today,
5 right? It's a secondary -- as I said, the second,
6 third, fourth job, and they can be full-time at the
7 hospital and then three nursing homes as medical
8 directors. So it's a secondary, tertiary income.
9 But I'm not concerned about the
10 secondary, teritary income. That's really -- not
11 at all. What I am concerned is the availability
12 when they're needed. And you need someone that is
13 on site, so I think the issue of attending NP could
14 be merged with the issue of medical director and
15 explore it, right? You wouldn't put two NPs, but
16 one NP that can act as this and as that, I think,
17 will start to streamline directives for what -- for
18 directing the orchestra, the clinical orchestra in
19 that nursing home, and we will start to see
20 improvements.
21 I want to also build on what Samir said
22 in terms of the knowledge and skills. Absolutely
23 needs to be in the basic education of anyone at the
24 entry level, not even master, sort of, specialty
25 level.

1 SAMIR SINHA: Agreed.
2 DORIS GRINSPUN: It also needs to be on
3 the workplace.
4 SAMIR SINHA: Yeah.
5 DORIS GRINSPUN: We have a large
6 workplace already in place, so they're not going to
7 wake up tomorrow. All we will create is more
8 clashes, if not, and that's where the issue -- I
9 brought the issue of the organizations, 120, that
10 they're already the BPSO and creating some system
11 where these evidence pieces are embedded in the
12 structure of the organization whether in the EMRs,
13 which is a good way, so that when workers come,
14 whether it's a PSW, whether it's a social worker,
15 whether it's whoever, can see what's the best
16 evidence to practice on 'A', 'B', 'C', 'D' and also
17 can learn from that.
18 That's what the homes that we are
19 embedding the orders, as they're called -- in EMRs
20 when the worker goes, they click if they're not
21 sure that's what they need to do, or they want to
22 know what's -- why -- if they ever have the time to
23 think why, right -- they click the order set, and
24 all the evidence is behind that because it comes
25 from the evidence-based guidelines that we produce.

1 And it's transforming -- it's transforming other
2 countries, and it's transforming the homes that are
3 starting to embed it here.
4 U/T So again, you need the people, the
5 right basic number of people, and, yes, absolutely
6 from regulated and unregulated in terms of the
7 basic care guarantee and also of the other
8 professions, absolutely right and much appreciated
9 that you reminded us of that. It is in our
10 documents, and we will send it.
11 And you need the knowledge so they can
12 practice those that are already in place, that,
13 otherwise will not have it. The new ones may come
14 with, but the ones that have it will not have it,
15 so that's where they -- we are also helping hugely
16 in homes already as we speak.
17 Unfortunately, most of the homes we
18 help, you need to know that of these 120, are
19 not-for-profit homes. And the reason is that the
20 for-profit operators have said to me directly,
21 Doris, why would we be interested when if we do
22 better and there are less pressure injuries, less
23 fall [sic], our funding is taken off? If next year
24 we get less money, why would we do it?
25 So these are the things that need to be

1 remedied because if we keep taking money because
2 they do better or only right when they're doing
3 bad, it's a lose-lose; it's a lose-lose.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Well, let me thank you all. This is very helpful
6 and actually allows us to move more quickly because
7 we can get so many different views on the subjects
8 we started out wanting to talk about and the, sort
9 of, peripheral matters that come up which are
10 sometimes more important than what we wanted to
11 speak about.
12 And we know you're all -- we know all
13 of you have other things to do, and we do really
14 appreciate your cooperation, and please bear with
15 us. We're working our way through this, and with
16 your help, hopefully, we'll come out the other end
17 and contribute something useful. But thanks very
18 much.
19 DORIS GRINSPUN: We are ready to
20 deliver. What we need is the marching orders and
21 the funding; we meaning our different health
22 professionals.
23 IRMAJEAN BAJNOK: Yeah.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Thank you.

1 IRMAJEAN BAJNOK: I think we all are.
2 We're ready.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Okay.
5 DORIS GRINSPUN: Thank you. Thank you,
6 every --
7 MIRANDA FERRIER: Thank you,
8 Commissioners. Thank you.
9 COMMISSIONER ANGELA COKE: Thank you.
10 COMMISSIONER JACK KITTS: Thank you.
11 IRMAJEAN BAJNOK: Thank you for
12 listening.
13 COMMISSIONER ANGELA COKE: Thank you,
14 everybody.
15 COMMISSIONER JACK KITTS: Bye-bye.
16 Thanks.
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Bye, everybody.
19 -- Adjourned at 11:38 a.m.
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25

1 REPORTER'S CERTIFICATE
2
3 I, JANET BELMA, CSR, Certified
4 Shorthand Reporter, certify:
5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;
9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;
13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.
16
17
18 Dated this 23rd day of November, 2020.
19
20

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22 ______________________________
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3 72-5 I was not asking, what I said was: And
4 you know that, Samir.
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6 85-9 of word index What I said is BPSO (i
7 would never say PSOS :)
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