Long Term Care Covid-19 Commission Mtg.

Dr. Pat Armstrong and Dr. Hugh Armstrong
on Tuesday, November 17, 2020

neesons
A VERITEXT COMPANY

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

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 17th day of November, 2020, 9:00 a.m. to 10:10 a.m.

BEFORE:

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

PRESENTERS:
Dr. Hugh Armstrong, Distinguished Research Professor, Professor Emeritus of Social Work and Political Economy
Dr. Pat Armstrong, Distinguished Research Professor in Sociology and Fellow of the Royal Society of Canada

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Dawn PalinRokosh, Director, Operations, Long-Term Care Commission Secretariat
Sanjay Bahal, Team Lead for Operations, LTCC
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Kate McGrann, Gowling LLP
ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

I N D E X

The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and no other purpose

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: 28, 29, 57

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following pages: None

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following pages: None

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I guess you -- everybody knows everybody? You've met Commissioner Coke, I take it?

HUGH ARMSTRONG: We have indeed.

PAT ARMSTRONG: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. So are -- there's the two of you, I take it you're not waiting for anyone else?

PAT ARMSTRONG: No.

HUGH ARMSTRONG: No.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we're here. So I guess we could make a beginning.

HUGH ARMSTRONG: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): As you may know, we have been working away at the investigative stages of what we've been doing, and we've been meeting with people and trying to get a better understanding of the current state of affairs.

We did deliver a very brief interim report just to try to put a few things forward, weren't particularly revolutionary, but nevertheless, we felt they needed to be said sooner

rather than later.

So we're now at, kind of, a second, more reflective stage, and that will be -- your presentation, I suspect, will be very helpful to us.

We do have a transcript if -- I don't know if you've been on the website, but we do have a transcript, and we will publish it. We do that just so that people who are interested in what we're doing will have some idea of what, in fact, we are doing as we work away at the -- at the problem.

We -- we're kind of functioning from the notion that we need to be a bit expeditious about what we're doing -- we -- just given the circumstances that we're in, you know, Wave 2, if that's what it is, and then may not be over depending on whether or not there's a vaccine.

So that's kind of where we're at. We tend to ask questions as we go along, if that's okay, rather than wait to the end and go back. And we're ready when you are.

HUGH ARMSTRONG: Okay. Well, let me start. I'll introduce myself, and then I'll introduce Pat, and she will deliver our initial

thoughts on this. But, yes, if you want to intervene from time to time and ask us questions, we're both prepared to do that, probably Pat more in the first part since she will be making the initial presentation.

As you know, I'm Hugh Armstrong. I'm a Distinguished Research Professor and Professor Emeritus of Social Work and Political Economy at Carleton University.

While in Ottawa, I was also the vice chair of the Ottawa Carleton CCAC, and then a bit later, I was the vice chair of the counsel on ageing of Ottawa.

In that latter respect, I served as the council's representative to the Community Advisory Board of the Ottawa Hospital which is where I used to meet Dr. Kitts every month or so for a while.

In any event, I'm going to now turn it over to Pat for our initial presentation.

PAT ARMSTRONG: Thank you for this opportunity for sharing our research. As you know, I'm Pat Armstrong. I'm a Distinguished Research Professor of Sociology at York University and a Fellow of the Royal Society of Canada.

We started studying health care

40 years ago when our daughter broke her leg and ended up in traction in the hospital for a couple of weeks. And we realized this would be an excellent place to study women's work.

And after we looked a great deal at hospitals, we moved on to home care, and then in the -- 1990, the Ontario Pay Equity Commission asked me to look at female-dominated workplaces, and that took me into long-term care, and we've been there for the last decade or so.

I'm the principal investigator on our just-finished ten-year project called Re-imagining Long-Term Residential Care: An International Study of Promising Practices.

It was suggested to us that we start by briefly -- and I mean briefly; I won't be more than 15 minutes -- four topics to provide a basis for a discussion but, of course, happy to be interrupted anywhere.

So the one was outline our project, the big project: (1) talk about models for care; (3) talk about physical environments; and (4) accountability, if that's okay with you.

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

PAT ARMSTRONG: All right. So our objective is to identify promising practices that treat everyone who lives in, works in, and visits in long-term care with dignity and respect, practices that put life into years rather than years into life, as a German nursing home manager put it. We seek to make long-term care a positive choice, not the last and worst option, as it certainly has been recently.

We're particularly interested in those practices that are sensitive to gender, to culture, to racialization, to age, and other social locations, and that promote equity. In doing so, we take context into account.

It's truly an interdisciplinary project that includes physicians and philosophers, those with training and nursing and history, economics and epidemiology, architecture and cultural theory to name only some of the 12 disciplines among our 26-member research team or least faculty involved.

Half of them were senior faculty, many with years of experience in this area or with our methods. The other half were fresh -- bringing fresh eyes, as we talked about it, who hadn't actually studied in this area, but we thought it

would be useful to have both.

Our -- throughout our project, our work was informed by our union employer and community partners and still is, I would say.

Initially, we structured our work around four areas: approaches to care, work organization, accountability, and financing and ownership recognizing the overlap which we addressed by changing the membership in each of these theme areas halfway through the project and by having annual face-to-face meetings.

So we used multiple methods in doing this major research project, but the most innovative one was our rapid-site switching team ethnographies. We take a team of 12 or 14 researchers into a home over a week. We worked in teams and in shifts interviewing and observing in Norway Sweden, Germany, the U.K., the U.S., and four Canadian provinces.

