

Long Term Care Covid-19 Commission Mtg.

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



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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

1 PRESENTERS:

2 Dr. Hugh Armstrong, Distinguished Research
3 Professor, Professor Emeritus of Social Work and
4 Political Economy

5 Dr. Pat Armstrong, Distinguished Research Professor
6 in Sociology and Fellow of the Royal Society of
7 Canada

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9 PARTICIPANTS:

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11 Alison Drummond, Assistant Deputy Minister,
12 Long-Term Care Commission Secretariat

13 Ida Bianchi, Counsel, Long-Term Care Commission
14 Secretariat

15 Dawn PalinRokosh, Director, Operations, Long-Term
16 Care Commission Secretariat

17 Sanjay Bahal, Team Lead for Operations, LTCC

18 Derek Lett, Policy Director, Long-Term Care
19 Commission Secretariat

20 Kate McGrann, Gowling LLP

21 ALSO PRESENT:

22

23 Janet Belma, Stenographer/Transcriptionist

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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

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

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, I guess you -- everybody knows everybody?

4 You've met Commissioner Coke, I take it?

5 HUGH ARMSTRONG: We have indeed.

6 PAT ARMSTRONG: Yes.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 All right. So are -- there's the two of you, I

9 take it you're not waiting for anyone else?

10 PAT ARMSTRONG: No.

11 HUGH ARMSTRONG: No.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 Well, we're here. So I guess we could make a

14 beginning.

15 HUGH ARMSTRONG: Okay.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 As you may know, we have been working away at the

18 investigative stages of what we've been doing, and

19 we've been meeting with people and trying to get a

20 better understanding of the current state of

21 affairs.

22 We did deliver a very brief interim

23 report just to try to put a few things forward,

24 weren't particularly revolutionary, but

25 nevertheless, we felt they needed to be said sooner

1 rather than later.

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

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

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

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

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

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

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

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

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

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

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

25 We started studying health care

1 40 years ago when our daughter broke her leg and
2 ended up in traction in the hospital for a couple
3 of weeks. And we realized this would be an
4 excellent place to study women's work.

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

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

15 It was suggested to us that we start by
16 briefly -- and I mean briefly; I won't be more than
17 15 minutes -- four topics to provide a basis for a
18 discussion but, of course, happy to be interrupted
19 anywhere.

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

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

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

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

15 It's truly an interdisciplinary project
16 that includes physicians and philosophers, those
17 with training and nursing and history, economics
18 and epidemiology, architecture and cultural theory
19 to name only some of the 12 disciplines among our
20 26-member research team or least faculty involved.

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

1 would be useful to have both.

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

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

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

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

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

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

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

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

25 Third, the importance of leadership

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 In these communal spaces, dying and

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

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

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

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

25 In addition, the most widely publicized

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

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

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

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

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

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

1 care and the support homes in improving care.

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

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

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

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

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

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

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

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

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

13 "To the extent that empowering
14 people in aged care may involve
15 risk, that risk should be approached
16 by minimizing harm and responsible
17 management, not excluding it
18 entirely. Risk is part of life.
19 There is dignity in risk. Older
20 people should be able to make
21 decisions that may involve taking
22 reasonable personal risks, and their
23 right to control and choice should
24 prevail to the extent that it is
25 reasonable and does not harm

1 others."

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

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

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

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

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

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

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

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

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

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

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

25 So it's hard to assess if there are

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

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

6 PAT ARMSTRONG: They spent a lot more
7 money.

8 HUGH ARMSTRONG: And --

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

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

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

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

1 care because of the conditions there.

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

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

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

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

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

9 PAT ARMSTRONG: Well --

10 HUGH ARMSTRONG: Go ahead, Pat.

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

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

25 HUGH ARMSTRONG: The new homes that are

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

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

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

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

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

1 we're moving in the opposite direction.

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

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

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

1 PAT ARMSTRONG: Growing grass is boring
2 to watch.

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

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

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

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 M-hm.

19 HUGH ARMSTRONG: They wanted to see the
20 action.

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

25 Commissioner Coke.

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

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Yeah.

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

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

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

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

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

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

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

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

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

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

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

25 But we've heard throughout that you

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

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

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

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

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

1 have these, I'll call it, tensions?

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

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

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

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

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

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

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

8 PAT ARMSTRONG: I get you.

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

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

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

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

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

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

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

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

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

10 Pat.

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

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

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

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

21 Does that address your question?

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 It does. It does. Yeah, I was -- it -- yeah, it's
24 just a -- a curiosity to try to see places that
25 have avoided the difficulty of attracting staff

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

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

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

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Okay.

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

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 You froze.

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

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

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

13 The other thing I would say is when --
14 we met with Mr. Smitherman when he was in the
15 Ministry -- we -- and they were developing these
16 rules. We were suggesting that maybe the best
17 things inspectors could do is go and stay for
18 24 hours in a -- in a resident bed, and maybe that
19 would be a very good way of finding out what it was
20 like to live in a home.

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

1 penalties on the directors personally?

2 PAT ARMSTRONG: No.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 You know, they do that sometimes in the
5 environmental area.

6 PAT ARMSTRONG: Right.

7 HUGH ARMSTRONG: M-hm. M-hm.

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

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

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

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

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

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

25 PAT ARMSTRONG: Less so in Norway and

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

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

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

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

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

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

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

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

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

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

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

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

13 PAT ARMSTRONG: Not in Sweden and
14 Norway.

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

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

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

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

3 HUGH ARMSTRONG: Up on the ceiling.

4 PAT ARMSTRONG: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

21 Sorry, Jack.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 another story.

2 COMMISSIONER JACK KITTS: I agree.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 PAT ARMSTRONG: Thank you.

5 HUGH ARMSTRONG: Very good. Thank you.

6 COMMISSIONER ANGELA COKE: Thank you.

7 PAT ARMSTRONG: Good luck with your
8 work.

9 HUGH ARMSTRONG: Good luck in your
10 work.

11 COMMISSIONER JACK KITTS: Thank you.

12 COMMISSIONER ANGELA COKE: Thank you.

13 -- Adjourned at 10:10 a.m.

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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 18th day of November, 2020.

19
20 *Janet Belma*

21
22 _____
23 NEESONS, A VERITEXT COMPANY

24 PER: JANET BELMA, CSR

25 CHARTERED SHORTHAND REPORTER

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