

Long-Term Care COVID-19 Commission

Via Zoom
on Tuesday, September 22, 2020



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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held Virtually via Zoom, with all participants
15	attending remotely, on the 22nd day of September,
16	2020, 1:30 p.m. to 2:58 p.m.
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

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7 PRESENTERS:

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9 Samantha Peck, Executive Director, Family Councils

10 Ontario

11 Tiffany Fearon, Client Services Manager, Family

12 Councils Ontario

13 Natacha Dupuis, Bilingual Outreach Manager, Family

14 Councils Ontario

15 Cathleen Edwards, Education Manager, Family

16 Councils Ontario

17 Lynn Mahoney, Counsel, Gowlings WLG

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1 PARTICIPANTS:

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3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5 Ida Bianchi, Counsel, Long-Term Care Commission

6 Secretariat

7 John Callaghan, Counsel, Long-Term Care Commission

8 Secretariat

9 Derek Lett, Policy Director, Long-Term Care

10 Commission Secretariat

11 Dawn Palin Rokosh, Director, Operations, Long-Term

12 Care Commission Secretariat

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14 ALSO PRESENT:

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16 Olivia Arnaud, Stenographer/Transcriptionist

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1 -- Upon commencing at 1:30 p.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, let me tell you: First of all, as I said
5 before you joined us, thank you, the three of you,
6 for coming.

7 The way we would like to do it is we'd
8 like to hear what -- we don't have a set pattern of
9 questions. We would like to hear what you have to
10 say. I would just caution you that we'll ask you
11 questions as we go along. We're not trying to be
12 rude, but we just find it better to ask the
13 questions as they come up --

14 SAMANTHA PECK: Mm-hm.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 -- rather than wait until the end and go back.

17 SAMANTHA PECK: Okay.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 So we're ready when you are.

20 SAMANTHA PECK: All right. So perhaps
21 I'll start. I'll tell you just a little bit about
22 our mandate to set the context for the work that
23 we've been doing to support families and hear their
24 concerns through the pandemic.

25 We are a Ministry of Long-Term Care --

1 provincial Ministry of Long-Term Care-funded
2 organization. We're a charitable, not-for-profit.
3 We were incorporated in 2015. We have federal
4 incorporation, but we have a provincial mandate,
5 although our work actually goes back to the late
6 1990s as a program, working with families to, at
7 that time, just assist them with developing their
8 peer-support groups in long-term care.

9 Over time, our mandate has evolved to
10 supporting public policy development at a
11 provincial level and assisting families and helping
12 them navigate the long-term care system and, still
13 to form, effective peer-support groups within
14 long-term care homes.

15 These groups, Family Councils, have
16 powers and standing under the Long-Term Care Homes
17 Act in Ontario which gives them certain powers to
18 advise licensees of concerns and recommendations
19 they may have about the functioning of the home.

20 So we estimate that probably about
21 80 percent of Ontario's long-term care homes, which
22 is over 600, have Family Council. So there were
23 500 groups who work with the home, ideally
24 collaboratively and in partnership, to improve the
25 quality of life of people living in those homes.

1 And so our mandate is to support those
2 groups, to engage in research, policy, analysis,
3 public policy discourse to advance the sector as a
4 whole and to embed the family voices in decision
5 and policy being made in long-term care.

6 We have a collaborative relationship
7 with the Ministry of Health. They're our funder
8 but also our partner in the public policy work.

9 COMMISSIONER FRANK MARROCCO (CHAIR): I
10 thought I heard you say earlier you were funded by
11 the Ministry of Long-Term Care and the -- so now
12 you say and Ministry of Health?

13 SAMANTHA PECK: No, we were funded by
14 the Ministry of Health and Long-Term Care when it
15 was combined. Now we're funded by the Ministry of
16 Long-Term Care, but we have relationships with both
17 ministries depending on what issues specifically
18 we're specifically working on.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Okay.

21 SAMANTHA PECK: It's mostly with
22 Long-Term Care.

23 And so we're a staff team of four.
24 There's three of us here today. I'm the executive
25 director, have been since January 1st, so nothing

1 like being a new ED during a pandemic, but I've
2 actually been with Family Councils of Ontario,
3 formerly Family Councils Program, for 12 years now.

4 Tiffany is our client services manager,
5 responsible for our conflict resolution as well as
6 equity and inclusion portfolios.

7 And Cathleen Edwards is our education
8 manager who also has research analysis and
9 development in her portfolio as we go.

10 And then we have a bilingual outreach
11 manager based in Sudbury for work in Northern
12 Ontario. So that's sort of our scope, quite
13 broadly.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 How does somebody become a member?

16 SAMANTHA PECK: Ah. So FCO is not a
17 membership organization, but for Family Councils at
18 the long-term care homes, membership is defined in
19 legislation as any family member or person of
20 importance to a resident is entitled to be a member
21 of the Family Council.

22 Well, "person of importance" has been
23 interpreted to mean, and this is supported by the
24 Ministry of Long-Term Care, is that it's family by
25 choice -- so a friend, substitute decision-maker --

1 or someone who had a resident in a long-term care
2 home but their resident has since passed away, they
3 may continue to be a member of the Family Council,
4 subject to that provision being in the council's
5 terms of reference, so agreed upon by the group.

6 Staff are not permitted to be member --
7 home staff are not permitted to be members of the
8 Family Council, nor are people with a contractual
9 relationship to the Ministry of Long-Term Care if
10 they have responsibility for long-term care homes.

11 Even if a staff person, let's say at a
12 [indecipherable] home has a loved one living in
13 that home, so they're a family member of a
14 resident, they still cannot be a member of the
15 council because their right to be a member is
16 subject to a list of those who are not permitted to
17 be members. And this is to protect the
18 confidentiality and the autonomy of those Family
19 Councils.

20 The home licensee, usually delegated to
21 the administrator of the home, has duties to
22 consult with the council, report back or respond to
23 concerns within ten days, and to, where possible
24 and feasible, act upon the concerns and the
25 recommendations of the council.

1 So in the legislation, there's no
2 direction given to Family Councils as to what they
3 have to do. It's all on the onus of the home to
4 fulfill its duties to work with, respond to,
5 protect from interference, and so on to the Family
6 Council.

7 In terms of the COVID experience, many
8 of the issues that families are concerned about
9 with COVID pre-date it, but these issues have been
10 exacerbated.

11 So the big one is staffing. Now,
12 long-term care has a staffing crisis. This isn't
13 news. This has been in discussion for a long time.
14 And what we mean by staffing is not only the number
15 of people in a long-term care home but the types of
16 staff and their skills and competencies.

17 Mostly when we talk about a staffing
18 crisis, it's a lack of PSWs or personal support
19 workers. Those are the folks who provide the vast
20 majority of the hands-on care to the long-term care
21 residents, bathing, assistance at meal times, and
22 so on.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 We met with the association yesterday, so we still
25 have that, but go ahead.

1 SAMANTHA PECK: What families are
2 concerned about with the lack of PSWs -- oh,
3 Natacha is coming in now. She's just connecting.
4 She's our bilingual outreach manager from Sudbury.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Hello, Natacha.

7 NATACHA DUPUIS: Hi. Sorry I'm late.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 That's fine. There's three commissioners: Myself,
10 Frank Marrocco, Commissioner Coke, and
11 Commissioner Kitts.

12 SAMANTHA PECK: We're just talking
13 about the issues that families are all concerned
14 about.

15 So as outreach manager, Natacha hears
16 also a lot of those concerns and a lot of the
17 heartbreak. I'll let her expound on that in a bit,
18 but I'll just give a high level of the concerns.

19 So staffing: So families are concerned
20 that without an adequate number of personal support
21 workers that residents will not have the quality of
22 care to which -- the [standard of care] (ph) they
23 should be receiving; so with consequences such as,
24 you know, pressure ulcers from not being turned
25 properly or being left too long in incontinence

1 briefs because of not being toileted or people not
2 having enough time to eat if there's someone who
3 requires to be fed or to have assistance with
4 eating.

5 And those things all have real
6 consequences on the quality of life and care a
7 person, who's often quite frail and increasingly
8 lives with dementia, may suffer.

9 So malnutrition, dehydration, pressure
10 ulcer wounds occurring or increasing. And
11 sometimes it's also about the psychosocial -- or
12 often about the psychosocial well-being. Residents
13 may need encouragement to participate in
14 activities, they may need assistance getting to an
15 activity, things such as that, and then dealing
16 with responsive behaviours from dementia; so
17 wandering, sundowning, all those things that are
18 expressions of unmet need that take time to be
19 supported and to be understood.

