Long Term Care Covid-19 Commission Mtg.

Group Meeting
on Tuesday, January 26, 2021

77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 26th day of January, 2021, 4:00 p.m. to 5:39 p.m.

BEFORE:

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

PARTICIPANTS:

Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat;
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat;
Kate McGrann, Counsel, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;

ALSO PRESENT:

Carissa Stabbler, Stenographer/Transcriptionist

-- PROCEEDINGS COMMENCED AT 4:00 P.M. --

JESSICA FRANKLIN: Thank you so much for joining us this afternoon. My name is Jessica Franklin, and I am the Policy Lead at the Commission Secretariat. I am joined this evening by my co-facilitator, Kate McGrann, who is counsel for the Commission, as well as a number of our fellow team members.

So Dawn Palin Rokosh is the Director of Operations. Rose Bianchini is also here. Rose is a policy analyst. And you would have met Angeline Hawthorn, who let you in to the meeting, as well as Adriana Diaz Choconta, who is also here to assist on our team.

So thank you so much for being here. We have all Commissioners for this call. I'd like to introduce you to each of them.

Chief Commissioner Frank Marrocco is here. There's the wave from Commissioner Marrocco. We also have Commissioner Angela Coke and then Commissioner Dr. Jack Kitts as well.

So for this evening's call, Commissioner Marrocco will be the lead, but all three commissioners are here and listening in.

I would also like to acknowledge and

thank Rosemary, who's the chair for the Champlain Region Family Council Network, who assisted in sharing the opportunity and identifying participants.

I also want to let people know that if you do experience connectivity issues, please don't fret. You can certainly rejoin the meeting at any time. And if you are having technical issues and are running into issues kind of getting back in the meeting, please reach out to Angeline Hawthorn via email, who you've been in contact with before this session.

Also, I see that a number of participants have turned on their cameras, which is great, so please feel free to do so. This session is not being video recorded, but if you would prefer to stay off camera, that is fine as well. It is whatever your comfort is.

I also wanted to let you know that this session is being recorded by our court reporter, who is present on the call, and the transcript will be posted onto our website, but your names will not be present.

So when you are speaking, you will appear as your participant number, so

"Participant 1," for instance. And if you want to refer to what another participant has said, we just ask that you refer to them by their participant number, which is displayed on the screen.

Before I turn it over to Kate, does anyone have any questions about anything I've mentioned?

Okay. Over to you, Kate.

KATE MCGRANN: Thank you, Jessica. One more note on confidentiality in this session: As Jessica has mentioned, this is being transcribed, and a transcript of our meeting here today will be posted to the website.

We've ensured that your participation is anonymous through assigning you participant names and numbers in our outreach to you, but the information that you're sharing today will be posted to the internet. So please be aware that any identifiable stories that you may be sharing as this -- all of this information will be [INDISCERNIBLE].

Turning now to the agenda for this meeting, we'll begin the session with some introductory remarks from Commissioner Marrocco, and then we'll proceed to question 1, your

responses from all of you in order of the participant number that you've been assigned starting with participant 1 and moving through.

We'll repeat exactly the same process for question 2. Once we've finished hearing from all of you on both questions, there will be some concluding remarks, and then we'll wrap the meeting up.

In order to ensure that the Commissioners hear from all of you on both questions, we're asking that each one of you speak for up to four minutes in response to the first question, and then in response to the second question, again, if you could speak for up to four minutes.

We understand that you've all been through a great deal, and we know that four minutes is not sufficient for you to share everything that you have to discuss with the Commissioners, but the four-minute time limit is here to ensure that you all get to share some of your story within the course of this meeting.

If there's additional information that you wish to convey to the Commission, you can do so through written submissions and other avenues that

I described on our website.

If that's something that you're interested in doing, you can either get in touch with us in the same way that you did as part of entering this meeting or through what's described on our website.

One last note is that we will keep track of the time for you, so you don't have to watch a stopwatch or anything like that while you're speaking to the Commissioners.

As you get close to the end of your four-minute mark, either Jess or I will un-mute our mics and let you know that you're coming close to the end of your time and ask you to try to wrap up your remarks in about a minute or so. So you'll have some warning so you're able to complete what you're saying.

Are there any questions about any of that? Okay. Well, then, I will turn to Commissioner Marrocco for some opening comments.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you all for agreeing to do this. In order to do what we're doing, we need to stay grounded in reality, and this is the most effective way that we can think of to do that.

So your experiences we can then relate to what we're told about less personal things, like policies and so on. But we couldn't do our job properly if all we were talking about is paper and policies. We need to understand what went on, and your experience has helped inform us of that. So thank you very much for agreeing to do it. I know it can be painful because you've done this before.

Let me also say that I'd like to start the way all three of the Commissioners have agreed to start these sessions, by observing one minute of silence for those who aren't here.

[Moment of silence]

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you all very much for that. Well, let's -- I think the best way to begin is to begin.

KATE MCGRANN: Thank you, Commissioner Marrocco.

So we'll begin with the first question; which is, please tell us about your experience caring for a loved one in the long-term care home during the pandemic. How has the pandemic impacted you?

Please go ahead, Participant 1.

PARTICIPANT 1: Hello. Thank you very

much for allowing us to do this.

The pandemic has affected our family quite a lot. I also am chair of the family council for the home as well, and so I can also speak with -- for other families as well, if possible.

My mother has been in the home for four years coming up February. She went in after -- with a -- you know, diagnosis of dementia, and she had suffered two strokes. My father then suffered a stroke, so he was not able to care for her, henceforth the entry into the home.

