Long Term Care Covid-19 Commission Mtg.

Meeting with Dr. Iaboni
on Wednesday, January 13, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 13th day of January, 2021, 11:00 a.m. to 12:00 p.m.

BEFORE:

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

PRESENTERS:

TORONTO REHABILITATION INSTITUTE, UNIVERSITY HEALTH NETWORK:
Dr. Andrea Iaboni, Geriatric Psychiatrist and Clinical Researcher, Medical Lead of the Specialized Dementia Unit
Hannah Quirt, Registered Practical Nurse and Project Coordinator, Dementia Isolation Toolkit

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat

Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat
Alain Daoust, Team Lead, Long-Term Care Commission Secretariat

ALSO PRESENT:
Deana Santedicola, Stenographer/Transcriptionist

The following is a list of documents undertaken to be produced

INDEX OF UNDERTAKINGS

The documents to be produced are noted by U/T and appear on the following pages: 42:25

-- Upon commencing at 11:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning.

DR. ANDREA IABONI: Good morning. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): So I am Frank Marrocco, Doctor, nice to meet you. And is it Dr. Quirt?

HANNAH QUIRT: No, it is just Hannah.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, hello, Hannah. And there is Commissioner Dr. Jack Kitts.

COMMISSIONER JACK KITTS: Hello.

COMMISSIONER FRANK MARROCCO (CHAIR): And Commissioner Angela Coke.

COMMISSIONER ANGELA COKE: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): We constitute the Commission, and 11:02. We are sorry we are a couple of minutes -- I'm a couple of minutes late myself, but anyway, we are here, and we are ready to go.

DR. ANDREA IABONI: Great.

COMMISSIONER FRANK MARROCCO (CHAIR):

So you know the drill, basically. There is a transcript. At the end, we post the transcript. And Mr. Callaghan will -- Mr. Callaghan, are you conducting the questioning here? How are we doing that?

JOHN CALLAGHAN: Yes. What are we doing?

DR. ANDREA IABONI: So I have a presentation that --

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, I knew that, Doctor. I knew that.

JOHN CALLAGHAN: Ida is doing the --

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, okay, Ida. Go ahead. We're ready to go when you are.

IDA BIANCHI: Dr. Iaboni has a presentation, and we'll just get started with that. Do you have the ability to share your screen, Dr. Iaboni?

DR. ANDREA IABONI: So Hannah is going to be sharing. I get confused if I have too many things happening at once.

IDA BIANCHI: Dr. Iaboni, why don't we start by having you give the Commissioners a bit of background about your training, your education, and

what you are doing currently.

DR. ANDREA IABONI: Absolutely. So I just wanted to start, though, by saying thank you for allowing me to speak to you today. I have been following your work and have been, you know, really thinking that you are doing a great job. I thought your initial report that came out was really important in terms of your observations thus far.

So just to give you a bit of information about myself, I'm a Geriatric Psychiatrist, and I really specialize in dementia care and in long-term care. All of my clinical practice is in that area, and so I come to you as a consultant of long-term care as a specialist.

I'm also a clinician scientist with an interest in innovations in dementia care, and another important role that I have is Medical Lead of our tertiary Specialized Dementia Unit here at Toronto Rehab. So this is a unit that admits patients or residents from long-term care who may have behavioural and psychological symptoms that put them or others at risk in their home, and so we treat and care for those individuals.

I also have various leadership and advisory roles in the province, but more recently I

have been leading the Dementia Isolation Toolkit Working Group, which formed during the first wave and really has been focussed on the rapid dissemination of best clinical and ethical practices for the care of people in long-term care during the pandemic.

I want to let me colleague Hannah also introduce herself.

HANNAH QUIRT: So I am a Registered Practical Nurse. I have been working in long-term care in a variety of both management and frontline positions for about six years. I worked in the first wave in a long-term care home here in Toronto. I worked as an Associate Nurse Manager, and that was a part-time job, while I also balanced my role with Andrea as a Project Coordinator of the Dementia Isolation Toolkit, and so that is kind of where I fit in here.

COMMISSIONER FRANK MARROCCO (CHAIR):

Just before you start, if I could, Deana, are you able to get everything?

THE COURT REPORTER: It's a little fast.

DR. ANDREA IABONI: I'll slow down.

THE COURT REPORTER: If you could go a

little slower, that would be really helpful.

COMMISSIONER FRANK MARROCCO (CHAIR):

I was being tactful, Doctor. That is where I was going.

DR. ANDREA IABONI: Yes, we'll try to be slower.

IDA BIANCHI: Dr. Iaboni, if you could go back to the previous slide, you talk about -- the slide talks about your role with the Behavioural Supports Ontario. Can you give the Commissioners a little bit of background about what that is?