20 And -- yeah?

21 COMMISSIONER JACK KITTS: Just a quick
22 question about the staffing. So you have to have
23 the right number of people with the right skills
24 and competencies.

25 SAMANTHA PECK: Yeah.

1 COMMISSIONER JACK KITTS: Does the
2 acuity of the patients in the home factor into that
3 in terms of the number of people and the skills and
4 competencies, and do you have a way to measure the
5 acuity of one home versus the other or one ward
6 versus the other and staff according to the acuity,
7 or is that not considered?

8 SAMANTHA PECK: So homes are -- there
9 is an acuity measure called the Case Mix Index, and
10 that most directly affects funding. So that's done
11 at a ministry level.

12 In Ontario, there are, within the
13 legislation and associated regulations, rules about
14 staffing. What families want is something that is
15 closer to a mandated four hours of care per
16 resident per day. That's not something that's
17 currently done in Ontario.

18 Now, PSWs have been increasing measures
19 to ensure a higher standard of training for those
20 people for when they enter long-term care. So
21 that's about, you know, the qualifications and
22 competencies.

23 And then when you look at the needs of
24 residents, those needs have only increased over the
25 past -- even in my time, ten -- say, ten years, the

1 last decade. People are older, frailer, and
2 sicker, with a higher chance of living with
3 dementia by the time they enter long-term care. In
4 part, that's because people are living longer.
5 Ontarians are living to an older age. It's also in
6 part because of -- and this is, you know, in part a
7 good thing -- an increased attention paid to home
8 and community care.

9 So people are living in their
10 residences longer. That means, though, by the time
11 they go into long-term care, they have higher needs
12 than they would have ten years ago.

13 There's a saying: It's something like
14 retirement home folks are the long-term care
15 residents of 10 to 15 years ago. Those who were
16 living in long-term care 10 to 15 years ago would
17 have been more likely in a higher level of acute
18 care. So there are just higher needs, and you have
19 people who may require dialysis, so there's
20 specialized needs there; two-person transfers for
21 bariatric people. So there's a lot that goes along
22 with just PSWs providing care right now.

23 Also, then, in terms of staffing, it's
24 the nurses. So some rural communities have a
25 really hard time getting registered nurses or

1 registered practical nurses. It's hard to get
2 geriatricians. Canada as a whole has a lack of
3 geriatricians and physicians who are focused on
4 working with older adults. It's not a sexy career.

5 So that all, pre-COVID, existed. So
6 issues around attracting and retaining staff --
7 part of it for PSWs is pay. They do not get paid
8 as much in long-term care as they do compared to
9 hospital.

10 It's a really hard job. It is, you
11 know, 24 hours a day. You may be working, you
12 know, overnight shifts. It's also that many homes
13 don't offer full-time employment for PSWs. PSWs
14 may not have benefits. So they may be cobbling
15 together a living at multiple sites.

16 When you look at COVID, then, what we
17 saw at the beginning is there was issues with staff
18 working at multiple sites, so going from home to
19 home. That's an increased infection risk. So that
20 was a big issue. It's since been addressed for the
21 pandemic with the emergency orders from the
22 provincial government limiting the number of sites
23 staff can work at.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Can I just stop you there? I'm trying to

1 understand that because if I limit the number of
2 people or the number of sites that you can go to...

3 SAMANTHA PECK: Mm-hm.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Well, I'm solving one problem, which is the
6 transmission of the disease, but doesn't that mean
7 that somebody along the line doesn't have somebody
8 that they need because now the person can't go to
9 the...?

10 SAMANTHA PECK: Mm-hm.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Yeah, okay.

13 SAMANTHA PECK: So you're solving the
14 problem at that critical juncture, which was -- and
15 so at the beginning of the pandemic, there were
16 three sort of critical issues to address. One was
17 we didn't have enough staff. So then staff were
18 pulled in from school boards, et cetera, so there
19 was a reallocation.

20 There was also lack of testing
21 available, and staff needed to be tested so often,
22 and that was really difficult, was to get enough
23 tests. That's since been rectified.

24 And then also at the beginning, one of
25 the critical issues was a lack of understanding of

1 asymptomatic transmission, plus the presentation of
2 COVID-19 in older adults, which was not the same as
3 with younger folks.

4 So all of that combined kind of created
5 a perfect storm in long-term care. So we already
6 had a staffing crisis; you layer that all on.

7 So with the restriction of multiple
8 sites a person could work at, yeah, you did solve
9 part of that problem. You did reduce the risk of
10 transmission from home to home, but then you didn't
11 have, say, enough staff at different sites.

12 And so homes are bringing in agency
13 staff, which has always happened. Homes have
14 always needed to look to agencies for temporary
15 workers, but those people weren't subject to the
16 same stipulations around multiple sites, so there
17 was still a bit of a loophole there.

18 But it was because homes can't, in many
19 cases, attract and retain PSWs.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 That's what I was going to ask you. You know, why
22 do people work -- I mean, I can imagine the answer,
23 but that's not good enough.

24 Why do people work at more than one
25 home? What are their reasons?

1 SAMANTHA PECK: The reasons being many
2 homes do not offer full-time PSW positions. So you
3 may simply not have enough hours in your week to
4 make a living if you're only working at one home.
5 If one home only offers you 25 hours, I'm just --
6 and I'm just making up numbers --

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Mm-hm.

9 SAMANTHA PECK: -- and you need
10 full-time employment, you're going to have to work
11 somewhere else as well.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Now, do they do that -- from your perspective, do
14 they offer -- let's just take your example,
15 25 hours. Because that's all they need, or are
16 they offering 25 hours for some other reason?

17 SAMANTHA PECK: I don't have anything
18 to necessarily back this up concretely. What I've
19 heard anecdotally --

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 That is your speculation?

22 SAMANTHA PECK: This is my
23 speculation --

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Right.

1 SAMANTHA PECK: -- based on pure
2 anecdote that part of it is to avoid paying
3 benefits because that's a cost to the long-term
4 care home, and that money has to come out of
5 somewhere. And part of it might just be that, you
6 know, homes are going to need some part-time people
7 just to cover some shifts. That's just a reality
8 of having, you know, 24-hour scheduling.

9 But I think a lot of it is that homes
10 don't necessarily get enough money to pay for all
11 of the PSW hours that they need. So that's a
12 systemic issue. And then some homes will just
13 prefer or for whatever reason try to cut costs by
14 eliminating benefit packages.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 So are the PSWs unionized in these places or not?

17 SAMANTHA PECK: It depends. It really
18 depends. What --

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 But being unionized doesn't -- sorry. But being
21 unionized doesn't stop this practice from
22 happening?

23 SAMANTHA PECK: To the best of my
24 understanding, it doesn't stop it.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.

2 SAMANTHA PECK: Now, there are also, in
3 terms of PSW pay and benefits, discrepancies
4 between not-for-profit, for-profit, and municipal
5 homes.

6 So municipalities -- the one I'm most
7 familiar with is the City of Toronto -- because
8 they have increased monies in the budget from the
9 municipality, they pay PSWs more than a for-profit
10 or a small independent home may. So then you have
11 increased tension within the sector, looking at
12 operator type in terms of what the pay and
13 scheduling availability is there. So that may have
14 an impact on the ability of some homes to recruit
15 and retain staff.

16 PSWs also -- it's not really seen as a
17 great career option. It's, in some cases,
18 literally back-breaking work. It's hard. You
19 don't have the same degree of professionalization.
20 So, you know, PSWs have a lower number of hours
21 they need to complete to be able to work as a PSW.
22 It's not seen with the same status as an RN or an
23 RPN. And I'm not saying they should be the same.
24 I'm just saying that PSWs aren't well-respected
25 within the sector, and part of that comes with, you

1 know, some lower pay.

2 There's also the impact, mostly in
3 PSWs, of many of those people are women from
4 racialized communities. And so part of that has to
5 do with newcomer women in Ontario for employment
6 being strongly encouraged to go into PSW work
7 because it's needed and because it's seen as an
8 easy option.

9 What that creates -- and once again,
10 this is speculation and anecdotal; I don't have
11 firm evidence to back this up, just anecdotes -- is
12 that it creates a culture in long-term care that is
13 exacerbated by the gender and race divide, the
14 racialization divide of staff. And leadership is
15 often -- and I'm going to speak about this quite
16 bluntly -- is older white men. Not that it's a bad
17 thing; it's just the way it is.