During the pandemic, there was no communication. We could not find out what was going on. There were a number of other families that I spoke with that had the same issue.

I ended up calling head office a number of times, and at one point a person from head office said, "Well, you do know that long-term care is where they go to die." That was not the correct response I wanted to hear at that point in time.

We could not find out what was going on in particular with my mom and, again, with other family members as well, you know, trying to find out what was going on with their loved ones.

We've come to learn that the

staffing -- this home had 160 residents. They lost 90 residents, 80 -- pardon me, 57 that I know of from COVID. The staffing levels were down. They lost two staff members as well, and then the spouse of another staff member passed away as well.

The PPE was not available. There was -- at one point, the incident command was called in, and when I -- they allowed me to sit in on a couple of calls, and when I tried to find out what was going on, I was given the pat on the back, they -- we're doing everything we can speech.

We were not given specifics. We were -- we have no idea -- even now we have no idea, you know, about residents being fed or cleaned with their basic personal care. I'm trying to find the polite way to put that one, their basic personal care looked after, so sitting in their own soiled clothing for long periods of time.

They were not bathed. They were not showered. Again, back to the eating. We have no idea at this point -- my mother is nonverbal and immobile, so I, you know, wouldn't be able to get any information from her.

Just before the pandemic started, she had started to cross the line of not knowing who my

sister and I were. She still knew my father's voice. They just celebrated their 62nd anniversary. She still knew my father's voice, but without being able to go in, with no contact whatsoever, she now does not know him at all, which is harder on him obviously than it is on her because that knowledge is not there.

Medical issues, again, not knowing. The main thing being communication, I think, was a huge issue, as well as staffing, PPE, all the things that everybody has talked about.

You know, as to fixing it, I just don't know the issue there as well. I did end up during -- in the second wave, I wrote a letter. A report came out. There was an investigation done over a four-, five-week period. I can provide report numbers if necessary.

I ended up writing a letter to Minister Fullerton, MPP Blais. I wrote it to the fire department. We learned that none of the staff -- there was no fire drills from February onwards to November. There was no fire safety training done whatsoever within the home.

So after the flames settled down coming out of my ears, I contacted all of the various

different government officials I could think of to lodge a -- like, a major complaint about this. The other reason being, like, again, there was staffing -- there was nobody on in terms of nursing to cover somebody who may have been ill.

The report that the Ministry did, which is the part that really angers and frustrates me, is while this investigation was going on, the Ministry knew of these fire drill and fire safety issues that were not being handled properly, but they waited to hand the report to the new ED when she stepped in in November.

Why was nothing done at that point in time? Why did they wait? You now have 90 residents. I also learned that only 6 staff need to be on -- in the home during a night shift. That's ludicrous. How does 6 staff get 90 residents out of a home that are basically not cognitively aware or immobile? That's just outrageous.

KATE MCGRANN: Participant 1, I just want to let you know that you're coming up on the end of your time.

PARTICIPANT 1: Okay. So again, communication about these fire drill -- you know,

all these different things. This is just ludicrous. It should never have happened in that respect.

And, again, 6 staff at night for 90 cognitively impaired residents or immobile residents is another outrageous thing that -- it's just not possible.

I'll stop there because otherwise I can keep on going forever, so I will take a moment and stop there. Thank you very much.

KATE MCGRANN: Thank you very much, Participant 1.

Participant 2, please go ahead. Participant 2, you'll want to un-mute yourself.

PARTICIPANT 2: Got it. Okay. Sorry.

I've been a caregiver for three family members, two parents and an aunt. That included arranging and overseeing home care followed by retirement home and long-term care home residency.

One family member died in long-term care in the first wake of COVID in a residence that had a serious outbreak in which 50 percent of the residents were infected, and 15 percent died. 14 percent of the staff were infected with no deaths.

I've also been active in supporting families and in the family council work for several years.

Before I start, I'd just like us all to pause and think of ourselves as the children we were and as the older adults we will become. We were important before we were old enough to become productive members of our communities, and we will all be important even after we are no longer economically productive members of our communities.

Rather than describe more sad long-term care pandemic stories, I have some key messages for the Long-Term Care Commission that I would like to explain today.

In order to turn long-term care around from its current deficient situation, essential family caregivers must be recognized as experts in our families' care and with an overall general knowledge of the elderly and of the long-term care system often missing from other subject matter experts in the sector.

Essential family caregivers should not only be partners in care consulted in the last part of the development of a new long-term care system. They should be invited to be among the primary

stakeholders leading the process.

Through necessity, the pandemic has caused essential family caregivers to become more knowledgeable about the various policies and players in the long-term care sector.

This increase in knowledge and in comprehension of the impacts on long-term care have come despite a sector that is secretive, bureaucratic, and close (ph) with information that might portray a home, its owners, or operators or the sector in a bad light.

Essential family caregivers must have the support of government to be recognized in legislation for the essential role they play in the lives of their family members in long-term care and also to be recognized as essential advocates for all residents in long-term care.

The government will find essential family caregivers to be committed and highly motivated in creating a long-term care system that's worthy of the elders whose care is in our hands.

The pandemic has shamed us into recognizing our failures in long-term care to date. While its lessons are fresh in our minds, we must

act on rethinking long-term care. In this effort, the families who deal with the long-term care system on a daily basis must be essential part of designing the new elder care system.