Each team was international and interdisciplinary and was primarily made up of faculty, unusual, as I'm sure you know in most research projects. This approach, along with our other methods, promoted extraordinarily rich discussions and debate about what we had seen,

heard, and learned and allowed us not only to identify what we call ideas worth sharing but also to consider critical tensions. And we've shared some of the stories from that research in the four small books and a whole host of publications. So that's our project.

But more recently, we were asked by the City of Toronto -- I should say more recently -- last year -- to look at models of care prompted by a Toronto Star story on the Butterfly Approach mainly. And we looked at a large number of those models often called culture change models, the Butterfly, the Eden Alternative, Montessori, to name only a couple -- or three of them, actually.

So in looking at all these models, we found four common themes. One was flexibility for residents, staff, and families in terms of when, how, and what is done as well as who participates.

Second, there was an emphasis on personal connections among staff, residents, families, and on emotions. The focus is primarily on -- I should say there -- the focus is on process rather than on tasks, and there is a resistance to measurement.

Third, the importance of leadership

committed to change, to education, to communication, consultation, and teamwork, and to reducing hierarchy giving staff more autonomy.

Fourth, home-like physical and social environments that remove institutional indicators are common in all of them, but how you do that is different in all of them.

And there's really a fifth theme in all of the models. They require more staff and continual hands-on training, but I think you've learnt a lot about that since you've been starting this commission.

So based on our research, and that of others, we concluded that while there are important principles and good ideas worth sharing and adapting from these models, there is no one perfect model. This is especially the case in a very diverse city like ours and a very diverse province like ours.

Instead, we recommended that the homes learn from and with each other including the full range of staff in the process and families and residents, of course. Building in continual adaptation and supporting local innovation are critical -- if I can unstick my pages -- to

continually changing issues and populations and to prevent the institutionalisation that can happen with models.

Many of those we interviewed understand what needs to be done and how to do it in order to put the principles into practice. There is agreement that the focus should be on care processes rather than on tasks and the social as well as the clinical aspects of care, but they lack the supports required to do so including the need to hire and train more staff while supporting continuity through scheduling and through providing more full-time and secure part-time employment to promote those personal connections.

Like the models, we pay considerable attention to the physical environments. We do so because they are important to both the conditions of work and the conditions of care, a relationship that we have long understood as critical to moving forward.

From our perspective, physical environments include a wide range of factors including sites, smells, decor, flooring, lighting equipment, food, and laundry facilities, supplies, private nurse -- privacy, nurses stations, uniforms

lighting, communication systems, and location, among others, just as a starter.

There's considerable agreement in the models and in the research that physical environments need to change, but there's less consensus on how they should change. And you've heard about this lack of consensus, I think.

Two areas in particular have been subject of debate. First, the size of the units and the size of the homes. Our Nordic team members were shocked to see units of 35 residents in our Canadian homes, but they began to see that maybe their units that could have as few as eight people in it could be too small and become confining.

Smaller-sized units can make it easier to close off sections with outbreaks and feel more like places to live, but the home itself need not be small; and larger homes can have economies of scale and offer a wider range of activities and services for residents while providing more flexibility and staffing. Homes do need to be near the communities of residents, and those communities will vary in size and, thus, so will the homes.

The second big area of controversy is the size of the rooms. Private rooms can be lonely

and isolating. Multiple residents have told us that they loved having a roommate to talk to, to share visitors with, and to get help from when necessary.

Moreover, having all private rooms in Sweden and Norway did not prevent COVID or prevent significant differences in infection rates between the two countries. This is not to suggest there should not be private homes or to suggest we shouldn't get [indecipherable] four-bedroom ones, but rather, that all private rooms are not the simple solution to COVID or to many of the other issues in long-term care.

Perhaps less controversial are three other issues directly related to creating spaces to live. Food and clothing top the list of issues for residents and families. Food is not only central to physical health but also to social life. Meals are the major event of the day.

High on the list was food cooked on site and, even better, on the unit by people who know the residents, food that is culturally appropriate and that draws on local ingredients.

Equally important was flexibility in eating times and snacks throughout, flexibility

that requires a kitchen, and food prepared by employees in the home. Assistance from people who have time and the skills to do so are also critical, as we saw in the military reports most recently. When such services are subcontracted, they regularly bring people from outside into the home, and these transients often have little training in infection control, let alone in how to deal with the care needs of the residents.

Clothes, we would argue, are central to dignity and to identity. I must say, when we mention clothes and laundry to our friends, they say, why would you study that? As -- when you mention this to residents or family, they know instantly.

They require -- clothes and laundry requires space to store and means to keep them clean, and they need skilled people to assist residents with dressing. A sufficient supply of linens and appropriate means for collecting and processing the dirty laundry are also essential to limiting infections as well as to the look, feel, and smell of the home. And again, the military reports, I think, highlighted that.

In these communal spaces, dying and

death are regular occurrences that require their own spaces, spaces for the residents who are dying and for the families as well as for the staff to support each other and to grieve. Effective culturally sensitive and appropriate means for dealing with death are part of both good care and safe homes.

With governments moving ahead and developing new beds, these and a host of other issues about the physical environment need to be taken into account including infection control, community spaces, and places for families. In doing so, it's critical that these plans include meaningful consultation with everyone who is connected to long-term care.

Finally, accountability: You've already heard a great deal about the importance of inspections, transparency, data, and enforcement.

We would like to add three points to the accountability discussions. First on regulations: Our comparison of regulations in the six countries indicate that the countries with the most for-profit owners had more standardized, complex, and deterrent-based regulatory approaches.

In addition, the most widely publicized

scandals were in for-profit homes and were most likely to result in more detailed regulations but not in the regulation of larger structural issues such as profit or staffing levels.

We obviously need regulations, but we need to assess regulation in terms of their origin and impact eliminating those that do not significantly improve the quality of care or of work while adding other regulations that do.