18 COMMISSIONER FRANK MARROCCO (CHAIR): I
19 mean, I hope it's not just automatically. That
20 would be bad for me.

21 SAMANTHA PECK: No, it's just an
22 observation.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Yes.

25 SAMANTHA PECK: But many PSWs, and

1 especially PSWs, are racialized women. So there's
2 a power imbalance. You don't see a lot of those
3 people come up through the ranks, in part because
4 there isn't much of a rank to go up through with
5 PSWs, but there's still a gender and race divide
6 and PSWs experiencing racism from their peers and
7 in some cases from families, which also then leads
8 them to leave either that home or the sector as a
9 whole. Because who wants to work somewhere where
10 you're delivering difficult, intimate, hands-on
11 care and facing dehumanization on a regular basis?

12 So there's a lot at play that is
13 contributing to a poor experience for PSWs, so
14 underpaid, under-appreciated, no career laddering
15 or path, impacts of systemic and institutionalized
16 racism. Caregiving is often women's work, and, you
17 know, there's a historical background as to why
18 that's often devalued. But those are all the
19 things that sort of are creating a perfect storm
20 within long-term care.

21 And then you layer on top of that a
22 global pandemic and people feeling unsafe to go to
23 work, and that relates to those other two points --
24 actually, three other points: So lack of testing.
25 So people not knowing if they were symptomatic --

1 if they were ill or not and not being able to get
2 testing.

3 Lack of personal protective equipment
4 was a huge challenge at the beginning of the
5 pandemic. Homes did not have enough masks, gloves,
6 and gowns. So they were -- so this is known that
7 there was an increased need to get more PPE into
8 long-term care homes. That's why there were
9 drives; the government was pushing for it.

10 There's also anecdotes in the media of
11 hoarding of PPE and it not being given to PSWs or
12 having to reuse it when, really, they were the ones
13 who were being most likely to get infected from
14 working with a resident.

15 And because we didn't have enough
16 information on presentation and symptomology in
17 older adults of COVID, we may have a PSW who's
18 overworked and underpaid, who doesn't have the PPE
19 that they need because it isn't being given to
20 them, doesn't have access to a COVID test, might be
21 working with someone, an older adult who is
22 asymptomatic but infected and they don't know it
23 which creates this incredible culture of fear
24 because who wants to go to work and potentially
25 die.

1 Plus, you know, the power imbalance
2 that comes with being sort of the lowest on the
3 ladder and the other culture -- you know, I'm
4 saying culture of long-term care, so the entire
5 thing, not just ethnic, racial, gender, and so on
6 that goes with being, you know, a PSW.

7 So the staffing crisis was really
8 exacerbated by COVID, but it was by no means
9 created by COVID.

10 There have been studies, commissions,
11 planning tables going back years that have
12 highlighted that long-term care has a staffing
13 crisis. And it's only getting worse.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Why do you think nobody was able to do anything
16 about it or at least anything significant about it?

17 SAMANTHA PECK: So I wouldn't say they
18 weren't able. I say it was a choice. So this is a
19 system that people created, so they had a choice
20 about what to do about it. So I think the reason
21 why nothing has been done so far is health, A, is
22 the biggest portfolio in Ontario. There's already
23 a good chunk of change in the provincial coffers.
24 It's only going to increase as the population ages.

25 We have an aging population. That just

1 is what it is. So we're going to have more folks
2 who require more care. Long-term care has a long
3 waiting list. It's an expensive problem to fix.
4 So there's that part of it.

5 But it's also a broader challenge
6 around ageism, so people not wanting to go into
7 caring for older adults. You see that with the
8 number of geriatricians per person in Canada
9 compared to other -- perhaps the Nordic countries.
10 It's a lot lower here.

11 You know, staff can get paid more in
12 community or hospital, so there's attracting people
13 that could work in long-term care. So part of it,
14 it's expensive to fix; there have been other
15 priorities in the province. You also have this
16 ongoing tension between the province and the feds.
17 Long-term care isn't in the Canada Health Act, so
18 that might be seen as an indicator that it's not as
19 important.

20 And then, so how do you increase the
21 funds that we need for long-term care to be
22 delivered well?

23 There's also -- right now, there is
24 ongoing culture change in long-term care, which is
25 a good thing, where we're moving towards

1 resident-centered, family-centered experience
2 where -- you know, smaller homes and so on, but all
3 of that comes with a price tag, and it's not cheap.
4 So finding that money is difficult.

5 And also, we don't want to -- most
6 people don't want to think about long-term care.
7 So socially, culturally, it's not something that
8 gets a lot of buzz, unlike the reproductive health
9 right now or caring for children. Both of those
10 things are important, but so is supporting the
11 experience of older adults.

12 So I think there's a few issues at play
13 both in terms of practical but also as in -- just
14 the impacts of ageism in our society, not wanting
15 to think about long-term care.

16 So getting voters to, let's say, from a
17 political standpoint, vote for a platform that will
18 radically increase the funds to long-term care
19 could be a hard sell. I know that, you know, if I
20 were running for office, let's say, I could see it
21 as being a hard sell for people because it's not as
22 sexy a sell as let's take care of children or, you
23 know, any other multitude of social issues. It's
24 important, but it's not top of mind for people.

25 So I think you can't talk about issues

1 in long-term care without talking about staffing
2 because that's -- you know, what we saw in the
3 Gillese inquiry around serial killings in long-term
4 care that pointed to staffing, and previous
5 inquiries, works, tables talked about staffing.

6 So during COVID, that was one of the
7 big conversations, but then the others were around
8 things that have been mostly fixed right now: So
9 the availability of PPE, testing -- although
10 testing is still an issue. I was on the phone just
11 this afternoon talking to a family member about the
12 long lineups to get tested for COVID because it's
13 still an -- it's a barrier still within long-term
14 care.

15 So that's -- any questions about
16 staffing?

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Yeah, I do have -- well, does somebody, one of the
19 other commissioners have a question?
20 Commissioner Kitts?

21 COMMISSIONER JACK KITTS: Yeah, when we
22 speak about staffing, it always goes to personal
23 support workers.

24 And so my question is, is that the key
25 that needs to be fixed, or is there staffing

1 shortages and problems across the gamut of nurses,
2 RNs, NPs, RPNs? When you're talking about staffing
3 in the home, is it really about PSWs?

4 SAMANTHA PECK: I'd say it's mostly
5 about PSWs -- and maybe I'll call on Natacha for
6 this; I'll give you a sec. In Northern Ontario,
7 there are also challenges around attracting other
8 clinical staff that also need to be addressed
9 because it's different.

10 Natacha, do you have anything that you
11 want to add to that?

12 NATACHA DUPUIS: Well, PSW in the North
13 is the major challenge in long-term care because
14 they end up going to bigger cities where they can
15 get paid more money. So they're not making much
16 more than minimum wage. So nursing and RPNs -- RNs
17 and RPNs tend to not be so much of an issue up
18 North. It's mostly, I would say, a good 90 percent
19 PSWs, the lack of them.

20 COMMISSIONER JACK KITTS: Thank you.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Do you think -- it was suggested to us that there
23 are foreign-trained professional people who would
24 be able to contribute, and for one reason or
25 another, are excluded somehow. Did you have a

1 sense of that?

2 SAMANTHA PECK: Um --

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Any one of you?

5 SAMANTHA PECK: Somewhat. That there
6 are folks who come in from other countries who --
7 as they are pushed into PSW work, but then what
8 I've heard is that -- again, anecdotally, that many
9 of those PSWs actually have been -- I've heard that
10 some have been nurses or physicians in their
11 previous country of residence, but -- and this is
12 sort of a broader issue is around recognition of
13 credentials from outside of Canada.

14 And so those folks are, you know,
15 directed towards PSW or other work within long-term
16 care. It could be environmental, dietary, and so
17 on but are then put to the bottom of the ladder
18 again, when really, if we had better recognition of
19 foreign credentials, those folks could be playing a
20 role in long-term care more in line with their
21 skill set.

22 Because there are very capable people
23 who come to Canada and who could have a better role
24 to play in long-term care. Not saying that PSWs
25 aren't very valuable, but if you have someone who,

1 you know, was a registered dietitian or a
2 registered nurse, I can see that they'd have a
3 better role to play in long-term care.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 But they would play it as a personal support worker
6 or another role?