Family caregivers were chosen by their family member to care for them and to represent their interests when they sensed that they would one day no longer be able to do so themselves. For this reason family caregivers in the context of elder care are just as essential as parents in the care of their children.

Family caregivers in most cases have legal obligations as POAs and substitute decision-makers to inform themselves about their family member's most personal and medical details in order to oversee their family member's care.

Family caregivers are not visitors. That is why I use the term "essential family caregiver." The long-term care system as it is today does not respect the role of essential family caregivers and by extension does not respect the rights of the residents they represent despite the resident's Bill of Rights in the long-term care act.

Essential family caregivers are not

informed about their family member and about the conditions in the home. Essential family caregivers had to gain as much information as they could during the pandemic from window visits, occasionally answered telephone calls, brief conversations with stressed staff outside the home after their shifts.

Families created email networks to keep one another informed as best they could with information gleaned from outside the home. Families were assured that all was under control and that they would be informed if their family member's situation changed.

In the meantime, homes stated that all protocols and procedures were being followed. It was obvious even from outside the home that their assurances were empty. Many --

KATE MCGRANN: I just wanted to let you know you're coming up on the end of your time.

PARTICIPANT 2: Okay. Many people call themselves experts in long-term care, the Ministry, the doctors, et cetera. I won't go through the list. Well, if the care we have seen before and during the pandemic is any indication, it's a hollow claim indeed.

Essential family caregivers came into their own during this pandemic. We realized we have a broader picture than do those now considered experts in long-term care. We have a very meaningful knowledge of how the system works and does not work, and we have ideas about how long-term care might be rebuilt to serve the needs of the frail elderly.

We have come to respect our own potential contribution to rethinking long-term care. Now is the time for the rest of the population and for government to recognize us as the experts we are. Thank you.

KATE MCGRANN: Thank you very much, Participant 2.

Participant 3, please go ahead.

PARTICIPANT 3: Hi. I'm a member of my local family and friends council and have been for a couple of years since my wife was admitted. She first went to an assisted living while we were waiting for our number to come up within the selection process.

She was eventually chosen by the home, moved in, and I -- I especially chose a home that was not-for-profit, which was -- as far as I'm

concerned, saved my wife's life basically. She's -- she was in her previous home, and that was wildly expensive, and certainly a lot of corners were being cut when it comes to the provisions for staff. So I was very happy when she moved into her long-term care home.

After the pandemic had occurred, it was a number of months where there was very, very little communication, especially about her as an individual. But more importantly, our care plan, as far as I was concerned, is the contract between me, her care -- care provider. The care plan was our contract.

And when I found that there was major deviations, like there was no physio for three months, and my wife is in a position where physio is an absolute must, when I found out that that was not provided, I was not made aware of any changes in her -- delineation in her care plan that was not being actioned. So I was pretty miffed about that.

One of the things that I have never fared well with is I've never felt like I was a sought-after participant in my wife's care. I didn't directly find out -- or I didn't read well enough that the only way I was going to be able to

get in to see her was by describing myself as a designated caregiver.

I thought that that was an application that I had to make to the home that I didn't feel qualified, et cetera, et cetera. Well, I found out I could just name myself, but that information certainly wasn't made available to me willingly.

And so I got in, and I was very glad to be able to get inside the building and to participate in whatever rules were in effect in order for me to be able to get in and see my wife.

But I -- one thing I found out that I had no knowledge of and couldn't find out is when there was changes in the building compared to what it was pre-pandemic, I was not able to find out whether that was a provincial covered -- provincially covered mandate or whether that was something that was interpreted by the local home where I was or wasn't able to do something.

And when it came to letting people inside the home, whether we're in outbreak or not in outbreak, as far as I was concerned, the whole access while we're under a pandemic mode is a risk management type perspective.

In my wife's building, there have

been -- well, several buildings involved, and there have been a number of staff members who have caught it and died. I think about seven or nine residents have caught it and died.

And I've never felt like a sought-after participant in any of the things that have happened there. And the designated caregivers are even more -- they're tested more often than the staff members. Staff members get tested once a week, and they have to show up whether their results are back in or not.

We have to have an active -- meaning the designated caregivers have to have an active window within the last seven days. Well, reality, it's only six days because even if we get the test at 7 o'clock in the evening, our day one is finished at midnight. So if we get tested Wednesday at 7, our coverage ends up running out Tuesday at midnight.

KATE MCGRANN: Participant 3, I just want to let you know that you're coming up on the end of your time.

PARTICIPANT 3: Okay. One of the things I would like to know or find out is when there has been an exposure of somebody on the

floor, did that person come into my room and directly expose me? And I have no way of finding out.

The staff know who came in, but the designated caregivers are not allowed to find out if somebody has -- that has had the virus has come into their room or not while they were there. And I have no way of going forward with that. That's it.

KATE MCGRANN: Thank you, Participant 3.

Participant 4, please go ahead.

PARTICIPANT 4: Good afternoon, Commissioners. Thank you for providing this time for family. I have a prepared response to question 1, and it's three minutes and 59 seconds in length, so I'll talk real fast. Okay?

Over the course of -- first of all, just a note of encouragement. Over the course of your mandate, you've heard some very painful and troubling circumstances regarding long-term care in Ontario.

And despite the Province not extending the report timelines for the Commission, which I hope they will, what you do in the process of

inquiry and deliberation will prove invaluable long after this pandemic is relegated to a distant nightmare.

In my experience, I have a friend of 30 years who is in long-term care to whom I provide support, a nice fellow in his 70s with no immediate family, but a person with a lifetime of complex psychiatric disorders who were it not for long-term care, may well have been living under a bridge in Ottawa when this pandemic started.

