

# Long Term Care Covid-19 Commission Mtg.

Dr. Bernard Leduc, President & CEO, Montfort  
Hospital  
on Monday, October 19, 2020



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1 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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6 --- Held Virtually via Zoom, with all participants  
7 attending remotely, on the 19th day of October, 2020,  
8 2:58 p.m. to 3:30 p.m.

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14 BEFORE:

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

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21 PRESENTING:

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23 Dr. Bernard Leduc,  
24 President and CEO Montfort Hospital

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1 PARTICIPANTS:

2

3 Jessica Franklin, Policy Lead, Ministry of  
4 Long-Term Care

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6 Alison Drummond, Assistant Deputy Minister,  
7 Long-Term Care Commission Secretariat

8

9 Derek Lett, Policy Director, Long-Term Care  
10 Commission Secretariat

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12 John Callaghan, Lead Counsel, Long-Term Care  
13 Commission Secretariat

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15 Dawn Palin Rokosh, Director Of Operations at  
16 Ontario's Long Term Care Commission Secretariat

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20 ALSO PRESENT:

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22 Pierre Flez, French Interpreter for Dr. Leduc

23

24 Judith M. Caputo, Stenographer/Transcriptionist

25

DOCUMENTS TO BE PRODUCED BY DR. LEDUC

IDENTIFICATION PAGE

1) White's Book published in September 2019 7  
by the Assembly of the Francophone Language in  
Ontario.

2) Report for the Healthcare Region of 7  
the East of Ontario For the Champlain Region.

1 -- Upon commencing at 2:58 p.m.

2

3 COMMISSIONER MARROCCO: Doctor, if  
4 you're ready, we are.

5 We're trying to understand the  
6 implications of something that's going on around us  
7 as we're trying to understand it. So it's a bit  
8 confusing on our end.

9 When I'm speaking to you, Doctor, I  
10 don't have to worry about the English, it's only  
11 the others that have to worry about my ability to  
12 understand en Francais. So I'll speak normally  
13 unless you tell me I should stop.

14 DR. LEDUC: (In English) No, we are  
15 good. Thank you.

16 COMMISSIONER MARROCCO: Okay.

17 THE INTERPRETER: Sorry, this is the  
18 interpreter.

19 Do I understand, therefore, I only  
20 interpret into English?

21 DR. LEDUC: (In English) yes.

22 THE INTERPRETER: Okay, thank you.

23 COMMISSIONER MARROCCO: So, Doctor, I  
24 think probably the best thing is to let you start.

25 Do you mind if we interrupt with

1 questions as we go along?

2 DR. LEDUC: (In English) let's do.

3 COMMISSIONER MARROCCO: Okay.

4 DR. LEDUC: I'd like to thank the  
5 Commission for allowing me to share my experience  
6 in long-term care facilities around COVID-19.

7 So my name is Dr. Bernard Leduc, I have  
8 over 20 years experience in family medicine as well  
9 as hospital settings.

10 When I arrived in Ottawa, I had the  
11 chance to work for two to three years in a  
12 retirement residence. And since 2010, I have the  
13 pleasure and privilege of working in the Montfort  
14 Hospital as CEO, that's a university hospital,  
15 since 2013.

16 I'm also, since August of this year,  
17 CEO of the Health Standards Association of  
18 Standards Canada -- (In English) Accreditation  
19 Canada.

20 THE INTERPRETER: Accreditation Canada --  
21 I'm sorry.

22 DR. LEDUC: (In English) and policy  
23 CEO, and board chair.

24 So the Montfort Hospital is a  
25 university hospital of world class focused on the

1 best care for the people. In early 2000, we  
2 developed a partnership with long-term care partner  
3 in the private sector, which is now Revera, to open  
4 a long-term care facility of 128 beds on the  
5 grounds of the hospital. And this long-term care  
6 facility targets mainly Francophone residents.

7 So the Montfort Hospital is engaged in  
8 the fight against COVID-19, and it had 18  
9 hospitalized patients during the first wave, and we  
10 were up to 15 last week. And we were asked to be  
11 involved in the outbreaks on the long-term care  
12 facility on the grounds of the hospital as well as  
13 for another long-term care facility.

14 We also opened the COVID-19 Assessment  
15 Centre in April, and I'm particularly proud to say  
16 that we opened, starting today, a new assessment  
17 centre in Orleans.