DR. ANDREA IABONI: Certainly.

So what Behavioural Supports Ontario is what my role is?

IDA BIANCHI: A bit of both, please.

DR. ANDREA IABONI: Okay. So, yeah, Behavioural Supports Ontario is a provincial agency that is focussed on providing care to people with responsive behaviours in long-term care and also in the community.

Within that organization, I have been a sort of academic advisor. I have worked on an advisory role for them in a number of different ways. I'm also on a number of their working groups

developing best practices to use in long-term care, and they are an important partner of the Dementia Isolation Toolkit. They actually supported the tool.

IDA BIANCHI: Okay. Thank you.

And by "responsive behaviours", can you just elaborate a little bit on that?

DR. ANDREA IABONI: Sure. So there is different ways of looking at these sort of behaviours, the more medical model, and then the more sort of patient-centred perspective.

But from a psychiatric perspective, we talk about people with dementia developing behavioural and psychological symptoms of dementia, so that is maybe mood symptoms or agitation or, in some cases, aggressive behaviours.

And the way we think about them from a person-centred perspective is that these are responsive behaviours. They are behaviours that people exhibit in response to situations in their environment or in themselves that -- expressing their needs that are not being met in some way.

And so those are kind of two different ways of describing these sorts of behaviours that can be symptomatic of people with dementia.

IDA BIANCHI: Thank you.

DR. ANDREA IABONI: Great so next slide, please.

So as the first wave unfolded in the province, and we were confronting this need to implement public health and infection control directives in long-term care and also on our hospital unit, you know, it became really immediately apparent that this was easier said than done, that, you know, these measures of isolating people who were suspected of having COVID or confirmed of having COVID was actually very difficult to put in practice in long-term care for a variety of reasons, and I am going to touch on some of those reasons.

At the very same time, we were starting to see the impact of this isolation on residents, and so we all faced these dilemmas where we wanted to protect the community from the virus, but we also didn't want to put these individual residents at risk for harm.

And so the question of how we can achieve these measures in a way that is effective, that achieves the infection control goals, but that is also safe and that is also compassionate for the

residents really drove the development of my toolkit.

So it is going to, I think, be the focus of my recommendations to you today. I feel like this is really how I spent most of my time in this pandemic is trying to answer this question and then thinking about what the barriers have been to doing this in the province.

Next slide, please, Hannah.

So this is just to give you an overview of what this Isolation Toolkit is. So it has two aims. There is our main aim, our big aim, which is really about supporting compassionate, safe, and effective isolation or quarantine of residents in long-term care, so where are these measures necessary, how do we do it in a way that is safe for the resident.

The secondary aim, we call it our sneaky secondary aim, is really about supporting the staff in long-term care, supporting their moral resilience during the pandemic, because these difficult decisions that we are making creates a lot of distress in the staff having to just, you know, keep someone in their room even when we can see that that is causing them harm.

And so really we wanted to help build this resilience in the staff to make decisions and do what they can with the resources that they have at their disposal, and there are four parts of the toolkit. There is an ethical guidance tool, like an ethical framework, and then a decision-making tool that flows from that framework.

There are person-centred isolation care planning tools, and then communication tools, so ways in which we can communicate with the residents, why we are asking them to stay in their room, which is really, I think, an important part of ethically delivering that intervention.

So that is just to give you an overview of the toolkit. I am not going to actually talk that much more about the toolkit. It is out there. It is a tool that we disseminated widely across long-term care, it is being used, but there are a lot of barriers to its use, a lot of limitations, and this is where, I think, I am going to focus what I am going to talk about.

Next slide, please.

So then I just have one other sort of background slide, and that is about -- speaking about the harms to the residents before I move on

to my recommendations, and so I know that you have heard from long-term care residents about their lived experience during the pandemic. I want to share with you about what I have observed about the psychological effects on the population that you probably haven't directly heard from, and those who aren't able to speak for themselves, those with more advanced dementia, who actually make up the majority of long-term care residents, people with cognitive impairment and other -- or language impairments.

And so my experience of this is, again, as a consultant in long-term care and also through having to isolate residentes with dementia here on our hospital unit.

So the first key to think about is that isolation within a long-term care room is really akin to confinement. Unlike isolation in our homes, long-term care residents don't have the freedom to take a walk or go grab a snack or a drink or even change their point of view. You know, they are there in their room looking in one place. Their rooms are often sometimes stark, and I don't know if you have actually had a chance to visit a long-term care home, but, you know, some

residents have a lot of personal possessions, but many of them don't.

They may not have access to a television or any other sources of stimulation or activity, and many of these rooms are actually too small for any meaningful physical activity.