However, for over three years now, he has been in the care of staff at Fairview Manor in Almonte. My friend is well looked after and well loved by nursing and personal care staff.

While I cannot get in to visit and spend in-person social time with him, something he greatly values, staff have taken pains to connect us through occasional video calls, and, of course, we talk by phone.

While he has suffered from depressive incidents, partly due to the isolation, he has fared better than many.

I recognize that managing in this pandemic has been a learn-as-you-go process for everyone, but of particular concern to me at this

point in time is expectation management, a role that must be vigorously -- rigorously set from the top.

Our small community was made painfully aware of the ravages of this pandemic when during the first wave another long-term care home, a private home in our community lost 28 or 29 residents from the coronavirus.

Fairview Manor has been, thank God, spared this agony as management and staff have worked tirelessly to interpret sometimes conflicting Ministry guidelines and have found themselves in the middle of difficult exchanges.

One example that comes to mind is while Ministry was telling directors of care to isolate residents to avoid in-home transmission, it was allowing, even encouraging residents to be taken on outings by family members.

I remain concerned that the Ministry has not grasped the complexities of long-term care administration at the ground level and that an effective accountability framework and resource model still does not exist.

I have three points that I'd like to offer you.

1, the Province has been in the middle of transitioning from a LHIN structure to this regional Health Team structure. But when the pandemic hit, the channels were not clear, and accountabilities were muddled.

2, places like Fairview Manor are taking it upon themselves to find innovative ways to meet quality of care and performance objectives. But these approaches come at a cost. Staff are exhausted, management is set to focus on -- more on Ministry directives and directions than in home administration, and residents may be getting less attention. This is a dangerous cocktail as we are surely not out of the woods yet.

And thirdly, while vaccinations are not a panacea in the short-term, communications about them are part of the confused situation around expectations management. My friend has been anxious about when this vaccine will be administered, and we just learned yesterday that they're going to begin the day after tomorrow, so that's good news.

Anyway, that's all for now. Thank you.

KATE MCGRANN: Thank you very much, Participant 4.

Participant 5, please go ahead.

PARTICIPANT 5: Thank you. In 2015 our mom moved into the long-term care that I'll be speaking of today, and prior to this, she lived almost a year in a retirement home where her care was impacted by significant staffing shortages and appalling care issues.

A PSW at the retirement home hit her a few days before her move into long-term care. To be clear, the long-term care home also has a history of staffing and quality of care issues. It's an old building with a high number of ward rooms. Our experiences with long-term care and retirement homes run deep, and I can't say they have ended well.

On the day before the lockdown in March, Mom was talking and singing with us, and in the weeks that followed, we watched her rapid decline through our window visits.

Her severe dementia, mobility, and sensory issues added to the challenges of communicating, and Mom never tested positive for COVID-19; however, our family feels that she didn't receive adequate care for hydration, nutrition, or cognitive stimulation in the weeks and days leading

up to her death.

Her life diminished over the weeks. With the room isolation, she was locked in her dementia without the lifeline of her family to reorient her to the threads of really who she was. And Mom slowly slipped away and died without her family by her side.

At the start of the pandemic, our family reached out to all levels of care leaders, politicians, the home administration, and CEO and media. We tried to sound the alarm on the crisis unfolding in our long-term care home, but the response from all levels seemed be moving in slow motion.

Calls were made to the inspections branch and the Ombudsman's Office, but nothing was done. I was told it was the home's responsibility to reach out for help and that for-profit homes like ours were less likely to ask for it. And not that they didn't need the help. It's just that they did not ask for it.

We watched the numbers of COVID positive cases for residents and staff rise along with the number of COVID deaths. We asked the CEO of the home to call in the military to help shore

up staffing, and he replied that in a worst-case scenario, the military may be a possibility. "How much worse could it possibly get?" we asked.

We lived in terror over what was really happening inside the home. Our mom was 97 years old when she died in April of 2020.

By June, over 90 percent of the residents had tested positive for the virus, and 36 percent of the residents died of COVID-19. Other residents, like our mom, died because of the pandemic, and these numbers are not tracked. This home remains one of the hardest hit long-term care homes with COVID-19 in Ontario.

Today in Ontario, we see more residents and PSW deaths in long-term care with the most recent death being a 19-year-old young man. Horrific stories highlighting the ongoing systemic issues continue to pour out of long-term care and retirement homes across the province. And what concerns me is that this crisis has become worse in long-term care.

At the beginning of the pandemic, we didn't know how to manage the virus. Eleven months into the pandemic, there are no excuses for the continued suffering or the continued state of

crisis. There have been very few strategies implemented to make it safe for people living and working in long-term care.

All of us have an obligation to those who have suffered to advocate and do the work to ensure transformative change happens for those most vulnerable needing long-term care. Thank you.

KATE MCGRANN: Thank you very much, Participant 5.

Participant 6, please go ahead.

PARTICIPANT 6: Thank you. My brother was transferred on April 1st last year from the Ottawa Hospital to Carlingview Manor, Revera because the hospital needed the bed.

He was supposed to be in 14 days' isolation, which was not true, and he was on the locked floor for dementia. Residents who wander in and out, who wander the halls, wander in and out of rooms constantly. It was a free-for-all, and there was absolutely no monitoring.

I raised a number of concerns during this period, and I was told not to worry.