18 So for sure the pandemic has  
19 highlighted deficiencies in the systems,  
20 specifically for long-term care. So we often said  
21 that mental health came second when it comes to  
22 healthcare, but I think now we can agree that our  
23 elders are also second class citizens when it comes  
24 to healthcare.

25 The pandemic highlighted the age, and

1 derelict state of some of the residences, as well  
2 as the state of care for the residents. And those  
3 who were in rooms of three to four residents were  
4 particularly vulnerable.

5           And talking of equality, I'd like to  
6 draw your attention to the fact that availability  
7 to Francophone residents is much lower than the  
8 average for the province. And the White's Book  
9 published in September 2019 by the Assembly of the  
10 Francophone Language in Ontario does reveal this.  
11 And the recent report for the healthcare region of  
12 the east of Ontario for the Champlain region as  
13 well highlights the same fact; and it reveals  
14 there's a lack of about 405 beds for the  
15 Francophone population.

16           So if you believe it necessary, I'll be  
17 happy to transfer these documents to the  
18 Commissioners.

19           COMMISSIONER MARROCCO: That would be  
20 very helpful, Doctor, thank you very much.

21           DR. LEDUC: Thank you.

22           COMMISSIONER MARROCCO: Alison Drummond  
23 our executive director, and Dawn will be happy to  
24 receive them from you when you're in a position to  
25 send them.

1 DR. LEDUC: Thank you.

2 So I'll humbly share my experience that  
3 I see as a board chair of the first wave and now  
4 the second wave.

5 So the first wave revealed all the  
6 unknown about this new disease and all the  
7 difficulties linked to that; and anxiety, as well  
8 as fears about the stocks of PPEs. We focused a  
9 lot on intensive care at first, and the orders we  
10 received was to cease all other activities as much  
11 as possible and create capacity. And after news,  
12 this image we have now of a credit card with no max  
13 on it, and we have to do what was needed to be able  
14 to tackle this wave that was coming.

15 It's not necessarily clear in my mind  
16 that the same thing was done for long-term care.  
17 So at the hospital in the first wave, the fact of  
18 ceasing our activities meant we had a pool of  
19 resources that was available. That meant we were  
20 able to open up assessment centres and go and help  
21 in long-term care facilities.

22 The big concerns about the availability  
23 of PPEs, meant that we took maybe the wrong  
24 decisions or decisions that had detrimental impacts  
25 in long-term care. For example, excluding visitors

1 and caregivers from long-term care facilities and  
2 hospitals, and that limited greatly the capacity of  
3 caregiving.

4 And there was limiting one worker to a  
5 single site, that was also the timing of the  
6 pandemic with school holidays, where people had to  
7 self-isolate upon return from travel.

8 So we created an environment that was  
9 quite different from us in hospitals, where there  
10 was a full lack of resources. And whereas we could  
11 tackle more, they had difficulties having staffing  
12 at 50 percent of their usual capacity.

13 And we had a case where all the staff,  
14 and the cooking and nutrition staff for residents,  
15 had to be at home isolating because they tested  
16 positive, or for whatever reasons. And we saw it  
17 as a real difference in culture between long-term  
18 care and intensive care -- (in English) that was  
19 acute care.

20 (Through interpreter) because long-term  
21 care facilities is seen as a place where people  
22 live, and there was a lot of reluctance due to the  
23 fact that hospitals would come in and take control,  
24 and would change the place of residence for those  
25 people.

1                   They had their limited possibility of  
2 stocking up on PPEs, and the practices for  
3 infection, prevention and control were not up to  
4 the standards that we were used to in a hospital  
5 setting, which brings me to the need of  
6 reintroducing inspections for long-term care. Not  
7 necessarily just to react or to punish, but truly  
8 to help the residences to improve the quality of  
9 care and safety of residents.

10                   And the Accreditation of Canada is now  
11 reviewing its accreditation process, so they can  
12 have a continuous and collaborative approach with  
13 the organizations rather than just doing  
14 inspections every four years. That's important to  
15 have standards that the organizations can respect.

16                   And maybe to conclude, what I see with  
17 the second wave is really the availability of human  
18 resources. Hospitals are now at capacity, not  
19 necessarily only because of COVID-19, we have  
20 increased our efforts for testing clinics, and we  
21 are another trying to catch up on the backlog of  
22 surgeries that were cancelled previously. But we  
23 see the level of patients for other levels of care  
24 increasing, and that's due to our incapacity to  
25 transfer those patients to long-term care

1 facilities.