7 SAMANTHA PECK: I think they could have
8 another role. If you have a foreign-trained nurse
9 who comes to Canada and we had appropriate
10 on-boarding and recognition of credentials, they
11 could be working as a nurse in long-term care. And
12 that would help with the other aspects of the
13 staffing crisis around nursing, around, perhaps,
14 dietitians, around medical directors in long-term
15 care, which is hard to get -- physicians in
16 long-term care -- as well.

17 I think, of course, paired with that
18 recognition of foreign credentials and on-boarding
19 to the Canadian Health System is looking at the
20 impacts of racialization on the staff experience.

21 Tiff, I'm going to call on you for
22 this.

23 Tiffany is our lead for our diversity
24 equity inclusion work and has been doing a lot of
25 work and exploration around the experiences of

1 mostly racialized peoples in long-term care. Yeah.

2 TIFFANY FEARON: Okay. So I'm happy to
3 provide a bit of feedback on that.

4 I think whether it's an experience of
5 the residents or the families or the staff,
6 sometimes there's a lack of understanding of the
7 diverse experiences that comes with racialized
8 individuals, and I think it's that lack of
9 recognition for their backgrounds, their
10 experiences, the culture aspects, the way that we
11 interpret different things: There's a lot of
12 miscommunication there.

13 So for the resident experience, we have
14 to think about residents that might not speak
15 English as a first language and how that's going to
16 impact the level of care that they receive as well
17 as how they are going to be treated and understood
18 by the staff that's taking care of them.

19 And then when we look at the staff
20 experience, as Samantha mentioned, a lot of them
21 are women that come from racialized communities.
22 The majority of them are women from Caribbean or
23 African ethnicities, as well as Asian, South-Asian
24 women, and some of their experiences aren't closely
25 noted.

1 There's been experiences of racism
2 towards them as they're taking care of residents,
3 whether that be from the residents or their
4 families making the work experience not very
5 tolerable. But for many of them, that's really the
6 only jobs that they can get, and there's hours that
7 they're able to pick up.

8 Also, as Sam stated earlier, most of
9 them are working various jobs. There is many of
10 them that are agency workers, so they can't depend
11 on full-time work, and I think that presented a
12 really big issue during this pandemic because many
13 of them depended on having two, three, or four jobs
14 at different homes to make ends meet.

15 And from the family perspective, when
16 it comes to that diversity, they want to ensure
17 that their loved one is receiving the type of care
18 that they would have received if they were at home
19 with their own families. And a lot of the times,
20 they're not able to, say, get cultural celebrations
21 or recognition or cultural foods that would enhance
22 the experience that they would have had if they
23 were living at home.

24 So I think it's a very intersectional
25 topic where there's a lot of things that we have to

1 think about from the resident, family, and staff
2 perspective and ensuring that everyone, whether
3 you're working in long-term care or living in a
4 long-term care home, that you can have an
5 experience that's based on equity and equality.

6 SAMANTHA PECK: Mm-hm. So I have --
7 yeah, go ahead.

8 COMMISSIONER JACK KITTS: Yeah, just
9 back to the PSWs and the international graduates
10 from various health positions and Health Force
11 Ontario and all that, do you see anything that's
12 happening now or about to happen that is going to
13 help to relieve this PSW shortage?

14 SAMANTHA PECK: I'll throw it to
15 Cathleen in a sec, but I think there's a couple
16 things that have been innovative in long-term care.

17 So in-home training that is paid. So
18 that is mostly for personal support workers so that
19 they can learn and earn money at the same time.
20 And they'd be supervised, of course -- you know,
21 high standards -- but to have living classrooms in
22 which people can learn on the job, it's better for
23 people for whom they can't afford to be unpaid
24 while going through schooling. So I think that's
25 one.

1 Cathleen, you've got some other
2 examples as well.

3 CATHLEEN EDWARDS: Yeah, I'll share a
4 really good, strong example. It's called the Green
5 House Project. It's based off of the Eden
6 Alternative out of the United States. It's very
7 popular in the United States. They have a mix of
8 for-profit, non-profit, charitable homes.

9 And there are statistics. They've
10 actually done research on COVID-19 in Green House
11 homes compared to non-Green House homes in the
12 States, and there's a significantly lower risk of
13 being infected and having an outbreak of COVID-19
14 in those homes.

15 But one of the features tied to
16 staffing that's really innovative is that they
17 cross-train staff. So a PSW is not just a PSW.
18 Yes, they do provide that care, but they also
19 provide recreation. They also provide, you know,
20 laundry services. They also provide cooking and
21 meals and dietary support.

22 So it's a role called a Shahbazim,
23 which is basically they're cross-trained to do
24 every single role because what happens in Green
25 Houses is that each unit is built as its own kind

1 of neighbourhood. So it would house 10 to 12
2 individuals who would live there. It has an
3 open-concept kitchen and laundry room and family
4 room. They eat at this big, long communal dining
5 room table that has enough room that staff can also
6 join the residents at meals. Residents can engage
7 in helping to prepare and cook meals. They can
8 support cleaning. They can support laundry.

9 But when you're thinking about COVID-19
10 and a lot of the other things that leads to
11 potential cross-contamination and infection
12 protocol, they really have it kind of nipped in the
13 bud because you're not having unnecessary traffic
14 coming through where you live.

15 So again, just thinking about long-term
16 care homes as the residents' home: When you're at
17 your house, you don't have -- well, right now you
18 might have your family traipsing through because
19 everyone's home, but typically you wouldn't have,
20 like, your neighbour walking through, you know,
21 your kitchen as you're doing something because they
22 need it to get -- it's the shortest way for them to
23 get to the school or the park or whatever.

24 But in the traditional design for
25 long-term care homes, that's what happens

1 sometimes. To get to one specific neighbourhood of
2 the home, you actually have to go through another
3 neighbourhood of the home. So that in itself
4 creates, you know, infection control issues because
5 you are getting that cross-contamination of someone
6 going through that space that doesn't need to when
7 they're delivering food to that specific area, when
8 they're delivering laundry to that specific area.

9 So by cross-training your staff, you're
10 empowering them to basically focus on what the
11 residents need. So if the residents are hungry,
12 you have them help make food, and you make meals
13 when the resident is hungry. You would do laundry
14 because they need laundry done.

15 And again, because it's all on-unit and
16 onsite, you're minimizing that cross-contamination.
17 So it's very much focused on valuing the -- they
18 call them "elders," but valuing the life and the
19 skills and the history of that older adult, forming
20 that trusting relationship, that knowing
21 relationship. So empowering the staff to
22 understand the residents they're working with, to
23 get to know them and take that extra little bit of
24 time to talk to them because they recognize that
25 they're not quite themselves that day, that they're

1 having a rough day.

2 And if you talk to the staff who really
3 do embrace the Green House approach, they're much
4 more satisfied. There's much less turnover because
5 they're empowered. They're recognized as experts.
6 They know the residents because they live with them
7 every day. Because of the design of their job with
8 the flexibility to spend the time with what they
9 recognize is what that resident needs, they aren't
10 worried about, you know, I only have five minutes;
11 how do you nicely say to them, I have to back away
12 because I need to do something else.

13 Anecdotally, I can say, so I taught in
14 Durham College in the Activation, Coordination and
15 Gerontology Program, which was a post-graduate
16 certificate for people who'd work in recreation.
17 We had a lot of PSWs who would opt to leave their
18 careers to take that specific course, and the
19 reason they said they were doing it, for a few
20 reasons is, one, as they got older, their health
21 was failing.

22 It's a very labour-intensive job,
23 repetitive strain injuries. It's tough because
24 you're on your feet a lot. If you injure yourself,
25 you don't really have the time to -- you know, to

1 take it easy because it's a team-based environment.
2 So if you have a restriction, that means someone
3 else has to pick up your load.

4 And so in the team itself of PSWs, it
5 kind of creates that resentment, oh, they're
6 taking -- you know, even though there's a
7 legitimate reason, it just creates that tension
8 between the teams, and that really takes away from
9 them working efficiently within that specific home
10 and that specific area.

11 They would also opt to do it just
12 because they felt the guilt of not being able to
13 take the time to dedicate to that person. They
14 wanted to build those relationships, and typically,
15 the PSWs I've met, they do it because they like
16 working with people. They care about people.
17 They're good people, but they're frustrated with
18 the rules and policies of not having the time to
19 show that person they care.