So in my observation of residents with dementia who are isolated, they very quickly lose their daily rhythms and routines, and they in that context can become delirious. We usually think about people who become delirious when they are medically unwell, so independent of them even having COVID. These might be people who are quarantined, who have no symptoms at all. They can become delirious and develop visual hallucinations and delusions after a period of isolation, just from the isolation itself.

Certainly residents who were walking independently become weak, they become unsteady, they become falls prone, and then we have seen a number of residents who transition into a wheelchair after 14 days in isolation.

Just a couple more examples or thoughts. The other one is around separation. So psychologically people are not just suffering from

the confinement, but also from the disruption of what we call their attachments or their social bonds. That is the bonds to family, friends, or to staff that they have a close relationship with. Particularly as in long-term care, there was so much disruption about staffing that -- you know, that people also lost their contacts with recognized and familiar staff.

Just psychologically we know a lot about the importance of attachment in children and adults, and when these bonds are broken, they create anxiety and grief, and so in people with dementia who may not understand or remember why they have been separated, they may feel rejected or punished, and I have cared for residents of long-term care who have developed delusional thinking in believing that their family members are either dead or in danger or that those family members have moved away and abandoned them, and obviously the distress generated by these kinds of thoughts is profound.

The last thing that is important to point out is that residents of long-term care homes don't always bounce back after their isolation or quarantine is complete. It is not just they have

14 days and then they are back to their normal self.

Many have not covered their previous vitality. Some have had persisting symptoms of depression, and for a few, the isolation was actually the start of a short and sharp period of decline before they ultimately passed away.

And really, no question that the isolation contributed to that passing.

IDA BIANCHI: Dr. Iaboni, could I ask you a question about --

DR. ANDREA IABONI: Sure.

IDA BIANCHI: As a layperson, I understand that folks with dementia already have a disruption to their circadian rhythms and engage in delusional thinking. Did you see that exacerbated in people who had not been diagnosed or had an earlier stage of dementia during this period of isolation?

DR. ANDREA IABONI: Absolutely. I'm talking about the new development of these symptoms, so people who didn't have these psychological symptoms before their isolation and within that period of time developed those symptoms.

A progression of dementia is certainly something that we have seen. Someone who was very independent and speaking freely and, you know, able to engage socially and interact with others, and then by the end of their isolation, had -- you know, was nearly mute, had actually lost their ability to speak.

So this is, I think, yeah, important to talk about, what the real harms have been of these measures.

Hannah, did you have anything to add here?

HANNAH QUIRT: I would echo what you have said. Yeah, I worked with a lot of residents who experienced these things, people who were recently admitted, had to go through a 14-day isolation, and then at the end of their isolation would no longer speak, wouldn't get out of bed, wouldn't have any motivation to continue the life that they had had before being admitted.

COMMISSIONER JACK KITTS: I have a question, Dr. Iaboni. We have heard that a number of residents in long-term care homes today really would have stayed at home with the right resources, and a high percentage of 70-plus percent, maybe

even higher, have dementia.

So I have got two questions.

Do you feel that there are a lot of patients in long-term care homes with dementia that could be better cared for at home, and if so, would you have considered moving some of them home if they could be cared for at home during a pandemic?

DR. ANDREA IABONI: Yes, it is a good question. It is often really hard to answer that because it depends so much about the kinds of community supports that they had in terms of their family members.

I think that there probably were some unnecessary admissions to long-term care during the pandemic, families who were in crisis because of lack of access to community services, some of the disruptions that happened in that setting. You know, they lost their day programs, and without the day programs, they couldn't function at home.

I certainly have seen anecdotal reports of that.

And so -- yeah, so I think that there probably are individual circumstances. It is hard to say across the long-term care if you could, you know, move a whole bunch of people out. I mean, I

certainly think where there is family that is willing to take someone -- and that is something I speak to later, you know, that we didn't really create a lot of flexibility in the system for families who were prepared to take someone for a period of time who, you know, with additional supports in the community could have managed for some months at home. We didn't really allow them that flexibility to do that. They would have lost the bed in the long-term care home. It would have been, you know, a permanent irrevocable sort of decision.

And that, I think, would have been an amazing opportunity to sort of take some of the pressure off of long-term care, would have been to allow people to take people home for a period of time where they were able to do that.

COMMISSIONER JACK KITTS: Would it also perhaps mitigate the effects of separation, because at their home they could wander and move around, whereas they couldn't at the long-term care home?

DR. ANDREA IABONI: Yes, absolutely. You know, that a lot of this could have -- a lot of this -- I mean, I think -- and the other part I am not sure that people were aware of is what they

were signing up for when they moved into long-term care during this period, that this quarantine period, you know, was really a significant burden on those people who were moving into long-term care, transitioning into the environment for the first time.