2 In the Champlain region, there's about  
3 900 long-term care beds that are vacant. So we  
4 need to find alternatives for these patients so  
5 that we can continue our activity. In other words,  
6 by opening up spaces in hotels or in new retirement  
7 residences, for example. But as we increase the  
8 number of beds, then comes the issue of recruitment  
9 of personnel.

10 So these are my humble thoughts about  
11 the situation.

12 COMMISSIONER MARROCCO: Doctor, who do  
13 you think should lead the effort to deal with the  
14 problems?

15 DR. LEDUC: I believe the efforts are  
16 done regionally, with the assistance of Health  
17 Ontario. And Jack can possibly attest to the good  
18 collaboration we have between colleagues,  
19 (In English) in Ottawa.

20 (Through interpreter) so we have  
21 regional tables that look at the activities  
22 reopening for long-term care facilities and the  
23 COVID testing.

24 COMMISSIONER KITTS: Bernard, can I ask  
25 a question? I didn't catch at the beginning, the

1 relationship between the Montfort Hospital and the  
2 long-term care home; it's beside your facilities,  
3 is that what you said?

4 DR. LEDUC: (In English) so we did  
5 strike a partnership with a private long-term care  
6 home operator. They have the licence, so they  
7 operate. But the building is on our site, we own  
8 the building.

9 COMMISSIONER KITTS: Was that one of  
10 the buildings that the hospital had to go in  
11 because of the COVID spread?

12 DR. LEDUC: (In English) yes, they had  
13 a bad outbreak in April.

14 COMMISSIONER KITTS: So the question  
15 then becomes, should Public Health long-term care  
16 homes and hospitals that triad, be a triad not just  
17 in response to an outbreak, but have that  
18 relationship that's fluid and smooth all the time?

19 DR. LEDUC: Having more formal  
20 relations with long-term care facilities would  
21 surely help, yes.

22 COMMISSIONER KITTS: Okay.

23 COMMISSIONER MARROCCO: Is there a  
24 reason why it didn't happen in the past, that these  
25 relationships were established?

1 DR. LEDUC: We have an excellent  
2 relationship with our partner, Revera. So we have  
3 quarterly meetings, and we look at a variety of  
4 indicators linked to the safety of patients, such  
5 as falls or wounds, etcetera.

6 We look at the satisfaction of  
7 residents and family boards. Where we didn't have  
8 that kind of relation with the second centre.

9 COMMISSIONER MARROCCO: Commissioner  
10 Coke?

11 COMMISSIONER COKE: Can you elaborate a  
12 bit more on some of the issues underlying the lack  
13 of support for Francophone population in long-term  
14 care?

15 DR. LEDUC: I think it's in the last  
16 report of the Health Services in French of 2019  
17 with the French Health Services Commissioner 2019.  
18 So it was said at the time we had one designated  
19 bed for 3,400 Francophone people; compared to the  
20 average of one bed for 170 Ontarians.

21 COMMISSIONER MARROCCO: We were told  
22 that there's a waiting list in Ontario of 38,000  
23 people. Do you have any sense of what percentage  
24 would be Francophone?

25 DR. LEDUC: (In English), I don't think

1 I have this --

2 (Through interpreter) no, I don't think  
3 I have that number. So out of the 128 Francophone  
4 beds, we do have some Anglophone patients that they  
5 understand they are joining a Francophone environment.  
6 But it's no more than three out of five. And the  
7 waiting list for the centre at the back was 180  
8 Francophone patients.

9 COMMISSIONER KITTS: Bernard, can I  
10 come back to the relationships with the long-term  
11 care homes. Your relationship with Revera sounds  
12 excellent, and I think that relationship will help  
13 things.

14 You said that you were called into a  
15 second long-term care home, but that wasn't so  
16 smooth. Can you let us know, compare and contrast,  
17 what worked in the first instance and what didn't  
18 in the second?

19 DR. LEDUC: Issues were different. The  
20 category of building in terms of long-term care  
21 facility was different. In both places, the  
22 clinical care was good, but the infection  
23 prevention control had to be improved.

24 And in the second residence, that's  
25 where we had an important lack of staff. There was

1 staffing issues in both, but in the second one it  
2 was more dramatic. And both residences had, at  
3 some point or another, due to isolation or testing,  
4 some leadership absence in the staffing on the  
5 spot.

6 COMMISSIONER MARROCCO: Do you have a  
7 sense, Doctor, what could be done to most quickly  
8 or promptly address the staffing problem or make it  
9 a little better than it is?