20 COMMISSIONER JACK KITTS: Okay.

21 SAMANTHA PECK: Good point.

22 COMMISSIONER JACK KITTS: Have these
23 programs begun, and what is the forecasted impact
24 on PSWs in the homes and in what time period?

25 SAMANTHA PECK: So I'm not sure -- I

1 don't think we have any Ontario-based data around
2 that, but what we have -- what the sort of
3 anticipated outcomes, I think, are is really, as
4 Cathleen has alluded to, is that if you have a --
5 so you have cross-trained people, meaning that if
6 you have -- you know, your environmental services
7 or your laundry person is unavailable, others can
8 step in to still ensure that there is the proper
9 care being given.

10 Smaller home neighbourhoods or units
11 that have dedicated staff are already essentially
12 cohorted so that if you have an outbreak of
13 whatever it is -- if it's influenza, it's enteric,
14 it's COVID -- you've got a greater chance of
15 minimizing viral spread because you already limit
16 the number of staff who are in a place.

17 And looking at, for COVID asymptomatic
18 or the presentation of COVID in older adults, we
19 know if someone presents with more sort of lethargy
20 and other symptoms. If you have staff who really
21 know that resident well, they may be more able to
22 pick up on unusual behaviour in that resident;
23 therefore, being able to see if maybe something's
24 happening.

25 And, I mean, it could be, you know,

1 prioritizing getting that resident tested for
2 whatever the illness currently spreading is. So I
3 think it has great potential for infection
4 prevention and control to have standards, meeting
5 high standards of care because you have
6 cross-trained people.

7 You have resident-centered care, which
8 increases quality of life for residents, meaning
9 specifically, reduction of isolation and boredom.
10 So if someone can actually engage with the
11 activities of their household, they're less likely
12 to be bored or to feel lonely, I mean, because it's
13 also more normal. In a household, you often
14 contribute to the running of that little community,
15 so it's got better resident outcomes.

16 And the conditions of work are the
17 conditions of care. Dr. Pat Armstrong from
18 York University says that regularly when she's
19 speaking mostly about experiences of PSWs and other
20 frontline workers, that if they are satisfied with
21 the conditions of their work -- so they have
22 cross-training opportunities, they are paid well,
23 they have good scheduling, they can make a
24 connection with the resident -- that has positive
25 care outcomes.

1 So models of care like Green House,
2 Eden, what was called Butterfly, which is now
3 Meaningful-something out of the U.K., there is some
4 evidence to some of them, but they haven't been
5 rigorously tested in Ontario or, as far as I'm
6 aware, other Canadian jurisdictions. So it's very
7 much an emerging area of implementation and
8 research.

9 CATHLEEN EDWARDS: I can speak to the
10 Green House, a little bit about why in Canada and
11 especially in Ontario it is such a struggle to
12 implement. It's because of how we fund building.

13 Because there's a specific number of
14 rooms, every room -- the other thing about Green
15 House is every single room is private and has their
16 private bathroom. So that's another aspect.
17 You're just, you know, minimizing that
18 cross-contamination.

19 But I was on a Green House-led webinar
20 with architects, and they spoke about just the
21 design requirements in Ontario. And typically,
22 they find 15 -- 15 beds, 16 beds, so two units of
23 16 built together stacked tends to be the one that
24 financially makes the most money and is actually
25 something that can be feasibly funded.

1 If we went to the actual Green House
2 approach and looked at the design requirements they
3 have, the funding structure within Ontario would
4 need to be significantly changed. But again, a lot
5 of the practices that it does -- I think
6 cross-training specifically and empowering your
7 frontline staff who really are, like, you know, the
8 workhorse of your organization, those are things
9 that you just -- you think about how could we adapt
10 that, then, and the cross-training of -- so you
11 can't give full-time hours as a PSW. Could you
12 split it between PSW and kitchen staff, right?
13 When are your peak times? And then making a
14 full-time role, but it's split between both.

15 But I will say the Green House
16 approach, they did say that there was a home that
17 they are building and designing in Newfoundland.
18 So it does work in a smaller community for a
19 smaller home or for a home that has the flexibility
20 to fund it to be built in a proper architectural
21 design because there are specific requirements
22 within Green House Project.

23 But it definitely does -- they are
24 doing research in the States. They have done some
25 studies based off of COVID on how their homes are

1 faring, and just off the basic data, looking at
2 cases and comparing deaths and outbreaks compared
3 to the standard design for homes. They've done
4 significantly better.

5 SAMANTHA PECK: Mm-hm. Part of it is
6 the separate washrooms as well. I believe for
7 infection prevention and control because then
8 you -- it's just more contained.

9 So if you have a person within this,
10 say, eight-person unit who's ill, it's a lot easier
11 to provide -- and that it's identified quickly to
12 manage that spread. They can stay in their room.
13 You can have the infection prevention measures at
14 the door. They're not sharing a bathroom.

15 So those are things where -- but as
16 Cathleen pointed out, the Ontario design standards
17 and funding don't support that. We're still in the
18 phase of redeveloping old four-bed wards.

19 And some of the early data coming out
20 of the Ontario experience for COVID is that the
21 homes that had higher infection and death rates,
22 it's not so much about the for-profit,
23 not-for-profit, municipal licensee or licence.
24 It's about the age of the home, so that homes that
25 had four-bed wards fared worse because you couldn't

1 limit infection spread. In some cases, it was just
2 people were -- their beds were separated by a
3 curtain, which doesn't contribute to very good
4 infection prevention.

5 So there's, you know, the issues around
6 staffing and the funding to go with that is part of
7 it. How we use the people that are in homes is
8 another part, so -- and their work experience.

9 And then it's also about physical
10 design of homes. And those things all together
11 have a big impact on the resident and staff
12 experience and also around infection prevention and
13 control.

14 COMMISSIONER JACK KITTS: Are you
15 saying, really, that unless we change the
16 environment and the respect and the whole culture
17 towards PSWs, you're not hopeful that we're going
18 to be able to recruit, and if we do recruit, we
19 won't be able to retain them? Is that basically --

20 SAMANTHA PECK: Yeah.

21 CATHLEEN EDWARDS: Absolutely.

22 SAMANTHA PECK: That's a good way to
23 put it. So, I mean, if it were me and I were
24 looking for a job, I'd work at McDonald's sooner
25 than I'd work as a PSW. At least --

1 COMMISSIONER JACK KITTS: Okay. Thank
2 you.

3 SAMANTHA PECK: Yeah, because we need
4 to pay them more. We need to make long-term
5 comparable to other healthcare sectors, but we also
6 need to make the experience better so people stay.

7 People don't just stay in a job for
8 money. Most people don't. But you also have PSWs
9 and nurses and others who are trying to raise a
10 family or who they, themselves, are taking care
11 of and providing care to someone at home.

12 So if we want people to stay in a tough
13 job, we need to pay them well and make it so they
14 want to come to work.

15 COMMISSIONER ANGELA COKE: So you've
16 given us a very clear picture of what is happening
17 in terms of the PSWs, and obviously the numbers and
18 the environment and everything else is a big issue.

19 I'm just interested in your thoughts on
20 two things: Do we have the right mix of staff?
21 Not just the PSWs. We're talking about people
22 having a lot more clinical issues, a lot more acute
23 issues. Do we have enough of the right mix of
24 people in those homes?

25 And I'm also interested in your

1 thoughts about minimum standards of care and what
2 you think should be that minimum standard.

3 SAMANTHA PECK: So I think in terms of
4 the staff complement, we've done some research on
5 the experiences at homes and families that have
6 access to social workers or social service workers
7 in long-term care.

8 And in homes, what we found where
9 families did have that and residents had that, they
10 had a better emotional experience. There was less
11 conflict between families, residents, and staff
12 because the social workers were the ones who were
13 equipped to do sort of that conflict resolution and
14 management work and could help families and
15 residents who were struggling, helping them access
16 to outside services, so counselling or just
17 different mental health resources.

18 Not all homes have a social worker
19 because it's not required under legislation. So I
20 think that's one area where that would help the
21 experience, and I'm thinking of examples such as
22 where a home staff and a family member disagree on
23 something that has to do with clinical care, and
24 for whatever reason, they can't come to a
25 resolution themselves. So they'd be able to bring

1 in the social worker, who may not have the medical
2 experience but can help facilitate a resolution
3 wherein the staff feel heard and respected, so do
4 the families, and the outcome to residents are, to
5 them, getting the best care because sometimes staff
6 and families may disagree.