And so I think a lot of effort could have been spent on trying to minimize the need for those sorts of admissions during the sort of crisis period of during the waves, certainly during the second wave as well, because the overcrowding issue in long-term care also, you know, is difficult to address when we are still trying to put people in at the same time.

COMMISSIONER JACK KITTS: Yes. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

Doctor, there has been quite a lot written about the psychological effects of solitary confinement on prisoners, obviously.

DR. ANDREA IABONI: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

Is there a parallel?

DR. ANDREA IABONI: There is -- I mean, in many circumstances there isn't a parallel

because people, when they are able to understand that they are not being punished, then, you know, I think that that doesn't have quite the same psychological impact.

For some people with dementia, they really aren't able to understand why they are being confined, and I think in those circumstances it has a more close parallel because they may feel like they are being punished or imprisoned even, and then that adds that psychological burden of this sort of imprisonment or confinement in that population in particular.

If we could go to the next slide, I wanted to just show you something. I don't know if you have seen this. It was something we developed early on in the pandemic, that we realized when there was this asymptomatic spread that was happening and also that people were having trouble recognizing when someone had COVID in the context of dementia, where people can't say, Oh, my throat is sore or, you know, I'm having trouble breathing, and so we developed this to basically say that any time someone with dementia isn't their normal self, it could represent COVID-19.

And an important thing that is actually

published that is, you know, a scientific finding is that very few long-term care residents will actually present with a fever as the initial symptom of COVID. Only one in four will have a fever.

But, you know, as we expand the possible symptoms that could represent COVID infection, we also expand the number of residents who might need to be isolated as a suspected case, and so -- because failure to detect and isolate people who have COVID leads to this rapid spread of infections through a facility.

So it is a really important and necessary decision, this idea that we have to -- you know, this person might have COVID, they need to be isolated while we investigate this. And this was also borne out by the military report and others where residents with COVID or suspected COVID were not effectively isolated.

But like I was mentioning earlier, deciding to isolate a resident is also one that puts the individual resident at risk of harm, and so we are obliged to mitigate these harms, and this was, I think, where the really important failure in terms of our province was was -- and really the

focus of my first set of recommendations is that we really failed to allocate resources to support this screening and isolation of residents, which is, like, the sort of fundamental infection control process.

So I don't know -- if we go to the next slide, Hannah. This is where I talk a little bit about that aspect.

So we have to really devote resources to this to make sure that the measures are effective and that they are also not harmful to the residents.

And so initially it became really clear that we were not prioritizing tests from long-term care. So if we had a resident who had a cough, and we would put them in isolation and take a swab, they could be stuck in that isolation for, you know, ten days while they were waiting for a test to come back and their cough has long gone. It has resolved. You know, in ten days, even if they had COVID, they wouldn't be infectious anymore, but they are still there waiting for the results of that test.

And so, you know, that created, you know, a lot of unnecessary isolation and harm for

those residents, and I think over time it creates a reluctance in staff to make that call, right? Like who wants to be the one to say, Oh, I think Mr. Smith vomited this morning. Should we swab him? Right? Because, you know, they know this is, like, a sentence for ten days at least, you know, while you are waiting for that test to come back.

And I think even though if it is not explicit, psychologically I think it did slow down some of this detection because the testing just took so long.

I recently had a patient who was in isolation for two weeks for their quarantine. They had their swab on the last day, and it took a further week for that result to come back, so their quarantine fundamentally became three weeks. And, you know, it just seems unfair and -- that these tests are not being prioritized in this environment where we really need to know quickly if there is an infection.

Similar with the lack of use of rapid testing where that might have been valuable in really slowing people bringing the infection into the facility, testing staff, testing family members who were asymptomatic, that that wasn't something

that was actually rolled out, I think, in a way that it could have been.

COMMISSIONER FRANK MARROCCO (CHAIR): Were you ever given a reason, Doctor, why they didn't go to rapid testing, which would seem to be a bit of a game-changer as far as long-term care is concerned?

DR. ANDREA IABONI: Yeah, I wasn't privy to any of that decision-making, I'm afraid. I am not sure what the reason was.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Do you recall when rapid testing was approved?

DR. ANDREA IABONI: I don't know the exact date. It was certainly available through the fall, but I could get that, if you are interested.

COMMISSIONER FRANK MARROCCO (CHAIR): No, that is fine. We'll get that. Thank you, Doctor.

DR. ANDREA IABONI: Yeah, that is worth looking into.