As you've already heard, we also need to reassess documentation requirements and the extent to which they take time away from the care without improving it.

In the Norwegian homes we studied, they trust the staff to ensure hydration, for example, and provide staff with the time, training, and autonomy to ensure hydration charting by exceptions.

Second, when it comes inspections, in the Nordic countries, inspections were more formative than summative often offering assistance in meeting regulations rather than indicating failure to meet regulations.

We need formative inspections that focus on the quality of work and the quality of

care and the support homes in improving care.

Third, data: We also need verified data on how regulations are met and data that are accessible to the public. Oh, excuse me, I don't talk enough in these times.

The B.C. Senior Advocate found considerable differences between data provided by homes and the data the Advocates Office collected. And that's -- was particularly the case in the for-profit homes.

There must be clear enforceable penalties and timelines for those who do not improve.

Let me come to conclusion before I completely lose my voice. In sum, our -- in our research, we try to remember that these homes are homes are congregate places to live and to work.

We understand and take into account the perspectives of the entire range of those who live in, work in, and visit because they're all critical to care.

Sufficient staffing as well as appropriate training for all those involved in care constitute a necessary but not sufficient condition. Care is understood as a relationship

that needs support from the conditions of work which, in turn, are the conditions of care.

Because we understand that context, gender, and social locations matter, we focus on standards rather than on standardization and on ideas worth sharing. We also recognize tensions especially those between safety and risk which, of course, is absolutely critical discussion in these times.

To quote a recent council assistings final -- assistings final submission to the Royal Commission on aged care in Australia: (as read)

> "To the extent that empowering people in aged care may involve risk, that risk should be approached by minimizing harm and responsible management, not excluding it entirely. Risk is part of life. There is dignity in risk. Older people should be able to make decisions that may involve taking reasonable personal risks, and their right to control and choice should prevail to the extent that it is reasonable and does not harm

others."

That's a recent report, by the way, where they were well aware of COVID.

Well, there's no question that these are places where people live. The primary focus on home-like not only denies that we have very many different homes -- and we had great debates among -- in our team about what constitutes a home.

But home-like takes away from recognizing the benefits of communal living and building on the notion of community.

When we asked a resident's council here in Toronto if there was anything better about being in the long-term care facility compared to home, they unanimously said yes, and they offered three examples: One, they felt safe, and their example there was they would make -- someone would make sure that they got their diabetes shot.

Second, they said there were activities even though they spent a lot of time watching TV, that they -- that's all they would do at home.

Third, they talked about the -- oh, I lost my place -- having company, obviously, and that they would be all alone at home and would be frightened if they were home.

COVID has disrupted these benefits of communal living, but in preparing for the future, we need to keep these benefits into account.

We've only touched on some of the many things we've studied over our ten years, but we're happy to try and address any issues you'd like to raise.

COMMISSIONER FRANK MARROCCO (CHAIR): The -- we -- on -- you know, Ontario, we've been told, faces a problem with a shortage of beds. The number that we got was 38,000 beds are short.

Did other countries have this kind of problem? Was this common or uncommon?

PAT ARMSTRONG: It wasn't as common in Norway, Sweden. Hugh can speak to Germany. It is common in the U.S. and the U.K., but the funding mechanisms in the U.S. just really confuse the whole thing including we were in homes -- the homes we studied in the U.S. told us that they could kick people out after their Medicare dried up because the Medicare was time-limited, and so they sometimes sent people to the hospital and then brought them back because then the counting of the days could start again.

So it's hard to assess if there are

enough beds in the United States, but in Sweden and Norway, we didn't hear a lot about long wait times.

COMMISSIONER FRANK MARROCCO (CHAIR): Is -- did you get any sense of why -- how they were able to avoid that problem?

PAT ARMSTRONG: They spent a lot more money.

HUGH ARMSTRONG: And --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that concludes our report. We'll send them an email this afternoon, and then we'll be done.

HUGH ARMSTRONG: I could add that in Germany, they have a quite different system involving social insurance. And while there are some wait times, nobody gets in the day they'd like to get in; the wait times are much lower, and the number of beds and especially the number of staff is much larger.

It doesn't make sense simply to build more beds if you can't staff them, and as I'm sure you've heard from many, the staff shortages in Ontario are acute.

This is not to say there aren't people who are trained as PSWs and as nurses, RNs, RPNs. It's that they have chosen not to work in long-term

care because of the conditions there.

I could add as well that the wait times are longer in the -- in the public homes and in the not-for-profit homes. They are shorter in the for-profit homes. This is because potential residents and family members know that the for-profit homes aren't as good.

So when you have a choice between three or five homes, and, of course, not everybody does; if you live in a small town, there's just, you know, one home in that town. But if you have some choice, you will prefer to go to the public or the not-for-profits.

PAT ARMSTRONG: Well, that's the pattern. The other thing is, of course, the wait times vary significantly across the province -- or across the country, I mean. They're particularly high in Ontario.

COMMISSIONER FRANK MARROCCO (CHAIR): The -- one of the things that concerns me or that I think about is that if you exclude the private sector, I don't know -- I don't know who'll build the homes you need. I have a -- kind of a concern that government won't, and I don't know if you you've thought about that or not.

I -- you know, I've -- I'm naturally aware of the experience in Wave 1 and the private-for-profit homes didn't seem to do as well, but I'm also conscious of the fact that you have to continually build at least until the population bulge changes. So I just wondered if you had, in the course of re-imagining it, had thought about that.

PAT ARMSTRONG: Well --

HUGH ARMSTRONG: Go ahead, Pat.