7 So right now, we're hearing a lot about
8 de-prescribing medication or appropriate
9 prescribing for things around antipsychotics and
10 other medications, and sometimes that's a tough
11 sell for families. It might be the right clinical
12 decision; for example, sleeping pills overnight
13 wherein someone in the morning is quite groggy,
14 could increase their chances of fall, they may be
15 eating less because they're so tired in the
16 morning.

17 So those are things where if we taper
18 someone off a sleeping pill, they may be more
19 awake, more alert, more ready to engage in
20 activities and to eat more in the morning, but a
21 family may be like, oh, I'm worried that Mom's not
22 going to get enough sleep, so let's not do that.

23 Bringing in someone to facilitate a
24 conversation wherein each side has an opportunity
25 to share their clinical expertise as a staff, but

1 their expertise as a family member -- you know, as
2 the family member, and they come to a better
3 resolution with better care outcomes. So that's
4 one thing. And also, those people are generally
5 the people with the real conflict and facilitation
6 skills in the home. Administrators and directors
7 of care may not have that expertise. So that's one
8 thing.

9 Homes that have registered or that
10 have -- so there's RNs, there's RPNs, and then
11 nurse practitioners. There have been efforts to
12 improve the availability of nurse practitioners in
13 long-term care, which the Ministry probably has
14 more data on this, but we've heard that it's quite
15 positively received in long-term care homes.

16 And when you have some of those nurse
17 practitioners, it can better support people with
18 very specific and high-clinical needs around
19 dialysis. So people don't need to leave their home
20 to go to hospital for dialysis. So it could be
21 specialized units within long-term care, and it's a
22 push towards that for taking dialysis.

23 People who are -- larger people who are
24 bariatric which require more support for management
25 of pressure ulcers and other poor health outcomes,

1 with nurse practitioners, that can help greatly as
2 well because they'd be in the home. The physicians
3 aren't in the home every day. So they'd often be,
4 you know, managing multiple homes, depending on the
5 size, the number of beds in a home.

6 So I'd say two other areas that really
7 improve outcomes for residents and families would
8 be social work and nurse practitioners.

9 COMMISSIONER ANGELA COKE: And the
10 standards of care?

11 SAMANTHA PECK: So standards of care:
12 This is something that we've actually gone back and
13 forth on over time.

14 We know there have been different bills
15 and different pushes to have a minimum for four
16 hours per resident per day. And so while we think
17 that increasing the number of hours that residents
18 receive of hands-on care every day, assigning a
19 specific number to it may cause homes to see that
20 as a minimum.

21 So there are going to be residents who
22 require less care; same thing, in part -- I'm
23 making up numbers -- three hours versus four. Then
24 there are residents, really, who require five hours
25 versus four.

1 So while a standard's good, we need to
2 make it so that we're not aiming for the minimum
3 and that the number of hours of care are looked at
4 appropriately so it's, what does that resident
5 actually need? So having those care needs clearly
6 identified. Who is best able to meet them? So not
7 putting all of the work on PSWs, but do they
8 need -- are we including occupational therapy and
9 things like that in that number? How do we monitor
10 that? How are we tracking that in a way that isn't
11 adding to the paperwork burden of frontline staff?
12 So how do we track, and how are we tracking
13 outcomes?

14 So I think the simple answer is, yes, a
15 higher standard -- or a standard of hours of care
16 is a good thing. We'd like to see standardization,
17 but I don't want it to be for the sake of it
18 because it needs to have meaningful outcomes to
19 residents that improve their quality of life that
20 isn't just adding more paperwork to frontline
21 staff.

22 COMMISSIONER ANGELA COKE: Thank you.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 Well, I don't know if there's any further
25 questions.

1 SAMANTHA PECK: So there's one other
2 topic I would like to touch on --

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Sure.

5 SAMANTHA PECK: -- that's been of real
6 concern to families during the pandemic, and that's
7 been the visitor restrictions.

8 Now, that was put into place in
9 mid-March wherein, pretty much overnight, homes
10 were closed to families and caregivers. At that
11 time, that was the right decision. I stand by it
12 because -- for the aforementioned perfect storm of
13 COVID; so PPE, testing, presentation, staffing, and
14 so on.

15 And families at the time did understand
16 the reason, even though they were heartbroken. The
17 day before I did get the heads-up that it was going
18 to happen because of our relationship with the
19 Ministry. So right decision at the time.

20 The fact that it's taken us -- and I'm
21 saying "us," you know, as a whole in the long-term
22 care sector -- so April, May, June, about six
23 months to have families safely coming back into the
24 long-term care home is way too long.

25 And so families, by about the two-month

1 mark, were starting to get really, really upset for
2 a few reasons. One is just, they've been
3 caregivers to their person pre-dating when they
4 moved into long-term care, and when someone moves
5 into long-term care, their relationship with who
6 their primary caregiver was or their family
7 changes, but it doesn't stop. But it does change.
8 So that person, that family member may not be
9 giving as much hands-on care.

10 But because of the aforementioned
11 staffing issues, families of long-term care
12 residents, many were still going into the home for
13 hours a day to provide care. So that would be
14 assistance at mealtimes, making sure that, you
15 know, Tiffany's mom ate enough at lunch. Or it
16 could be a resident with responsive behaviours
17 would only eat if assisted by a family member.
18 Could also have been assistance with toileting or
19 engagement in activities.

20 So these family members who were
21 providing care were shut out. So that meant not
22 only was the care needs of residents were affected
23 because you also had staff getting sick. You had
24 issues having enough staff, and now they've lost
25 their family. So it's the care outcomes there.

1 And then the psychosocial well-being of
2 residents really did suffer. So, you know, we had
3 be hearing, you know, if COVID doesn't kill them,
4 the boredom and the isolation will. They were --

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 How long do you think it should have taken to deal
7 with the problem?

8 SAMANTHA PECK: I think, in
9 hindsight -- of course, that's always, you know,
10 we're blessed with 20/20 -- in hindsight -- and we
11 started pushing for a plan. It didn't even need to
12 be let's open homes tomorrow, but we needed a plan
13 probably about the two-month mark because residents
14 were suffering, so their care needs and their
15 emotional well-being.

16 We were hearing families who were doing
17 window visits saying, my mom doesn't recognize me
18 anymore. She can't hold up the phone anymore. So
19 those were real indicators of decline.

20 And then there was also the breaking of
21 public trust in the long-term care system because
22 there was no plan about how to safely reintegrate
23 and reopen those doors. If there had been a
24 plan -- and what they were pushing for was just
25 develop a plan. It doesn't need to be that we

1 implement it tomorrow or next week, but families
2 need to know you're working on it. And this is to
3 the government: Families needed to know that the
4 province was working on it.

5 And in a way, that recognized the value
6 of family engagement in long-term care, so as care
7 partners who delivered care to residents, but also
8 as Ontarians who have an interest, you know, a
9 vested interest in long-term care, and for
10 families, they often fulfilled, you know, their
11 democratic engagement in the healthcare sector by
12 being the eyes and ears of the public in long-term
13 care.

14 And so with Family Councils, it was
15 through their engagement and the execution of their
16 powers to advise licensees of concerns or
17 recommendations. They can't do that without being
18 in the long-term care home and with having very
19 limited communication with the home leadership.

20 So families felt ignored, isolated.
21 They felt that they weren't valued. And after all
22 of this work being done in the Ontario healthcare
23 system around patient-resident-family engagement,
24 this was a huge step back. So families just felt
25 that they weren't important anymore.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 The danger that resulted in the restrictions on
3 visiting --

4 SAMANTHA PECK: Yeah.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 -- do you have a sense of when that -- was that
7 ever brought under control? I mean, because, you
8 know, we were talking about two months, and I guess
9 what I was trying to figure out is, well, if the
10 risk is the same, then the outcome would presumably
11 be the same.

12 And so I'm trying to figure out whether
13 it's planning, just the failure to have a plan in
14 place that people could hang on to while they were
15 going through this, or whether, from your
16 perspective, it got less dangerous after a couple
17 of months.

