

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.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

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9 TORONTO REHABILITATION INSTITUTE, UNIVERSITY HEALTH

10 NETWORK:

11 Dr. Andrea Iaboni, Geriatric Psychiatrist and

12 Clinical Researcher, Medical Lead of the

13 Specialized Dementia Unit

14 Hannah Quirt, Registered Practical Nurse and

15 Project Coordinator, Dementia Isolation Toolkit

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18 PARTICIPANTS:

19

20 Alison Drummond, Assistant Deputy Minister,

21 Long-Term Care Commission Secretariat

22 Ida Bianchi, Counsel, Long-Term Care Commission

23 Secretariat

24 John Callaghan, Counsel, Long-Term Care Commission

25 Secretariat

1 Derek Lett, Policy Director, Long-Term Care
2 Commission Secretariat
3 Angela Walwyn, Senior Policy Analyst, Long-Term
4 Care Commission Secretariat
5 Rose Bianchini, Senior Policy Analyst, Long-Term
6 Care Commission Secretariat
7 Alain Daoust, Team Lead, Long-Term Care Commission
8 Secretariat

9

10 ALSO PRESENT:

11 Deana Santedicola, Stenographer/Transcriptionist

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

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Good morning.

5 DR. ANDREA IABONI: Good morning.

6 Thank you.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 So I am Frank Marrocco, Doctor, nice to
9 meet you. And is it Dr. Quirt?

10 HANNAH QUIRT: No, it is just Hannah.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Well, hello, Hannah. And there is
13 Commissioner Dr. Jack Kitts.

14 COMMISSIONER JACK KITTS: Hello.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 And Commissioner Angela Coke.

17 COMMISSIONER ANGELA COKE: Good
18 morning.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 We constitute the Commission, and
21 11:02. We are sorry we are a couple of minutes --
22 I'm a couple of minutes late myself, but anyway, we
23 are here, and we are ready to go.

24 DR. ANDREA IABONI: Great.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

6 JOHN CALLAGHAN: Yes. What are we
7 doing?

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

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

12 JOHN CALLAGHAN: Ida is doing the --

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

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

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

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

1 what you are doing currently.

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

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

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

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

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

7 I want to let me colleague Hannah also
8 introduce herself.

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

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Just before you start, if I could,
21 Deana, are you able to get everything?

22 THE COURT REPORTER: It's a little
23 fast.

24 DR. ANDREA IABONI: I'll slow down.

25 THE COURT REPORTER: If you could go a

1 little slower, that would be really helpful.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

13 DR. ANDREA IABONI: Certainly.

14 So what Behavioural Supports Ontario is
15 what my role is?

16 IDA BIANCHI: A bit of both, please.

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

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

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

5 IDA BIANCHI: Okay. Thank you.

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

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

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

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

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

1 IDA BIANCHI: Thank you.

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

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

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

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

1 residents really drove the development of my
2 toolkit.

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

9 Next slide, please, Hannah.

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

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

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

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

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

22 Next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

1 14 days and then they are back to their normal
2 self.

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

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

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

12 DR. ANDREA IABONI: Sure.

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

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

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

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

11 Hannah, did you have anything to add
12 here?

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

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

1 even higher, have dementia.

2 So I have got two questions.

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

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

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

20 I certainly have seen anecdotal reports
21 of that.

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

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

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

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

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

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

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

15 COMMISSIONER JACK KITTS: Yes. Thank
16 you.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Doctor, there has been quite a lot
19 written about the psychological effects of solitary
20 confinement on prisoners, obviously.

21 DR. ANDREA IABONI: Yes.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Is there a parallel?

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

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

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

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

25 And an important thing that is actually

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Were you ever given a reason, Doctor,
5 why they didn't go to rapid testing, which would
6 seem to be a bit of a game-changer as far as
7 long-term care is concerned?

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

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Okay. Do you recall when rapid testing
13 was approved?

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

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 No, that is fine. We'll get that.
19 Thank you, Doctor.

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

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

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

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

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

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

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

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

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

1 COVID-negative.

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

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

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

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

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

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

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

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

25 COMMISSIONER JACK KITTS: Okay. Thank

1 you.

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

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

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

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

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

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

3 Next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 DR. ANDREA IABONI: Great. Thank you.
9 The next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 IDA BIANCHI: Thank you.

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

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

25 So the people who actually are the

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

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

9 DR. ANDREA IABONI: Both. Yeah.

10 COMMISSIONER KITTS: Both?

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

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

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

25 U/T DR. ANDREA IABONI: I will certainly

1 send that along.

2 IDA BIANCHI: Thank you.

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

11 So next slide, Hannah.

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

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

1 cope with isolation than we do in the community.

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

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

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

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

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

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

13 IDA BIANCHI: Commissioners?

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

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

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

1 pre-COVID.

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

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

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

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

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

12 COMMISSIONER ANGELA COKE: Okay. Thank
13 you.

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

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

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

1 lot.

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

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

1 care outside of the pandemic is excellent.

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

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

11 COMMISSIONER JACK KITTS: Okay. Thank
12 you.

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

17 But it was really helpful and very
18 enlightening.

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Yes. Thank you both for the
2 presentation.

3 COMMISSIONER ANGELA COKE: Thank you.

4 COMMISSIONER JACK KITTS: That was
5 great. Thank you.

6 COMMISSIONER ANGELA COKE: Take care.

7
8 -- Adjourned at 11:50 a.m.

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1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

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

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

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

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16 Dated this 13th day of January, 2021.

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