10 DR. LEDUC: I wish there was a silver  
11 bullet. And again, here is my personal perception  
12 that I feel that for a very long time now,  
13 long-term care has missed any kind of backup  
14 capability. And so we created a perfect storm here  
15 by removing the caregivers, the families and by  
16 increasing the workload.

17 You have to bear in mind the long-term  
18 care residents eat together, we're trying to foster  
19 social interactions. And from overnight, the  
20 residents were then confined to their rooms, which  
21 meant that the meals had to be brought to them into  
22 their rooms.

23 COMMISSIONER COKE: Bernard, the  
24 partnership with Revera, you say staffing, PPE,  
25 IPAC and sometimes leadership, those were four

1 important factors in these long-term care homes,  
2 and part of the differentiation between the two.

3 Does the hospital, because it's  
4 partnered with Revera, supply staff PPE, IPAC  
5 expertise, leadership to the Revera long-term care  
6 home?

7 DR. LEDUC: Not currently. Those we  
8 did for the first residence in the first wave, we  
9 had to supply PPEs and IPAC expertise and staff.

10 COMMISSIONER KITTS: Will that be the  
11 same for other long-term care homes in your area  
12 that you're not formally partnered with?

13 DR. LEDUC: We are occasionally  
14 approached by other residences. We had some  
15 residence that had an outbreak approach us for some  
16 help with residents. And I think we can help with  
17 infection, prevention and control.

18 COMMISSIONER KITTS: Does Public Health  
19 play a large role in these relationships?

20 DR. LEDUC: Yes. Public Health plays a  
21 role in maintaining the high standards of  
22 infection, prevention and control.

23 COMMISSIONER KITTS: Thank you.

24 COMMISSIONER MARROCCO: How do those  
25 relation -- how does the request occur? Who

1 originates, and once the request is made, who takes  
2 charge?

3 DR. LEDUC: So the beginning of the  
4 pandemic the request came through the regional  
5 table for the long-term care, and that's where it  
6 was culminated and there were representatives of  
7 the hospital, of Public Health and the region.

8 Does anybody have any further questions  
9 for Dr. Leduc?

10 COMMISSIONER KITTS: Just one. Do you  
11 feel that your area, Champlain, is better or much  
12 better prepared for Wave 2 than Wave 1?

13 DR. LEDUC: I believe we are better  
14 prepared. We understand the issues better. We're  
15 not as concerned about the supply of PPEs anymore.  
16 However, there's still a concern that it's a very  
17 vulnerable environment.

18 One of the things we did for the first  
19 wave that was a bit difficult at first was the  
20 principle of creating cohorts, so red zones, green  
21 zones. It's a bit different than a hospital where  
22 you can only assign a patient to a bed.

23 Over there, it's their place of  
24 residence, their apartments, so it was a bit of  
25 reluctance to us coming in and imposing that. But

1 I consider it wasn't one of the factors to best  
2 control the outbreak.

3 COMMISSIONER KITTS: Thank you.

4 COMMISSIONER MARROCCO: Well, Doctor,  
5 thank you for the presentation and thank you for  
6 answering our questions.

7 This fills in another portion of the  
8 story for us, and we want to thank you for your  
9 time. And if we have further questions, I hope you  
10 won't mind if we bother you again.

11 DR. LEDUC: Never a problem and thank  
12 you for the invitation, giving me the chance to  
13 chat with you.

14 COMMISSIONER MARROCCO: Thank you very  
15 much, Doctor. Thank you. Good afternoon.

16 COMMISSIONER COKE: Thank you.

17 DR. LEDUC: Goodbye, thank you.

18

19 -- Hearing concluded at 3:30 p.m.

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1 REPORTER'S CERTIFICATE

2  
3 I, JUDITH M. CAPUTO, RPR, CSR, CRR,  
4 Certified Shorthand Reporter, certify;

5  
6  
7 That the foregoing proceedings were  
8 taken before me at the time and place therein set  
9 forth;

10  
11 That all remarks made at the time  
12 were recorded stenographically by me and were  
13 thereafter transcribed;

14  
15 That the foregoing is a true and  
16 correct transcript of my shorthand notes so taken.

17  
18  
19 Dated this 20th day of October, 2020.

20  
21 

22 \_\_\_\_\_  
23 NEESONS, A VERITEXT COMPANY

24 PER: JUDITH M. CAPUTO, RPR, CSR, CRR

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