18 SAMANTHA PECK: So I think the lack of
19 a plan was wrong, but also, it did get less
20 dangerous.

21 So going back to the main issues at the
22 beginning of the pandemic, so presentation in older
23 adults, PPE, staffing, and testing, those were
24 solved by about the summer. And then as we saw the
25 decrease in positive tests with the increase of

1 testing and then homes had access to PPE, we knew
2 much better how COVID presented in older adults,
3 those issues were solved to the best possible -- so
4 it wasn't perfect. There was still risk, but
5 families really felt -- and we had been hearing
6 this from our sector partners, some of our sector
7 partners as well -- at that point, we could balance
8 risk and access. Going one way or the other
9 doesn't positively impact the resident experience.

10 So when we had those things sort of
11 under control, and that would have been, you know,
12 in the summer, it was time to reopen homes to
13 families. And it came in stages with a few false
14 starts, but where we are now, wherein each resident
15 or their substitute decision-maker if the resident
16 is incapable names two essential caregivers, those
17 people have open access to the home.

18 The home has to train them on use of
19 personal protective equipment and IPAC, infection
20 prevention and control, and to provide masks to
21 those families and then to have screening and all
22 of that to make it safe. That's a very reasonable
23 plan, and that's what families had been telling us
24 they wanted. They wanted access, but they wanted
25 to do it safely because they didn't want to put

1 anyone at risk, not themselves. Many caregivers
2 themselves are older adults with some underlying
3 health conditions.

4 They didn't want to put the other
5 residents in the home at risk, nor their
6 communities or their families at home. Families
7 wanted to be trusted to do the right thing and for
8 the system to enable them to do so.

9 We're still figuring out as a sector
10 some of the hiccups with that in order how to
11 appropriately train families on using personal
12 protective equipment and so on to ensure that all
13 have the same sort of standard of education and
14 support. So it is about the government not having
15 a plan. But then [indecipherable] that plan.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 And I don't want to monopolize the questioning, so
18 please -- but when you were trying to advocate for
19 this, where did you think you had to go to get
20 somebody to do this?

21 SAMANTHA PECK: So --

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Or was there a problem with that?

24 SAMANTHA PECK: There wasn't a problem
25 with it at the bureaucrat level, so the staff and

1 the Ministry. Brian Pollard, who is now in a
2 different area of the Ministry, I have a great
3 relationship with. He was very receptive and
4 understanding of the family concerns, but his hands
5 were tied because of getting information from the
6 Chief Medical Officer and what the Premier wanted
7 to do and so on.

8 So we had a very open door to the
9 Ministry staff, and we've developed better
10 relationships -- actually, now a very good
11 relationship with Minister Fullerton's staff.

12 But it was still -- I think the
13 bureaucrats, and I'm once again just saying, they
14 probably felt that their hands were tied too
15 because they didn't want any more people to die,
16 and there was horrible media coverage of the deaths
17 in long-term care. And I'm not saying that it
18 wasn't horrible. People died. People died. Staff
19 died. Mostly residents. And no one wanted that to
20 happen.

21 But also no one wants people to die of
22 decline from not being able to see their family or
23 to die alone.

24 Can you imagine being married to
25 someone for 40 years or having this be your parent,

1 and you're with them, you know, 30 hours a week,
2 because you're caring for them because you love
3 them, and at the end, they die alone because you
4 weren't allowed in?

5 Because while you were supposed to
6 be -- because even previous to this version of the
7 visiting policy, there was an exemption for visits
8 to people who were palliative and end of life.
9 Homes fought that, we heard. People died alone
10 with -- and, you know, with perhaps a personal
11 support worker or a nurse or someone dietary by
12 their side, but it wasn't their family.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 And, of course, if you're the personal support
15 worker, you're going to need some help with that
16 because --

17 SAMANTHA PECK: Mm-hm.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 -- that's going to leave a mark.

20 SAMANTHA PECK: And it does. And, I
21 mean, long-term care staff, they develop strong and
22 deep relationships with the people that they're
23 caring for. So they go through a loss, and that's
24 a whole other issue that is increasing in attention
25 within long-term care.

1 But during COVID, I don't really know
2 how much support staff were given when someone they
3 cared for died, and especially with homes that
4 faced tens of deaths, you know, many, many, many
5 deaths. Like, that's got to be -- that's got to be
6 devastating because -- and I don't think there's
7 any malice on the part of frontline staff. I think
8 they were all doing their best.

9 But that might feel worse to do
10 everything you can in your clinical ability and
11 still lose half of your home population and for --
12 and not being able to have those families come in
13 and try to help or try to at least be there with
14 residents and families.

15 So I think -- I think -- so basically,
16 the visiting policy we have in place now is good on
17 paper. The implementation is still lagging across
18 the province with some homes being more strict in
19 terms of their processes and what's in the
20 guideline, which is a problem.

21 I think -- you know, I think the
22 government eventually got it right. I really do.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 So it's a guideline. So then individual homes can
25 treat it as a guideline and --

1 SAMANTHA PECK: Yeah.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 -- do what they think they need to do, but they're
4 not bound by it. So you can agree with the
5 guideline but not agree with what the reality is.

6 SAMANTHA PECK: Yeah, and so some homes
7 kind of play around the margins where they'll do
8 some -- like, limit how family -- how much time
9 families have or things like that.

10 That is being addressed with the
11 government, and we are in regular conversation with
12 them to say, this is what's happening at these
13 sites so they can deal with it. So that is
14 important. They are taking it seriously.

15 There have been some instances of
16 conflict between a directive and the policy that
17 goes with it where they don't always agree or
18 public health advice and what the Ministry is
19 saying. So there's a bit of tension sometimes
20 there with whether it's the Chief Public Health
21 Officer or local public health units giving
22 conflicting advice versus the Ministry.

23 But I think we are making progress.
24 We're trying to restore -- the sector's trying to
25 restore trust with the families and invite them

1 back in, and I think the policy and the guideline
2 that's out now is good, and it does have most of
3 what we asked for on behalf of families. So the
4 government did listen.

5 I'm just sad it took so long. I'm sad
6 that in, you know, June, we didn't have more
7 talking about how, you know, the government's
8 working on it. I think that really -- people were
9 frustrated and angry that there wasn't at least
10 something coming that they could hold on to.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 What did you understand the process to be to get a
13 change? So two months go by, and you start to feel
14 that the restrictions on visiting should be
15 changed. So you speak to whoever that person was
16 that you said --

17 SAMANTHA PECK: Yeah.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 -- was your contact, but that person can't make the
20 decision. They've got to go somewhere else. Did
21 you ever -- I mean, how did that work itself --
22 what were you getting back, then, as this was...?

23 SAMANTHA PECK: So we would go to
24 whoever the Assistant Deputy Minister is who was
25 responsible for that. At the time, it was

1 Brian Pollard we had the most connection with.

2 FCO's in a bit of weird position with
3 funding. We're a provincial organization. We
4 haven't been downloaded to the LHINs. So we're
5 still housed and directly funded by the Ministry as
6 one of their -- under their Programs Branch, so we
7 still have a strong connection with them. So I
8 would go to Brian and say, here are the concerns.
9 Like, I was pretty much weekly talking about,
10 really, visiting.

11 But he would have to go to the
12 Minister, Minister's staff, talk to Public Health.
13 So there was a lot of different moving pieces, talk
14 to the sector because even now, I feel like, and
15 what I've been hearing anecdotally is that home
16 operators are still quite afraid of the risk of
17 COVID. So we're in a second wave. Whether it's
18 been publicly announced or not, we are.

19 And I've heard administrators say, you
20 know, we're going to be more strict than what's in
21 the guidelines because who do I want to get sued
22 by? Do I want to get sued by a family who can't
23 get in or sued by a family of someone who dies? So
24 it's fear because they -- they want to eliminate
25 the risk, but we can't.

1 We can only mitigate the risk because
2 otherwise we're basically incarcerating people who
3 have, you know, lived their lives contributing
4 meaningfully to society, you know, helping to make
5 Ontario what it is, and then when they're in their
6 later years and really need our help and our care
7 and our love, we're incarcerating them.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 There have been outbreaks in jails.

10 SAMANTHA PECK: Yeah, there have.
11 Yeah, and that's --

12 COMMISSIONER FRANK MARROCCO (CHAIR): I
13 don't know how much incarcerating them really
14 helps.

15 SAMANTHA PECK: No, but people feel
16 trapped that -- cognitively capable residents
17 weren't even allowed to, like, go out to buy, you
18 know, a pack of gum because they felt -- and that
19 was part of the not being able to leave the home
20 property, which is another issue, which you may
21 hear from Ontario Association of Residents'
22 Councils about that, and part of that is just
23 congregate living. There are challenges around any
24 setting of congregate living that have to do with
25 staffing, that have to do with balancing rights and

1 risk management.