So on April 25th, he was tested positive for COVID with breathing problems, chest pain, severe headaches, and it was my worst

nightmare. I got absolutely no information, no communication, my calls were not returned, and worse, the stress and worry with him being very sick and not safe. My only regular contact was with him because I had given him a cell phone.

On May 23rd, I was advised he was COVID-free. Between April 15th and May 19th, I left 35 -- 35 of my calls were not answered. Nine calls I left messages, and there was seven calls where I was able to talk to someone.

I got one call from the doctor after trying repeatedly from April 1st during that whole period, and no -- I got a call on May 7th and no updates otherwise.

When I was -- did manage to talk to somebody, I was always told not to worry. When I talked about the residents wandering in and out of his room and that there was COVID on his floor, I was told it was his responsibility to tell them to leave. He's a person with dementia and physical disabilities. I was told they were very short-staffed, and they had no one to go down and monitor.

I do completely blame them for him and all the others who got COVID during this time, and

there's also the post-COVID symptoms. I know they were very, very short-staffed, and I know they continue to be short-staffed. The few times that I did get to speak to someone, staff shortages were always mentioned.

So there was a brief period of improved communication after the first wave of COVID was over and then went down to very little again because of the second wave, and they were in lockdown three times this time. But it's still really, really bad.

During the time of the long lockdown, the shower rooms were locked. If you've got somebody that's disabled, cleanliness was an issue. There's no laundry. The laundry that he had sent down disappeared. It actually came back about a month ago from April.

They're giving him drugs and antidepressants, and we were supposed to be discussing the effectiveness, but despite my leaving messages, I still don't know, and no discussion has taken place.

I had the opportunity to be visiting outside during the summer, but they're back -- they were back in lockdown again. I'm older than he is,

and I have some limitations myself, and I'm very afraid of going inside that building.

I will say the staff did their very, very best during that time being so short-staffed, but things were really, really bad. There was lack of care for residents, at least on the dementia floor.

With having the shower rooms closed during the lockdown, I was told because of staff shortages, there was no one to sanitize between users, so they had no choice other than to lock it down.

So that's the situation. And there were 138 residents on May 8 that had contracted COVID, which is 43 percent, and 73 staff. And sadly, at that time, there were 42 residents who died. The numbers increased slightly after that. They raised to 61.

KATE MCGRANN: Participant 6, I just want to let you know that you're coming up to the end of your time.

PARTICIPANT 6: Yes, and I'm done. Thank you.

KATE MCGRANN: Thank you very much.

Please go ahead, Participant 7.

PARTICIPANT 7: Good afternoon, and thank you for the opportunity to address this catastrophic crisis of the pandemic through the lens of family in long-term care.

I worked on an acute response team which included elder abuse. Now there's a new term, summed up in a very succinct way, senicide or geronticide, which is the killing of the elderly or their abandonment to death. This is now the abject reality and lived experience of having a loved one in long-term care during this pandemic.

COVID has truly exposed the horrific, decades-old brokenness of the long-term care sector. It's also been a devastated unveiling of how the government has handled long-term care in this crisis.

My father has been a resident in a for-profit long-term care facility for two years and 19 days. His facility was one of the earliest hardest hit long-term care warehouses here in Ottawa. There were over 60 deaths in the short time frame.

Ironically, I worked in this facility as a new grad 40 years ago, and it was as appalling then as it is now. It was not my decision to place

him there.

My dad is a 91-year-old man that has dementia and complex health issues. He yearns daily to go home. My father's foremost a man who spent most of his life as an outdoorsman. He said he would never be in a cage again after fleeing a war-torn country.

He values family more than anything and has instilled a legacy of faith and trust in always doing the right thing for others. This is why as a society we are incumbent to fight for him and every marginalized voice [INDISCERNIBLE] in long-term care.

When the first lockdown happened in mid-March, we were devastated to learn that we weren't allowed to visit him. We were sick with the realization that he would not know how to navigate the sundowning that is associated with dementia. We were always present from 3 o'clock until he settled down for the night.

We knew from experience that the skill to de-escalate and mitigate his anxiety and agitation was essentially nonexistent in his facility, especially during acute staff shortages and temporary agency hires during the lockdown.

It was extremely difficult to hear his cognitive decline and increasing inability to recognize our voices over the phone and hear him plead for us to come and help him. Other times his very flat affect was just as distressing to us.

His moments of clarity were the hardest. He was inconsolable and asked us what he had done to deserve this existence at his age. He definitely felt abandoned, and the guilt that I carry about this will be with me forever. He said that he'd rather die now than never see us again.

I worry incessantly about not being able to do his diabetic foot care and that because he wasn't getting that care, it would affect his mobility, and it has.

We knew that cognitive stimulation and activities were not happening. From our window visits, it was clear that his hygiene and mobility was compromised. He appeared unkempt and in dire need of a haircut and in need of assistance to stand by the window. This was not how we left him before the lockdown.

Our attempts to communicate and voice our growing concerns were not addressed in a timely manner, if at all. The facility was extremely

inconsistent with Public Health and governmental directives, always confusing.

I can clearly recall my first visceral reaction on seeing my dad for the first time in five months. He was slouched in his chair, mentally unresponsive, unkempt, and there was an odor. His legs were very edematous from inactivity. He did not know who I was. I suspect he was sedated.

On my second visit, I truly witnessed the last few months of my dad's life. He had bruises on his back from a severe fall. He had cellulitis, both lower extremities, that was being treated with antibiotics after I pointed out his cellulitis to the staff.