You know, there is this idea of hygiene theatre. I don't know if you have heard this idea. It was certainly when, you know, we are taking everybody's temperature all the time, where we know

that most people are spreading COVID long before they have a fever, and I think that that's also a problem, was that resources were put towards things that were not actually all that useful, like doing twice daily temperature checks in long-term care which, you know, tied up a lot of resources, nursing resources, people having to go around and check all these temperatures twice a day, bringing that nurse into contact with every single resident in that home, even ones that they might not have normally had contact with, and then fundamentally three-quarters of these residents who have COVID don't have a fever, so it was a really low impact but very high intensive resource sort of activity.

So that was quite frustrating, I think, for a lot of people who were following this, that those nursing resources could have been better spent doing other sort of things.

And then this concern around that we weren't really quickly reducing occupancy levels, and I think that was what you spoke to earlier, this idea we weren't moving people into other settings where they might be cared for such as to their families where they were willing to take them, because we weren't building this flexibility

into the regulations that would allow us to do that, and we weren't building capacity in other settings, like the community.

So I guess this last point -- this next point, I think, is something that you guys have had an interest in, I'm interested to talk to you about this, is this idea of what do we do with those residents who are COVID-positive or suspected of having COVID who won't stay isolated in their rooms or who present an infection control risk to the home.

And my perspective is that it would not have been too difficult to create sort of regional long-term care based quarantine or isolation units. You know, there are -- I know there are a number of long-term care homes in the province who had large outbreaks who have not filled up their homes but have actually used the excess capacity to create separate units, separate floors, that they have left empty as COVID units but left empty for their own purposes for their home.

But if we found some way to incentivize those homes to open up to their region, you know, we could use those COVID spaces to cohort residents in a secure setting away from residents who are

COVID-negative.

And, you know, it just seemed like there hasn't been any kind of coordination or planning around any sorts of measures like this that could be delivered within long-term care, which I think is really in the best interests of the residents, that they stay within an environment that is able to sort of address their specialized needs and familiar with the kinds of needs of people with dementia.

COMMISSIONER JACK KITTS: Dr. Iaboni, we heard -- the other side was that just moving these residents out of their familiar room or environment was very harmful to their well-being. So, I guess, we are talking about isolation in your room, in your home, versus moving into a larger capacity. What is the lesser of the two evils?

DR. ANDREA IABONI: You know, I think -- so I think in my answering that, I think it depends a lot on what the other place is.

So if the other place is, for example, an acute care hospital that isn't really equipped for caring with people with dementia and that is not home-like and very institutional and scary and noisy and busy, then you are probably right that

people might be better off psychologically receiving the care in their own long-term care home.

But this is why I think, if they were moving to an environment that was equipped to care for their specific needs and that was home-like and that was familiar in that sense, you know, that wasn't a sort of scary hospital but was, you know, a long-term care home, I think that that would mitigate some of that distress.

You know, I certainly know what happens to people with dementia when they land in hospitals. It is not a pretty sight. Hospitals are not dementia-friendly environments for the most part, with the exception of my unit, which is an exceedingly dementia-friendly environment, but yeah, so I think that -- I think it is about finding the right environment. So that is where field hospitals might be problematic because those are also very noisy, scary, busy places, and that might be difficult for people to deal with.

But, you know, a floor in a long-term care unit that is not their own would still retain some familiarity to them, I think.

COMMISSIONER JACK KITTS: Okay. Thank

you.

DR. ANDREA IABONI: So the last thing was around the need for flexible funding to support IPAC measures, to support the isolation.

So one work-around that a lot of long-term care homes used when they had someone who needed to be isolated but who was not able to stay in their room easily on their own was to apply for high intensity funding through the province to pay for someone one-to-one, for them to allocate one staff member with that one resident to basically keep them company and make sure they didn't leave their room.

Obviously, this is a very expensive solution and also is very limited in situations where homes were in crisis in terms of their staffing where, you know, you don't have enough staff to allocate a single staff person.

But it actually for some homes was extremely effective and really helps mitigate the harms of that period of isolation for those residents.

So, you know, building in some of this flexible funding, allowing homes to increase their staffing during times of outbreak or crisis, if

they can find the staffing, I think is really important and valuable.

Next slide, please.

So this is really around the capacity of the workforce, and I think you guys have had a lot of testimony about this, and so I won't belabour it too much.

But certainly early on when I was working with some homes that were in a crisis situation, and we were trying to find help for them, it seemed like the help that was available at first was more punitive than helpful, that people were really focussing on the deficiencies in those homes.

But, you know, it wasn't surprising that those homes were having deficiencies in their care because they were down to less than half of their usual staffing and because people were sick.

So this pivot that you need obviously from this kind of compliance model that we use in our province to one that was really around crisis management and support, it seemed to take a really long time to put that into place, and certainly to some extent happened when the long-term cares had the hospitals become involved.