PAT ARMSTRONG: I was just going to say that part of the issue is we're going to pay for the capital expenses one way or another. The issue is, do we spend now and go into debt because of that or at least put it on this year's books or whether we pay it over time. And that's, I think, a choice we would have to make.

I wouldn't argue that right now you don't -- that you get rid of all of the for-profit homes instantly, but I think, in planning for the new homes, we not only have to take into account all of those things we were talking about in terms of physical environment, but also to think about funding directly the capital.

HUGH ARMSTRONG: The new homes that are

being built are largely being built by private equity, and they will get the money back from the government. The private equity borrows at a higher rate than government does. They, then, get the money back over 20 or 25 or 30 years from government for the capital -- on the capital side.

There's no reason why government couldn't borrow at lower cost than private equity and build themselves. What's happening now is that there are a lot of new builds being authorized by the Province, and they're overwhelmingly in the for-profit sector in part because there's an uneven playing field.

Whoever proposes to build has to come up with some initial money, and the way to come up with it is to borrow in capital markets. The not-for-profits, and to a lesser extent the public, have trouble borrowing to get the thing going.

They know the -- all operators know they'll get the money back eventually and at higher cost, as Pat said, if it's in the for-profits.

So while I don't think we can eliminate all the for-profits today or even the day after your final report comes out, we should be moving in that direction. And unfortunately in Ontario,

we're moving in the opposite direction.

Another issue is that one of the major chains, Revera, is owned by pensioners from the Federal Public Service, and the Public Service Alliance and the Professional Institute of the Public Service are now calling for the Crown Corporation that manages their pensions to move out of Revera.

The final thing I'll say is that because the for-profits now have a relatively bad, reputation, not only from the first wave, but as the Toronto Star has been revealing recently in the second wave, the cost of taking them over has probably gone down. Not only do governments borrow at very low interest rates right now, but the cost of taking these places over is down.

The -- there is the land cost, and a lot of these companies, especially the REITs that invest in them, they're in it for the land, and they'd be quite happy to move the homes out of downtown areas where the land is expensive, especially in major cities, and to put them out in the -- in the pasture. And the residents and their families tell us they don't want the residents to be put out to pasture.

PAT ARMSTRONG: Growing grass is boring to watch.

COMMISSIONER FRANK MARROCCO (CHAIR): Right. I --

HUGH ARMSTRONG: In fact, we'll tell you a story about that. We have one home in another province which was just off a fairly major road, but on the other side was a park. It was a lovely park. It had a feeding station for the deer, and so the residents could sit and watch the deer feed and lots of other wildlife and flowers and trees and so on.

What residents usually preferred to do was to sit looking across the fairly major roadway to a shopping mall. They wanted to be part of the action.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

HUGH ARMSTRONG: They wanted to see the action.

COMMISSIONER FRANK MARROCCO (CHAIR): I don't mean to monopolize the questions, and so -- but I guess I'll assume I'll hear from my colleagues if I am.

Commissioner Coke.

COMMISSIONER ANGELA COKE: Just on a different topic, I'm just interested in your thoughts around, you know, what you've observed in terms of the right, sort of, skill mix in the homes given the, sort of, rising acuity of residents, just your thoughts on what you think is an ideal, sort of, mix of folks in the -- in the homes.

U/T PAT ARMSTRONG: I don't -- Charlene Harrington, who is the big U.S. expert on staffing levels, has -- was part of our research team, and we're still working with her on other things. She has come up with numbers, but numbers that vary, to some extent, with the population in the home, and her numbers say with high complexity you should have at least six hours of care per resident per day, and she also has the proportion of RNs and RPNs or LPNs. And I can send the commission that study because there's a lovely chart, I think, that shows it.

And, of course, the RNAO relies to some extent -- you heard from the RNAO --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

PAT ARMSTRONG: -- already, and she -- they have a particular distribution that is, to

some extent, supported by Charlene's research, although Charlene would take it higher than that.

COMMISSIONER ANGELA COKE: Yeah. We'd appreciate getting that. Thank you.

U/T PAT ARMSTRONG: Okay. I'll send it to you.

HUGH ARMSTRONG: Let me -- I'll add something to that and -- which is that in our research that one of the keys was that there be teamwork, and one of the things in Ontario, in Canada, and in the U.S. much more than in Europe is a fairly rigid hierarchical division of labour with the people who are at the bottom being prevented from exercising the full range of capacities that they have.

So while, yes, we need an appropriate division among the various categories of care providers, we also need to pay attention to how they work together.

PAT ARMSTRONG: Well, and one of the things we have continually tried to stress is that this is skilled work. There's a lot of assumption that especially the work that PSWs do is work that any woman can do just by virtue of being a woman. And I think that what we saw in the military

reports is the importance of skill. Like, helping someone eat is not something any mother can do because it's very different, as I'm sure you know, to help someone who has severe dementia plus other complex problems to eat; and we have to -- we have to guarantee in that division of labour that people have the skills.

But we've certainly seen examples of teamwork where they all learn from each other in the process. In fact, in the homes we were in in Sweden and Norway, they include housekeeping and laundry and the food -- well, the food is done by what we would call nursing staff, but they include all of those people in their team discussions.

HUGH ARMSTRONG: And they build in time so they can have discussions and especially at turnover time of between shifts but also within shifts.

COMMISSIONER JACK KITTS: I want to build on that because in terms of the complexity, we've heard loud and clear from the day we started this that this is their home. This is a home environment, and that is, you know, something that everyone aims for.

But we've heard throughout that you

said today there's some tension between a home and a community, and maybe they want more of a community feel.

We've also heard that the acuity has gone up, so they often need continuing complex care that they would get in a facility, not necessarily a hospital, but a post-acute care facility. They often need specialty care now as well and, as you said, and even hospice care.