His skin had broken down from poor hygiene. His hair was long and very dirty. His dentition was atrocious. He needed assistance to move, and his cognition has eroded to the point where I had to keep saying who I was.

In between the lockdown, we brought him outside as much as possible. We began to notice slight, incremental improvements overall. He was beginning to come back to us with our love and nurturing and caring.

Sadly, my father has begun a slow final decline. The isolation and his grief over what he considers an abandonment, the resulting overall poor quality of his life in long-term has taken the wind out of his tattered sail.

We grieve his life with him because it's not living. It's a desolate, depressing existence in present long-term care in this pandemic. Thank you.

KATE MCGRANN: Thank you very much, Participant 7.

Participant 8, please go ahead.

PARTICIPANT 8: Am I on? Oh, hi. Kate, for my question number 2, the answer to question number 2 is about 40 seconds, so will I have a little longer with this one then?

KATE MCGRANN: Sure. Why don't we try to give you [INDISCERNIBLE], and then we can come back to you.

PARTICIPANT 8: Okay.

KATE MCGRANN: Please go ahead.

PARTICIPANT 8: Thank you. My major concern has been the lack of strong leadership in many of the long-term care homes. Managers manage resources. Leaders manage change, including the

appropriate response during crises such as a pandemic, yet for the most part, my family did not see confident decision-makers.

We did not see the utilization of critical thinking skills. We did not see solid communication skills applied to residents, family, staff, and other key community stakeholders. Instead, we heard the description of chaos and time-consuming work from some administrators.

On a positive note, in one home, managers were assigned to a resident home area for which they were accountable in terms of quality care, staff training and support, liaison with each resident and family on a weekly basis, et cetera.

In another home, when the first case of COVID was identified in Toronto, the administrator initiated staff screening, including temperature checks on arrival to and departure from the home, as well as verbally screening visitors. That home has had zero COVID infections to date.

A second home started the screening process after a staff member transmitted the virus to a resident. The eventual result was numerous resident deaths as well as staff infections. Those examples demonstrate the significant difference

quality leadership can and will make within our long-term care homes.

In my experience, I did not see any prior planning for a pandemic in terms of human resource needs, procurement of equipment and supplies, environmental limitations, and strategies to effectively and efficiently manage stakeholder information.

Such planning is essential, and the lack thereof has meant much tragedy for our families, friends, and community at large. Pandemic preparedness would include a plan for the procurement of PPE and the fundamental need for stakeholder education and training on IPAC standards and practices.

When initial orientation, annual training, and refresher training on IPAC does not happen, the potential for contamination with an infectious agent is widespread across that home.

Thus, at the outset of any outbreak, reorientation of all staff, volunteers, residents, and families is essential and foundational to stopping the spread of the virus.

In many of the homes, there was no dedicated area for the donning and doffing of PPE.

And doffing did not include the decontamination, which is critical because workers can become contaminated with infectious material while taking off PPE.

Many homes did not conduct a risk assessment of each staff position relative to PPE required, and without that knowledge and understanding, there was rapid transmission of the virus. As well, many homes did not instruct staff on how to safely provide resident care while wearing PPE.

This is mandatory, especially given the challenge of enforcing social distancing among residents with dementia. As well, in some homes, ill residents were not isolated to one wing with dedicated staff and other resources despite the common knowledge that cohorting is a standard practice to prevent the transmission of infectious agents.

In terms of senior staff, my concern is that in many homes, the clinical leadership, medical director and the nursing staff and the administrator/executive director, were ill-prepared, poorly organized, un-resourceful, and unsupportive in their roles in this pandemic

situation.

In my experience, managers were not on-site seven days a week, medical directors were often not accessible, and administrative leaders did not understand the need for transparency and ongoing communication with residents, family, and staff.

As well, I heard from many staff that their management team did not monitor nor support their efforts in keeping residents safe. Examples included no PPE available, limited access to hand hygiene products, PPE worn incorrectly, and the same PPE utilized in multiple resident rooms.

In addition, many staff felt that their managers did not monitor their physical and psychological well-being despite the fear, anxiety, and physical strain they were experiencing.

From a resident and family perspective, I know that efforts were limited in terms of ensuring the social connectedness of residents with their families. This despite the technology available: Email, teleconferencing, videoconferencing, and a simple one-to-one phone call.

Virtual visitation was supported by

many homes; however, the essential caregiver role was not recognized at the outset of the pandemic. The connection between residents and their families must never be disregarded given the social isolation that ensues and the role family members play in the resident's health, well-being, safety, and security.

I ask that the Commissioners consider my experiences when preparing your final report. Thank you.

KATE MCGRANN: Thank you very much, Participant 8.

I'm going to turn to Jessica now to read aloud question 2.

JESSICA FRANKLIN: Thanks so much, Kate.

And thank you, everyone, for your thoughtful and extremely informative answers to question 1.

As we go to question 2, you know, please make sure that if there was anything that you didn't feel that you were able to adequately cover in question 1, that you do share that with us.

And, of course, if you need to, you

know -- as Kate said, if there's anything else that you're reflecting on and want to share further if there's not enough time during the time slot, we certainly can provide you with ways to do that.

So question 2 is this: Reflecting on your experience, is there anything that could have been done that would have made the situation better? What is the most important thing that the Commissioners need to know as they consider recommendations?

We'll begin with Participant 1.

PARTICIPANT 1: Again, thank you very much. With regards to what could have been done, one of the first and foremost things that I think should have been done is more staff.