But I know that some provinces really invested in rapid response teams, and I think that there is still a role for that, that homes in crisis need immediate support around infection control, around staffing, to provide for the basic needs of the residents and that that is -- there is no real clear path for that. There is no way for homes to ask for that help right now, or even in the first wave, a home that I was working closely with had to go to the newspaper to talk about how desperate they were for staff before anything was done.

I think Hannah was going to speak a little around this idea of on-site medical staffing.

HANNAH QUIRT: Yeah, I just wanted to share a little bit about my experience and what the lack of medical and -- what on-site medical support felt like as a nurse in a long-term care environment.

It meant that as a nurse I was creating -- or making decisions that were really kind of a lot more than I should have been making. I was, you know, pronouncing deaths when a physician had always done that, and it also meant

that in my day-to-day when I was -- you know, I had a certain amount of hours laid out for giving medications and a certain amount of hours laid out for the management of the building, it also meant that I had to add a certain amount of hours for, you know, completing assessments that somebody who was medical had done before.

So it added another burden to nurses that were already stretched way too thin, and it was really, really challenging to not have that support on-site.

In terms of building the skill mix necessary for COVID-19 patients in long-term care, of course this is necessary and, I mean, I am never going to say that building capacity isn't important, but I also think it is really important to recognize that a lot of this capacity actually exists, and the reason that it is not used within the long-term care environment is simply because of the time that it takes.

So sometimes the nurses will reach out to an external resource to start subcutaneous fluids, not because they can't do it themselves but because the monitoring necessary for that and the upkeep of that is just easier if you ask somebody

else to do it because they don't have the time to do it themselves.

DR. ANDREA IABONI: This was something that we learned quite early on when you are supporting homes was that sometimes it seemed like they didn't have the resources even to provide the basic medical care that would help residents get through the outbreak, get through their infection. You know, we would say, Well, if they haven't eaten in three days, have we started fluids? And, you know, Oh, we don't have enough people to do that. And then, Well, have you tried sending them to hospital? Well, we are told not to send them to hospital.

And I know that you guys are looking into why our death rate in Ontario was so much higher than the international death rate in long-term care, and I think that those kinds of dilemmas that the long-term care homes were facing was a big part of it, that they were told not to send to hospital -- or felt that they had that message, that they couldn't send people to hospital, and they also didn't have the resources to provide the medical care, the really very basic medical care, the fluids and the oxygen that the

residents needed, you know, that may have saved lives, but they couldn't deliver.

And this also comes from the perspective of behavioural care for residents, for people in long-term care. So as the staffing became really tenuous, the abilities to provide basic sort of behavioural support care became more and more difficult. The staff who had that training and that expertise, you know, would be away sick, and staff that were filling in didn't have that familiarity with the residents and that expertise, and then that meant that residents themselves were experiencing -- or exhibiting more responsive behaviours because those sort of basic needs -- their basic needs and the basic understanding that we needed to deliver the sort of non-pharmacological interventions wasn't there.

And that comes to this issue of reliance on temporary and part-time workforce, which is that, you know, residents really need to be understood, they need to be known by the people who are caring for them, and when you have people who are just coming in to do a quick job and get out that day and not really invested in understanding the residents, then that is when you

see the problems with responsive behaviours and other psychological challenges in the residents increasing.

IDA BIANCHI: Dr. Iaboni, I just wanted to let you know that the Chair, Commissioner Marrocco, has had to step away, but he has asked us to continue with your presentation.

DR. ANDREA IABONI: Great. Thank you.

The next slide, please.

I guess this is a sort of more overarching thing, and I just wanted to speak to some of the frustration and the worry that we had through the first wave and also, I think, continuing to now, which is the feeling that our expertise and our knowledge of working with residents in long-term care were never really incorporated and consulted in the process of making decisions.

And that it was always very difficult to figure out who was making decisions. So when I knew of one of my homes that was in dire need, that they were facing a staffing crisis and many residents infected early in the pandemic, you know, sending frantic emails in all directions and hearing that, you know, yeah, we know about this

situation, but still seeing that nothing was happening, that no one was stepping forward, and so that created a lot of frustration that we -- really was never clear who was coordinating a response.

And so just my recommendation would be that long-term care is a specific environment that has its specific vulnerabilities and lack of resources and that we needed to have some kind of coordination, either across the province or across a region that was long-term care-specific and that this coordination would have some power to make decisions and allocate additional resources, that the decision-making that happened, that felt it was not accountable or transparent -- and I am sure you have heard about this as well, but constantly thinking, Well, how did we come to this or how have we reached this decision and not really understanding it, that the communication and consultation left something to be desired.