So when you have all of those components in a home, it makes it very difficult and confusing to understand the culture and -- because each of those various silos in the health system has a -- has their culture.

And I think, in the end, you know, the belief is that it's not -- doesn't require the skilled care that the other places do, otherwise they wouldn't be in the home; and so the staff have told us that they don't feel respected. They don't feel valued. They do feel like they're some lower tier in the healthcare system.

How did -- in your findings, how did you reconcile that, and is Ontario different from all of the rest, or are the homes in where you visited across the country and in Europe, do they

have these, I'll call it, tensions?

PAT ARMSTRONG: Well, if I can start, I'm sure Hugh wants to say something on this. We did recently -- well, last year, just before COVID hit, actually, a study for the Ontario Nurses Association. They wanted us to talk about -- well, to do a study that could be used as a way to recruit RNs, and RPNs into long-term care.

And one of the quotes that really -- the interviews that really stood out for me was that a woman who is in her mid-20s who had -- like almost everybody we met in long-term care -- hadn't planned to go and work there, hadn't been given much training in long-term care when she was getting her nursing education, but she said, my friends say to me, oh, you'll lose all your skills. And she said, are you kidding?

And she went through this long list of all of the skills she had to use during the day exactly reflecting what you said about complexity.

I think that there's no question that we have to recognize the skill involved, and there's also no question that this is not seen as a workplace that requires skills.

There's -- and I think part of it has

to do with it -- it's a labour -- a female labour force. It's a labour force of women mainly looking after women, and, of course, you add into that that we don't value old age very much, something I'm increasingly concerned about personally.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, so am I. I'm concerned about it myself.

PAT ARMSTRONG: I get you.

COMMISSIONER FRANK MARROCCO (CHAIR): But can I -- can I -- was there a jurisdiction that -- we've heard, as you know, the staffing shortages and the staffing difficulties; and you were touching on them in the sense of saying, you know, a more egalitarian -- a greater recognition of the skill sets required to do the work.

But was there a jurisdiction that seemed to escape this stigma -- I don't want to call it a stigma -- that's too strong a term, but that escaped this difficulty, the staffing difficulty?

HUGH ARMSTRONG: I'll speak to this first. We found one in Canada in another province where the director of -- was a very strong person, and she was into having all the workers know about all the jobs. So, for example, the receptionist

who was at the front door when you came in was also the person who delivered the menus for the noontime and evening meal. As a result, she knew all the residents personally. She knew their names. She knew their habits.

The director of nursing, when we were in there, was lowering the blinds at breakfast time because the sun was coming in that day. It was too bright, and so she was modelling the kind of approach that we would favour.

A third example there was that a PSW, they call them something else in that province, when going through orientation, was allowed to keep a swimsuit on as he was lifted into the bath in front of a number of other people. This was a very difficult experience for him, but it meant that he understood much better what the residents were going through when it was their time to be lifted by a mechanical device into a bath.

So there are, sort of, simple examples that can be used. Those three are all from the same home in another province.

In addition -- I'll say one more thing, Pat -- we have a number of physicians in our project. Three of them wrote a paper together in

the Canadian Journal on Aging, and what they talk about is how important, if they are to do their jobs properly, that they have good relationships with the other workers in the facility and that they have the appropriate amount of time away from a-fee-for-service model where they can get to know the other workers and work with them in a team-like fashion. They say that good medical practice depends on good social practice.

Pat.

PAT ARMSTRONG: You might want to talk to -- two of those doctors live close to here in Toronto. One of them is a former medical director, and the other is actually an emergency room physician. But both of them said, going into a long-term care home over a week to observe and interview really changed their views on what was required.

In terms of -- I -- if I understood your question, it was about -- in part, about how people are prepared, where do they get their education. And one of our problems in comparing across the countries is that there are different -- vastly differently ways of preparing people to work in these homes. Germany had an enormous

apprenticeship program that was combined with education in the formal sector, but the apprentices were paid while they were learning in this home; and they more than doubled the number of people providing care, but it was a much more flexible division of labour as well.

And in Norway and Sweden, the education program starts earlier, can be a stream, sort of, like -- well, anyway, the education starts earlier and is shared on the job as well. So it's very hard to compare across the countries because they're so different in terms of, you know, whether you have a stream in high school, for instance, that can start to -- in this direction, the extent to which it is part of the nursing education to actually spend the time in a nursing home that there are severe -- there are major differences across Canada too, not only what they're called, but what kind of preparation and what kind of minimum formal training they get.

Does that address your question?

COMMISSIONER FRANK MARROCCO (CHAIR): It does. It does. Yeah, I was -- it -- yeah, it's just a -- a curiosity to try to see places that have avoided the difficulty of attracting staff

because the staff with the skills, let's say, would prefer to work somewhere else. It was an attempt to see if somebody had successfully avoided that problem.

PAT ARMSTRONG: Well, certainly, we saw -- my -- one of our -- my favourite examples, Norway didn't have -- doesn't have nearly the trouble attracting people to work in long-term care. And one home we were in is part of the -- a huge town complex that includes the town swimming pool, a daycare centre, a spa, a cafeteria, the town cinema. It's all one building, and that has been very attractive to workers as well to people who are staff, it's -- or it has a daycare, did I say that?

So I think that it's more than the education system that would attract people to work in these places in Norway, for instance, or in Sweden.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

HUGH ARMSTRONG: It's also, of course, the pay.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

HUGH ARMSTRONG: Some decide they're -- despite the skills they have, the PSWs, they're going to go and work at McDonald's or some other fast food place because less stress, similar amounts of pay.