If you think about just in terms of PSW care, activity care, dietary concerns, you need the staff to be able to support the residents, particularly the residents who are immobile or need help to feed themselves.

The home that I'm affiliated with, if you will, is -- their management staff has been turned over -- like, I think we're on our seventh ED since last February, executive director since last February.

There's no continuity. There's no consistency. How can a home expect to run with any sort of semblance of order if their management staff is turned over every -- you know, every month or so? That's ridiculous. They need to have more continuity.

I also feel that the for-profit should be taken out of these homes as well, for that matter.

It all basically boils down to staffing. Communication is another huge thing as well. We were not provided with the correct communication to know what was going on, and, again, that goes to staffing.

I don't think I can say much more else other than everything seems to boil down to staffing. Now, I understand that the government has just, you know, provided X number of dollars to provide more staff, and they're talking 300 staff. Well, 300 staff over the province of Ontario is, like, nothing. It doesn't mean anything. It's not enough.

And they have to be paid -- you know, when you hire these staff, they need to be paid a living wage. They need to be paid benefits and

sick days and, you know, that type of thing, also provided with proper PPE gear, you know, to be able to care for residents. When they're moving from room to room with the same pair of gloves, that doesn't make any sense. It doesn't help the infectious side of things. So yeah, for me it's the staffing.

And homes need to be -- like, the companies that run these homes, they need to be held accountable for -- you know, for the things that happen. There needs to be accountability above all else.

I'll stop there because I think that pretty well -- you know, other people have said what I agree with, so, yeah, I think I'll stop there. Thank you.

JESSICA FRANKLIN: Thank you, Participant 1.

Participant 2, please go ahead.

PARTICIPANT 2: My chief recommendations are add essential family caregivers to the long-term care act with rights similar to those described in the resident Bill of Rights in the act.

Revise directive number 3 giving

essential family caregivers a separate section and status and do not include them under the heading of visitors.

Family members and essential family caregivers must be viewed as primary resources regarding residents and their well-being and must be viewed as part of the care team. They must not be viewed as spies or irritants in the long-term care home.

Their advice, questions, and interventions must not lead to reprisals against the resident or the essential family caregiver or other members of the resident's family.

2, improve staffing and staffing level standards and performance against those standards. Ban long-term care workers from working at more than one home on a permanent basis. Control the number of long shifts, that's 16 hours, and double shifts and the use of agency staff.

Ensure that doctors, nurses, PSWs, and management are personally suitable for the job of working in long-term care. Adopt the advice of the recent staffing study presented to the Ministry of Long-Term Care.

3, develop and regularly update new

care standards that reflect current knowledge and best practices in all aspects of care. Particular attention should be paid to dementia care and to palliative and end-of-life care, both of which are currently deficient in long-term care.

A potential solution could be to deploy community or hospital palliative care teams into long-term care homes as required.

All care should move from the current task orientation to person-centered care that recognizes the whole person and individual needs, especially the need for independence.

Train PSWs better and create a licensing system for them. They must be part of the registered staff in order to be considered a respected part of the care team. The scope of PSW work must be broadened to include observations that could indicate a problem that must be addressed. The scope of PSW training must include training in different cultural expectations and practices among residents.

5, pay all workers in health care enough salary and benefits so that they can work at one home. Pay and benefits should be the same as pay and benefits of hospital workers in health care

facilities. Going forward, require that all health care workers must comply with testing and vaccinations in order to work in health care.

7, train long-term care home management in their responsibility for regular and ongoing communications with families, family councils, and the public when necessary. These communications should respect the important role of family members and essential family caregivers in the care and well-being of residents.

8, free long-term care home management from having to report critical information to their owners or operators, a requirement that can lead to critical information getting delayed at best and manipulated at worst.

Critical information must be communicated in digital form directly from the home to the Ministry of Long-Term Care analysts. For example, when actual staffing levels fall below a set standard, it should be reported to the Ministry immediately.

Ministry of Long-Term Care must define what is a crisis. For example, X percent of residents are sick. X percent of staff are sick. X percent of staff have left. X percent of calls

and emails go unanswered. X percent of residents have not eaten. X percent of residents have a UTI. Those are just examples.

In the long-term care sector, homes avoid making information public for fear of tarnishing the reputation of the home.

9, train long-term care home staff in communicating with families about resident-specific information and train them in resident rights and essential family caregiver rights.

10, connect long-term care homes to a supportive network of regional public health and hospital groups and improve management's judgment of when to ask for help.

11, devise new and better ways to measure performance and meaningful outcomes in long-term care. Reeducate the sector that process indicators are not meaningful performance indicators.

12 --

JESSICA FRANKLIN: Participant 2, sorry, just to let you know, you're coming up to the end of your time.

PARTICIPANT 2: Okay. Remove inspectors from local areas where they become known

to long-term care homes. Relocate them to provincial level where they can be rotated and deployed as unannounced inspection teams.

I'll shorten the next ones. Build automated systems that automatically capture data from the long-term care home systems. Improve cross-training and lessons learned in homes that have suffered in outbreak so other homes don't repeat those problems.

Phase out private sector involvement in long-term care and in home care. Corporate goals for profit and protection of corporate reputation and information are inconsistent with topnotch care and need for full communications and transparency. Private companies just add to the government bureaucracy required to oversee them.

I think I could stop there. Thank you.

JESSICA FRANKLIN: Okay. Thanks so much, Participant 2.

Participant 3, would you like to go ahead?