And that we really, I think, could have benefitted from some kind of strategy, that the public health directives in and of themselves don't really present a strategy. They were more, you know, instructions, so do this, and so then rather than saying do this and here are the resources and

the tools that we are building to support you to be able to do this, and I think that that was the part that was really missing.

And that was the part that happened more effectively, I think, in other provinces and countries. They said, you know, we are going to have to accomplish these things to achieve the infection control that we need, and then these are the tools we are putting at your disposal to do it.

There was certainly a lot of organizing that happened, but a lot of it was informal, like the Dementia Isolation Toolkit. Although ultimately we did receive some funding from the province, you know, most of that work was done just by people who were concerned and wanted to contribute.

And then, yeah, the last part is the idea about being proactive. So, you know, especially over the summer it really felt that we could have been doing more to prepare and really invest in the long-term care homes and that failed to happen to any significant extent.

IDA BIANCHI: Dr. Iaboni, what steps do you think could have been taken in the summer to have prepared better?

DR. ANDREA IABONI: So there could have been, you know, decisions made about -- so acknowledging that there was certainly going to be a second wave. I think that -- it was almost as if we felt we had conquered it, and it wasn't coming, although we all knew there was a second wave that would happen, so developing the rapid response teams or sending funding to the long-term care homes to hire extra staff or invest in the training in the way that they did in Quebec of additional health care aides that could be deployed, you know, creating these units.

So I think that -- I mean, that is part of the challenge obviously in a pandemic is investing resources when there is some uncertainty about whether those resources will be needed, but, you know, if we had a plan at least to have COVID units for long-term care residents, then that could have been rolled out quickly in October and November when it became clear that the long-term care outbreaks were ramping up. But none of that planning really happened.

I mean, recently I know that they have rolled out this specialized care centre at the Congress Centre. I know my own hospital has been

involved in that, but, I mean, I think that that must have been decided so quickly that none of the people who would have been involved in this decision-making at my hospital were involved. I mean, they didn't consult with any of my colleagues in dementia care here, and they just created this hospital -- this space.

So again -- so I guess -- it seemed a little bit reactive, right, too little, too late, kind of a response.

IDA BIANCHI: Thank you.

COMMISSIONER JACK KITTS: So are you saying that there is a COVID centre now that has been created in the conference centre?

DR. ANDREA IABONI: Yeah, I think it is at the -- a Congress Centre that is in Etobicoke. It is a partnership with UHN and the Toronto Grace Hospital. They have opened 30 beds thus far. I don't know anything about the level of staffing or what exactly is there, but I do know that two -- so they do accept people with COVID or without COVID, but they don't take people who are wandering, and they don't take people who have responsive behaviours.

So the people who actually are the

people that nursing homes -- who are a risk in terms of spreading the infection are not the ones that they are willing to take. So it is more a place to decant when they have overcrowding, I think, is really the role.

COMMISSIONER JACK KITTS: Did you say they are decanting patients without COVID or with COVID?

DR. ANDREA IABONI: Both. Yeah.

COMMISSIONER KITTS: Both?

DR. ANDREA IABONI: Yeah. So their criteria -- if you want, I can certainly share with you the criteria that I have seen that is available. The criteria is that the long-term care home has some kind of a crisis, either an outbreak, or it could be something like the heating is out or something like that, and then they will take transfers from the long-term care for a short stay until the crisis can be resolved and then they go back again.

And yeah, they take both, COVID and not COVID.

COMMISSIONER JACK KITTS: Okay. If you could share that with Ida, that would be great.

U/T DR. ANDREA IABONI: I will certainly

send that along.

IDA BIANCHI: Thank you.

DR. ANDREA IABONI: Again, it is a unit that I think -- it is not clear to me that it is serving a purpose because they are not taking the people I think that long-term care homes really need to transfer out during the crisis because they are not taking people who are medically unstable, and they are not taking people who are at risk of transmitting the virus.

So next slide, Hannah.

So the last thing I think is really important, and it comes back to the sort of ethical elements of the toolkit, is this idea that we have somehow -- would be able to create a ring around long-term care, that we could shield residents in long-term care from the virus and carry on living our lives outside of long-term care.

You know, so the first part of that, the problem is that obviously it is extremely inequitable to say that we will only lock down our seniors in long-term care. As I have said, this is incredibly psychologically damaging for them. They have far less resources, personal and otherwise, to

cope with isolation than we do in the community.

And the second thing is that it is demonstrably ineffective, that there is obviously a parallel between community spread and spread in long-term care, that we have no magic bubbles to put residents under. They have to get close physical contact with their health care aides and staff in the long-term care, and invariably when there is spread in the community, there will be spread into a long-term care home.