PAT ARMSTRONG: I interviewed a human resource director in Norway. She had just -- she had relatively recently come from their equivalent of the CBC, and I asked her if anything surprised her when she came to long-term care. And she said, yes, I can't believe how hard these women work.

When I asked her what would she do if she was in charge, she said, I'd pay these women what they pay the men working on the oil rigs because these women work harder.

HUGH ARMSTRONG: In another -- in another study, we posed an issue of violence against workers. The violence against workers is more than six times higher than it is in the Nordic countries. And these are with populations, resident populations, that are quite similar.

And the chief reason that daily or almost daily violence against workers in Canada more than the Nordic countries was that they -- there are not enough workers in Canada.

If you are rushed to toilet somebody, and so they're sitting in soiled diapers for minutes, even hours, and you have to treat them fairly roughly, directly, to get them changed, the chances of frustration and of that frustration resulting in violence becomes much higher.

So if you have enough workers and if they have enough time and continuity to get to know the residents well, you're going to cut down on the violence.

There's also, of course, violence against the residents by some of the workers, but it comes from the same source. They are frustrated because they want somebody to move, and the -- and the resident won't move, and so they treat them roughly.

So we need enough time and enough continuity so that the residents and the worker -- and the workers get to know each other.

PAT ARMSTRONG: You also need enough autonomy, and we did see that in -- certainly, in Germany and Norway and Sweden, that there was -- the people providing the care had more autonomy in deciding what should be done when and how to -- with residents, so that -- it seemed to have

significantly increased the satisfaction on both sides and reduce the levels of violence.

COMMISSIONER FRANK MARROCCO (CHAIR): Did you look at -- I changes topics for a minute. Did you look at inspection regimes, and did you come to any conclusions about that that would be helpful to us?

Some of the evidence that we have heard suggests that there may not have been an adequate number of inspections, general inspections. I'm not speaking about an inspection in response to a complaint that somebody was assaulted or something of that nature, but I'm talking about the more general type of inspection. Did you come -- do you have any observations on that?

PAT ARMSTRONG: We have a paper on this, actually.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I apologize for not being more familiar with it. But I will -- I undertake to make myself familiar with it.

PAT ARMSTRONG: That wasn't a reprimand. It was just -- it was just to say that, yes, we looked at it, and, yes, we compared them, and I think Hugh wants to speak to that.

HUGH ARMSTRONG: We've -- we have found a number of things. One is there is more regulation where there is more privatisation. This is a pattern, not, you know, in every case.

So if, for instance, in the United States, it's very heavily for-profit; you get an awful lot of regulations.

In Norway and Sweden, much less for-profit, many fewer regulations. And one of the problems with inspections is that they have to deal -- the inspectors in Ontario, for instance, have to deal with hundreds of regulations. And then they come up with orders to fix those things. And then the homes don't fix them. They ignore them because the homes say, hey, we're too busy trying to provide care; we can't worry about whether the lettering on the bilingual sign is large enough or whether the corridor is wide enough. So that -- those are two problems.

The third thing I'd say is that we found -- and I used to work in education where I found this as well -- that formative inspections and assistance tends to be better than summative. That is to say you want to have the inspectors help the people in the home do better rather than having

them sweep in, find a bunch of mistakes, go away and write a report on them.

This is not to say you shouldn't have inspections that are summative. When you do, you have to apply real sanctions. You have to be prepared to fine the facility or to stop its admissions. You're very unlikely to withdraw the license because that, you know, leaves the 1 or 200 residents and the staff in the lurch. So you -- but you want to find ways to have inspections that uncover serious problems. Actually, have --

COURT REPORTER: I'm sorry, sir. You cut out.

COMMISSIONER FRANK MARROCCO (CHAIR): You froze.

PAT ARMSTRONG: We lost you here. Yeah. There, oops, he's back. Anyway, I will pick it up while he's trying to figure out if -- it's probably because two of us on the same system.

I think that we saw a lot in Norway and Sweden that they had -- they actually do less, kind of, reporting, too, on the things that we have been looking at. So, for example, I watched what are called occupational therapists there working with a resident encouraging him to walk. And I said,

aren't you afraid he will fall? And she said, well, sometimes people fall, but our job is to push people as far as they can go. And I said, well, isn't that fall, then, a problem for you? And she said, no, we only report on ones that result in injury, not every fall; and then when there is some kind of negative consequence of the fall, the team gets together and talks about why they think it happens and what -- how they can do -- what they can do to avoid that in the future. So it's formative on a daily basis rather than over long-term.

The other thing I would say is when -- we met with Mr. Smitherman when he was in the Ministry -- we -- and they were developing these rules. We were suggesting that maybe the best things inspectors could do is go and stay for 24 hours in a -- in a resident bed, and maybe that would be a very good way of finding out what it was like to live in a home.

COMMISSIONER FRANK MARROCCO (CHAIR): Did -- in any of the countries, did they impose -- instead of imposing a penalty on the home which would be a corporation -- I'm certain of that -- did you run into any regimes where they imposed

penalties on the directors personally?

PAT ARMSTRONG: No.

COMMISSIONER FRANK MARROCCO (CHAIR): You know, they do that sometimes in the environmental area.

PAT ARMSTRONG: Right.

HUGH ARMSTRONG: M-hm. M-hm.

PAT ARMSTRONG: No. It -- they -- we didn't encounter any places that did that. But I should tell you that in selecting the places, because we were looking for ideas worth sharing, in selecting the places we studied, we looked at the complaints. We looked at the verified complaints. We looked at the quality indicators, when they had them, that are available publicly. We consulted policy people in government and community organizations to say, where can we go to learn good ideas?

So we certainly weren't in the -- in the worst places, and we checked out a number where the smell of urine was so strong when you walked in the door that we decided those weren't places we were going to study.