2 But families felt shut out, and they
3 felt that that balance wasn't being struck. So the
4 process, going back to the process, Brian Pollard,
5 the other Ministry staff, sort of like the
6 Assistant Deputy Ministers and so on, they heard
7 and they understood, but they had to go through all
8 the channels and work with Public Health and so on
9 and managing risk and what people thought would
10 keep residents safest, which wasn't always what was
11 going to contribute best to their quality of life.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 And how would you hear about -- like, what was --
14 when things are changing or you think things
15 have -- what's the source of your information about
16 that? How would that happen?

17 SAMANTHA PECK: Most cases, I was
18 getting a heads-up from the Ministry, from either
19 ADM Brian Pollard or Mason Saunders at Minister
20 Fullerton's office. So I would get a heads-up
21 about something that was happening most of the
22 time.

23 Sometimes I heard about it like
24 everyone else did, but the government was -- the
25 bureaucrats, so the staff were pretty good, to be

1 fair, to give them a lot of credit, at giving us a
2 heads-up so that we could have advance viewing of
3 what the policy or the decision was, because they
4 rely on us to help families navigate and understand
5 it and to help translate policy and decision-making
6 for our constituents.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 On the other side of it, were the families
9 providing you with information?

10 SAMANTHA PECK: Yes. Lots. Families
11 will not hesitate to tell you what they think. So
12 my entire team, we were on the phone and e-mail a
13 lot, a really -- especially March, April, May,
14 those early months.

15 Families would tell us what they
16 thought should be different, what they were afraid
17 of. Sometimes they just needed to talk. We'd all
18 have calls with families where we'd say over the
19 course of half an hour maybe five or six sentences
20 because people just needed to be heard and to talk
21 at us.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Well --

24 SAMANTHA PECK: They would say -- just
25 one comment I got a lot was, you're the only one

1 who's picking up your phone. I can't get ahold of
2 my loved one's long-term care home. I can't get
3 ahold of the LHIN. I can't get ahold of the
4 Ministry. You're the only one who's answering the
5 phone.

6 So we acted as a conduit for
7 information to flow from grassroots level up to the
8 Ministry because we were able to take all of the
9 hundreds of calls we were getting, analyze, pull
10 out key themes and recommendations, and flow that
11 to government.

12 And then government could either bounce
13 things off of us, say, this is what we're thinking.
14 And we'd say, "yes," "no," "maybe," and then take
15 those policies when finalized and disseminate them
16 and then repeat the policy process.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Okay. All right. Anything further?

19 SAMANTHA PECK: I think those are the
20 main --

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Okay.

23 SAMANTHA PECK: -- the main things.
24 I'd say however you proceed with engaging families
25 most directly affected by the pandemic, you're

1 going to hear a lot of heartbreak. You're going to
2 hear a lot of anger. You're going to hear a lot of
3 frustration that this is one more commission, one
4 more inquiry, and we haven't even implemented
5 everything from the previous ones, and we can't
6 wait to make things better.

7 There have to be small things that we
8 can do now to improve the quality of the experience
9 for residents, families, and staff because we can't
10 wait.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Can we ask this before -- we can end the session
13 around now, I guess, but if there's a way that
14 occurs to you that we might get input directly from
15 the -- obviously, we can't meet with every single
16 family that has experienced this.

17 SAMANTHA PECK: Mm-hm.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 If you could think about a way in which we could
20 either meet with a representative group or they
21 could give a statement of some kind or something
22 could be drawn up so that we would be able to get
23 that kind of feedback and communicate that to
24 Ms. Drummond, our executive director, that would be
25 a help to us, actually, because we're struggling a

1 bit with how do we access all of the families who
2 give people a voice --

3 SAMANTHA PECK: Yeah.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 -- but at the same time, we recognize we can't meet
6 with everybody. So that would be a help to us.

7 SAMANTHA PECK: Yeah, and also
8 recognizing that you have a very short turnaround
9 time to deliver your report and complete your
10 mandate.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Yeah, we recognize that too.

13 SAMANTHA PECK: Yes, I'm sure you're
14 very aware of the pressures. I mean, there's a few
15 ways to do it.

16 If you wanted to go for breadth,
17 written submissions are an option, and that would
18 mean anyone who's affected, who's been affected may
19 be invited to do a written submission. So there's
20 that option.

21 What you could also look at is if you
22 want depth, so doing focus groups of, you know,
23 selected -- of families from homes, from specific
24 homes. So you could do a few of those. For that
25 channel, you likely want to go through the

1 administrator or someone else at the home, but we
2 could also echo that message, that if you've been
3 affected, here's how to go through it.

4 But I think it depends on what types of
5 information you want, if you're going for breadth
6 or depth or a combination of both.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Well, I think we're trying to get a -- see if we
9 can -- apart from what we -- information we
10 received from you, we're trying to get a sense of
11 if we can get something back from the people who
12 were affected.

13 SAMANTHA PECK: Mm-hm.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 We might pick up something that we didn't get.

16 SAMANTHA PECK: Yeah.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 And at the same time, the people know that we're
19 interested in what they have to say --

20 SAMANTHA PECK: Mm-hm.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 -- as opposed to you telling them you went and
23 spoke to us. So we're trying to figure out some
24 form of engagement, and if you could give some
25 thought to that.

1 We certainly have no problem receiving
2 written statements, but if you wanted to talk to
3 Ms. Drummond about that, see if you could come
4 up -- we would be relying more on you than us
5 trying to impose a system on you as to how we would
6 get that feedback, because we're not familiar with
7 your clients, I guess, or your -- the people you
8 represent, really, the interest you represent.

9 SAMANTHA PECK: Yeah.

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 If you could think about that, that would be a help
12 to us.

13 SAMANTHA PECK: Yeah, absolutely. I
14 mean, my first response is focus groups that are
15 well-facilitated and run, because then you get a
16 lot of information in a smaller time frame.

17 But my team and I will definitely put
18 our heads together. We've got some very skilled
19 and capable people to give it a think.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 All right. Any -- well, I want to thank you. Sam,
22 it looks like you had the burden of being the
23 spokesperson for the most part, and I want to thank
24 you very much for a very thorough presentation and
25 thoughtful, and it gives us something to think

1 about.

2 SAMANTHA PECK: Sure.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 And Cathleen and Tiffany, thank you both for
5 coming, and you may hear from us again.

6 SAMANTHA PECK: Well, my virtual door
7 is open for how I can help. I want to make
8 long-term care better. I think it can be. I don't
9 think it's an unsolvable problem or a broken
10 system. I just think that it needs attention, it
11 needs time, it needs money. But it's doable
12 because --

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 We're in a position where we can't -- normally, in
15 a commission, you do an investigation, you have
16 public hearings --

17 SAMANTHA PECK: Mm-hm.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 -- write a report, and so on. The only problem is,
20 you could tell from perhaps the Wettlaufer Inquiry,
21 that takes a long, long time.

22 SAMANTHA PECK: It does.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 And from our perspective, we're in the middle of
25 it.

1 SAMANTHA PECK: Mm-hm.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 It's not over and we're looking back. We're living
4 through it. Kind of turns our procedure
5 upside-down and makes us think that maybe we should
6 try to get some interim recommendations to the
7 government first and then see later on whether we
8 need to go further and actually have public
9 hearings or not.

10 It's hard to anticipate the end of the
11 process if you haven't gone through it yet.

12 SAMANTHA PECK: Yeah.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Anyway, that's kind of what -- that's what we're
15 thinking about.

16 SAMANTHA PECK: Mm-hm.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 And once again, thank you. Thank you very much.

19 SAMANTHA PECK: You are very welcome.
20 It's been a pleasure. I could talk for hours about
21 long-term care, but I hope what I've said so far is
22 helpful.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 It was, indeed. Thank you.

25 COMMISSIONER JACK KITTS: Thank you.

1 SAMANTHA PECK: All right. Thank you,
2 everyone. Take care. Best of luck with your work.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Thank you. Thank you.

5
6 -- Adjourned at 2:58 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, OLIVIA ARNAUD, Chartered
4 Shorthand Reporter, certify;

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth, at which time the witness was put under oath
9 by me;

10
11 That the testimony of the witness
12 and all objections made at the time of the
13 examination were recorded stenographically by me
14 and were thereafter transcribed;

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

18
19 Dated this 22nd day of September, 2020.

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