And so part of the frustration that we had in sort of as a -- in terms of -- in supporting people in long-term care over the summer, for example, was we were loosening our restrictions on the community and allowing people to go about, you know, their lives, go to cottages, opening up summer camps, and at the same time, our residents in long-term care were still in lockdown. We were still forcing people into 14-day quarantines when they came back from hospital, placing all those restrictions still on residents.

And I think that going forward we really need to think carefully about that and make sure that as we tighten restrictions in one setting, they should tighten in the other, and as

we loosen them, they should be loosened in the other. That is the only equitable way to approach this, and that has, I think, been burning us all who have been -- those of us who care for residents in long-term care.

I think -- is this the end of my slides? One more slide, Hannah?

Yes. So this is basically the summary of the main recommendations that have come out of our work on the Dementia Isolation Toolkit. And I am happy to take anymore questions that you might have.

IDA BIANCHI: Commissioners?

COMMISSIONER JACK KITTS: No, that was -- go ahead, Angela.

COMMISSIONER ANGELA COKE: Yeah. No, that was very helpful in terms of during COVID. I am just wondering if you have any recommendations and thoughts about issues that were happening pre-COVID that you think need to be, you know, considered going forward?

DR. ANDREA IABONI: About the whole sector? Yeah, I mean, I guess so. I guess all of the things that we are seeing amplified in COVID were obviously endemic as issues in long-term care

pre-COVID.

I have to say -- I want to talk about where there -- there had been improvements and that was -- so I have been working in long-term care -- I guess it has been eight years as a consultant now, and one of the most dramatic changes that happened over the time that I have been working in long-term care was the development of the BSO program and the money and the funds that were invested specifically in supporting the sort of mental health and the behaviours of residents in long-term care.

Since that investment, it has been really night and day in terms of how people think about and talk about these symptoms in the residents, how we support them, way more work on non-pharmacological approaches, really effective in terms of reducing antipsychotic use. You know, a lot of really great work had been done by the BSO leading up until the pandemic, which I think we are fortunate that that was done. That certainly left us in a better position than we might have been otherwise.

But a lot of those gains, you know, are sliding, I think, in the context of the pandemic,

not having enough time to spend with residents and deliver non-pharmacological approaches, increases in the use of medications to address some of the psychological distress they are exhibiting because people feel that they don't have other resources or avenues.

So that is, I think, one good investment that was made in long-term care leading up to this, but overall, the overarching problem has been the issues around adequate funding and staffing in that environment.

COMMISSIONER ANGELA COKE: Okay. Thank you.

COMMISSIONER JACK KITTS: But I want to come back to your thoughts or perhaps your opinion on the fact that there are people or residents in long-term care who a lot of health professionals feel should not be there, and I want to focus particularly on dementia, because that is your specialty.

So are there a lot of patients with dementia who are in long-term care homes that actually should be being cared for at home?

DR. ANDREA IABONI: I guess I would find it hard to answer a lot. I don't know about a

lot.

I think that people move into long-term care maybe a little too quickly, you know, that -- it is not unusual that by the end stage of dementia, if someone makes it that far in their disease, that they do need more support than might be able to be delivered in the community. For example, if they become, you know, incontinent or unable to walk and need a lot of daily personal care and -- you know, and they live with a spouse who is unable to do that who is older themselves.

Like that is an example. Well, my impression is that people are being moved into long-term care a little bit too quickly, you know, that they could go much longer in the community, and that in many ways actually that that would probably prolong their life, because I have to say that moving into long-term care, you know, is sort of an end of life kind of move for people with dementia. They get less activity, less social interaction, less support from their family, and not to say that -- I don't want to make it sound like people are dying of neglect or anything like that in long-term care, because for the most part I think the care that people receive in long-term

care outside of the pandemic is excellent.

But it really signals that somebody is reaching, you know, the end stage of their disease when they need to move into long-term care.

So what I think the issue is is that people are moving at an earlier stage where there could be more done to support them in the community either because they don't have the family support or because the community supports aren't meeting all of those gaps, aren't addressing those gaps.

COMMISSIONER JACK KITTS: Okay. Thank you.

IDA BIANCHI: So unless there are any other questions, Dr. Iaboni, thanks for coming and joining us, and we may be back to you with other questions or issues arising from your presentation.

But it was really helpful and very enlightening.

DR. ANDREA IABONI: So I'll certainly send you the information about this new unit that I have so you can see what is happening there.

IDA BIANCHI: And thanks to you too, Hannah. It was nice to meet you, and thanks for your thoughts on this.

COMMISSIONER FRANK MARROCCO (CHAIR):

Yes. Thank you both for the presentation.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: That was great. Thank you.

COMMISSIONER ANGELA COKE: Take care.

-- Adjourned at 11:50 a.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 13th day of January, 2021.

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