So to some extent -- and I've been involved in studies in at least 40 homes, I guess,

but those quality indicators primarily sent us to not-for-profit or government-owned homes. We only had in that mix one for-profit home, and it was in the Maritimes.

HUGH ARMSTRONG: The other thing I can say about the regulations is that their effect is usually aimed at the workers or the management within the facility. And we think that there should be more attention paid to structural indicators. If you find a problem, it may have to do with the number of staff. It may have to do with the form that the funding takes. It may have to do with policies of various kinds so that you start by looking at a home, but you could end up by looking at what's going on in the jurisdiction.

One of the papers that some of our colleagues wrote is called, It is a Scandal, and they started from media scandals, and then they look at the nature of those scandals in five different countries and ended up with, what happened? And what happened was, if anything, more of a burden on the workers, perhaps, on the direct managers but not on the jurisdiction and -- or not on the chain of nursing homes, for example.

PAT ARMSTRONG: Less so in Norway and

Sweden where they did go after the company if it was -- if it was a problem.

HUGH ARMSTRONG: Yeah. One of the problems in the United States in particular, and it's becoming a problem more in Canada, is that you don't know who really owns and operates the outfit, that there is -- there are so many different corporations involved, and the Moira Welsh in yesterday's Star, I think it was, was talking about a new private equity company that is heavily involved in the new builds in Ontario, but they won't operate them.

And you find that in a number of other places that we have looked at that, especially in the United States, where there will be one firm that owns the land and, perhaps, the building; another firm that operates the thing, except there's a third firm that runs the management and a fourth firm that runs the assisted living that's tied to the nursing home and so on and so on. It -- it's -- it can become difficult to find out who's responsible.

PAT ARMSTRONG: The -- to go back to where you started about new beds, there -- we haven't seen any indication, and maybe that's just

that it hasn't been made available, about the design of these new beds. Hugh mentioned that, you know, what good is a bed if you don't have a staff to look after it?

But the other question is, if we're -- are we going to learn more, then, about ventilation and air conditioning, for instance, which, you know, I'm sure will be top of the -- of the list and more private rooms?

What about all the other aspects of these buildings, and to what extent are we taking into account not just COVID?

I mentioned laundry. We have a book called Wash, Wear, and Care that is devoted to the question of laundry because it has a profound effect on infection control, on how the place looks, how it smells; and I don't know to what extent there's consultation with the people who work and live in those places or the families that visit in them.

The -- we have been in new builds where the workers, especially the smaller women workers, can't reach the medicine cabinet or where the toilet is put right in the corner, and you can't get your walker around it, and two people -- you

certainly can't do a two-person lift which is, you know, often what's necessary.

So I'm wondering to what extent in these new builds we've carefully considered, obviously, infection control but also these other aspects of the building.

COMMISSIONER FRANK MARROCCO (CHAIR): In the jurisdictions you looked at, did they attempt to prescribe the building and the -- for example, the size of the washroom, the position of the toilet or whatever? Did they -- did they have those kinds of standards?

PAT ARMSTRONG: Not in Sweden and Norway.

HUGH ARMSTRONG: Yeah, I don't think --

COMMISSIONER FRANK MARROCCO (CHAIR): So you were just expecting the common sense of the people building it to figure that, to think of that, the architect or whoever is designing it?

PAT ARMSTRONG: Well, and they did more consultation with the people who were actually providing care and the people living there. It's amazing how many of these places we've been in have huge atriums when you go in. And then the manager will tell us that they can't afford to change the

light bulbs because it takes a special equipment to change the light bulbs.

HUGH ARMSTRONG: Up on the ceiling.

PAT ARMSTRONG: Yeah.

HUGH ARMSTRONG: And another feature of, I think, the best homes is that they adapt. They change. They have spaces that can be moved from one activity to another.

So what formerly was a bar, for instance, now has become a woodworking shop or vice versa, that there's enough flexibility in the construction of the home that you can change it to suit different resident requirements in particular.

PAT ARMSTRONG: We would also, especially based on our work we did for the City of Toronto, argue that there should be community spaces in the home. I know this becomes a difficult conversation in the time of COVID, but having places where the community come in especially around language, around activities of various sorts, but also in ways to support the community as well. And I think that we really must take that into account in constructing how do we construct those safely so people can come in safely, is obviously an important part of that.

But that's partly where I talked about risk because the volunteers and families, as we've been learning over and over again, play an important in these homes. And we often forget that, especially around things like food and language, that they can be particularly important.

HUGH ARMSTRONG: We were in a home in Oslo which encourages residents to eat in a -- in a dining room on the ground floor, a cafeteria on the ground floor, that is also open to the neighbourhood. And so you get residents eating with maybe their friends who are still in their -- in their private homes.

This means that they eat better. They eat more, and that's good. And it also means that they have more social relations, and that's good.

Now, that's more difficult to accomplish in the time of COVID, but it's also the case that the Toronto homes eliminated their -- their cafeteria some years ago. I think --

PAT ARMSTRONG: Their public -- that were open to the public.

HUGH ARMSTRONG: Rob Ford was mayor then, and he thought this was an undue expense because it cost a bit of money, but it didn't cost

much; and yet now you've got these gaping empty spaces.

PAT ARMSTRONG: I should say that one of the things I spoke about briefly in the presentation was the importance of food cooked on the premises.

It's not just important for the -- for the residents. You know, smell of food tempts your palate, not if it's cooked 20 miles away. But also for the employees, we saw several of the homes we've been into in this immediate area are ones that have contracted out their food. And that means that some of them are built a long way away from where you can get food, but the staff has nowhere to get food; and that's an important consideration as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we've -- I don't know -- there don't seem to be any further questions, so I -- I think we've asked all -- oh, there is.

Sorry, Jack.

COMMISSIONER JACK KITTS: I am just -- I'm just, kind of, struggling with the culture change. Everyone says, we've been on this journey to change the culture in the long-term care homes

for the last decade or two decades. The fundamental principle that is in the Long-Term Care Home Act seems to me to define the culture or the mission statement that we should aspire to.

And I'm just -- I'm just, kind of, struggling with, you know, if we're going to make a recommendation around -- you know, finally after decades make an impression on changing the culture, what would you tell us we need to do? You know, what are the top two or three things we need to do to bring that movement along?

PAT ARMSTRONG: Well, the organization of work, I think, is central, and especially, not only having enough people with the appropriate training, but also, really, giving them more autonomy and that is itself also directly connected to teams working together because the accountability, then, can be to the team working together, and they can learn together, rather than dividing people up into really narrow categories.

That doesn't mean that you don't still have those narrow categories, but it does mean that you bring everybody together to think through how we're going to address these issues and how we're going to change together.

I absolutely don't think you do it by providing a computer program that constitutes your training, which is the direction that many of them are going in, and a lot of the culture change movement is about physical and this discussion of home life that I was trying to raise earlier.

But there is a real question about whose home. My home and your home don't necessarily look alike, but we are closer in terms of our backgrounds than -- you know.

And another thing I would -- I think is important and is missing from much of this conversation, although I'm -- I think you did hear about it, was the age difference, that there are more and more younger people in long-term care.

And so, for instance, a place like Castleview Wychwood has a whole floor that is dedicated to younger people which is -- which is also important in terms of culture. A lot of the culture change models are focused on dementia, and, as you well know, the majority of people in long-term care have dementia.

But there's a significant proportion that does not, and the culture change for those people is somewhat different from the culture

change, you know, for what we think is the usual resident.

So one of the things when we look at the models, and I think we sent you this detailed breakdown that we did of the various models, is that they tend to become institutionalised themselves, which is an old story for social scientists, of course.

So building in change over time was really important, and what we recommended in that Toronto report was that the homes learned about cultural change from each other and learned about what worked within their homes through much bigger connection to start with.

So that's -- the big question about how do you get culture change has to start, of course, with the work organization and enough staffing, but there are a lot of other directions it can go to, too, and the physical environment is high on the list of, especially, the Butterfly Model or -- and all of them talk about more home-like, but whose home? Does your home have carpet? Does your home -- you know.

HUGH ARMSTRONG: It shouldn't have carpets in a long-term care facility, but that's

another story.

COMMISSIONER JACK KITTS: I agree.

HUGH ARMSTRONG: Let me -- let me just add: We were in a home that had embraced the Eden Alternative which is one of the models. And what we found was that they had somebody from Eden Alternative central there who was supposed to be an educator. He -- she turned out to be as much a police officer as an educator as she tried to get the home to move up the categories to full accreditation as an Eden Alternative place.

So, for instance, there were a number of words that they were not to use so that it started with, you know, autonomy, flexibility, but then the institutionalisation became a problem.

That's one of the reasons we said specifically to the City of Toronto, don't embrace one model; one size does not fit all. We had other reasons for that such as the particular forms that diversity takes in Toronto. We all -- that -- but our two main recommendations were one size does not fit all, and you need to increase staff levels and mixes.

PAT ARMSTRONG: One of the other things that we -- I ended by saying we wanted standards

rather than standardization and that context matters. And it -- as I'm sure I don't have to tell you, there's a big difference between a long-term care home in Cochrane and one in Toronto. And that's why we would say standards.

But in terms of cultural change, I don't think cultural change can be imposed from the top, that there has to be buy-in, if you will, from the people who work in a home.

Now, in the Butterfly Model -- and we had first encountered this in the U.K. five years ago, I guess, in their -- one of their first homes where they worked out this model, they worked very, very hard at bringing the staff together and helping the staff.

But then they say in their model that if somebody isn't prepared to go along with this different way of relating to residents and these different kinds of teamwork organization, then you fire them.

I don't -- I don't think you need to go that far, but I -- but I think that you have to allow people the opportunity to learn how to do things differently, especially if you've been there for a long time.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I do -- I do think we've exhausted the questions, so let me, sort of, thank you very much for the presentation and for the responses to the questions.

We -- we're very much on a journey ourselves, and you've been very helpful in terms of putting up a few signposts for us along the way, and so thank you very much for that.

I, sort of, warn everybody, we may be back. We -- as we go along, we may have -- and some further questions, and I hope that won't be too great an inconvenience if it -- if it happens.

U/T PAT ARMSTRONG: We'd be happy to talk to you any time. And, as Hugh mentioned earlier, we're happy to put you in touch with the physicians, for instance, who are part of the plan.

I'll certainly get you Charlene's paper on staffing levels, and we'll get you the two papers we mentioned on inspection regimes and on scandals.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you. That would be very helpful, and I can assure you I'll read them. I'll certainly read the one on inspections for sure.

Anyway, in any event, thank you both very much for taking the time, and we'll see you again, perhaps.

PAT ARMSTRONG: Thank you.

HUGH ARMSTRONG: Very good. Thank you.

COMMISSIONER ANGELA COKE: Thank you.

PAT ARMSTRONG: Good luck with your work.

HUGH ARMSTRONG: Good luck in your work.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

-- Adjourned at 10:10 a.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 18th day of November, 2020.

_____

NEESONS, A VERITEXT COMPANY
PER: JANET BELMA, CSR
CHARTERED SHORTHAND REPORTER

WORD INDEX