PARTICIPANT 3: Sure. The scope of how I've been viewing some of this has been a lot more microscopic level, not macro, big picture. The other folks that have been supplying

recommendations are a lot more global in management processing than I could ever deal with.

I'm someone who, in my career, has always been in the trenches looking up on how to get out of a problem or a situation or whatever the case, and I don't have as much of a management perspective.

However, one of the things that I am most wary of is that we're going to be with this virus for a very long time. I don't think that we're going to be out of the water in -- within a couple of years. I think there's going to be an ongoing -- a problem that we're just not going to be able to get ahold of.

And that has to do a lot with how much society is going to be taking the vaccine, et cetera. Like, in my wife's home, there's an under 50 percent take-up rate even though Ottawa was one of the designator areas, and our home was one of the test facilities, and we still got an under 50 percent take-up rate.

And most of the folks that I have talked to there don't get flu shots, and they're not going to take the vaccine. They just -- they have their own reasons for not doing it.

So there's a -- certainly there's a not-me-first syndrome, but a lot of people just don't believe in vaccinations, and it's not going to -- the problem isn't going to happen to them.

So I expect that we're going to be dealing with this virus in many of its bounce-back forms for a long term to come and how we're going to be able to handle that.

So one of the things that I know is on the list for upcoming is the rapid test. How are we going to handle rapid test deployment? What is our requirements? Should we have people who do not take the vaccine need to undergo several of the rapid tests per week, for example?

Could there be an education function that goes out for the training of PSW and perhaps even some form of an incentive program to get PSWs to participate more voluntarily as opposed to a punishment? Is there some form of a participant inclusion that we could provide for people who want to get -- to be part of the vaccination program?

I was lucky enough to have had the second dose, and I don't know how protected I am. My wife is going to be having the second dose in a couple of days, so she's as protected as she can

be. But I'm still not allowed to be out in the hallway with her. I can only be in her room.

Today she wanted to be in the main area because they're off of lockdown as of today. She wanted to be with other people to eat, so I had to stay in her room while she ate. And I typically go there over lunch hour to help feed her. Today she wanted to be with other people, and she's a very social kind of person.

So how do our rights unfold? What are the expectations of the vaccine program? Anyhow, I'm going to stop there. I'm too wrapped up in this.

JESSICA FRANKLIN: Thanks so much, Participant 3. And just to say, from the global to the individual, all perspectives are very much welcome, so thank you very much for sharing that.

And I just wanted to let participants know that we are doing quite well for time, and so we'd like to offer, if you would be interested, an offer for you to just share one final statement, just under a minute or so. We'll go and do one final round.

If there's anything that you really want to make sure the Commissioners are aware of,

we'll do that at the end. We'll continue on with responses to question 2, but we do have enough time for just one final statement if anyone would like to share that. So myself or Kate will direct you in doing that.

All right. We'll move on to Participant 4 with your response to question 2. Thanks so much.

PARTICIPANT 4: Thank you, Jessica. So I want to just preface my comments by saying I am by no means an apologist for the long-term care system in Ontario. I believe it's in crisis. It's broken, and you've heard a lot from a lot of people already about what's wrong with the system.

I just want to say -- I want to point out that there are some success stories, and to me, the home that I'm associated with, Fairview Manor, is one of those success stories in infection prevention and control. But as we all know, this can change at any moment, and, you know, we could be in a very bad situation.

But in my humble opinion, I would like the Commissioners to note that not just -- to note not just what witnesses have told the Commission, but to look also at who these witnesses have been.

And I think you will find that we family members who have participated, generally seniors in our 60s and 70s, white-haired or no-haired, and we are ultimately the next generation of residents in long-term care, so we have a vested interest in getting long-term care done right and done soon. So we urge you to work with that thought.

We, ourselves, are reaching a point where we rely on the home to do for our loved ones what we are no longer able to do financially, socially, culturally.

Small locally administered homes like Fairview Manor are often staffed by friends or family of residents who have known them for a good portion of their lives. Such links between residents and staff can be very important in determining how exceptional care in a pandemic is delivered.

So I humbly offer the following three recommendations for your consideration: 1, I think the Ministry needs to fast-track online connectivity, not just for medical consultations but so that audio/visual communications becomes a standard feature for connecting every resident to

their family members. This becomes critical in pandemic situations, I believe.

Number 2, while today the Province has announced 11.8 million in funding for Ottawa area homes, I think it needs to do more for homes with good records too. You know, so not just to reward those that have had -- you know, had failures, which definitely need help, but places -- other places need help too.

So a longer-term strategy for long-term care should include smaller homes with higher staff-to-resident ratios and include, if possible, only single bedrooms to reduce the impact of transmission in multi-bed areas. That's a big ask, but I think it's something to look for in the long-term.

And lastly, I think the accountability framework for long-term care -- and you've heard this said by a couple of others here. It needs to be dramatically overhauled to make the pandemic response of prevent, isolate, contain an ever-present part of continuity planning and not a one-off.

So for me, that's how I would wrap it up. Thank you for your time and your perseverance

in providing the best possible report you can. Thank you.

JESSICA FRANKLIN: Thank you, Participant 4.

We're going to move on to Participant 5. Please go ahead.

PARTICIPANT 5: Thank you. So I agree with the comments that the participants have made prior to me speaking.

So what could be -- what could have been done that would have made [INDISCERNIBLE]. Well, I think the Provincial and Federal Government stepping in sooner to better manage the outbreak crisis in long-term care would have helped, that residents' rights to safe and quality care was given priority over everything else, that staffing issues were addressed earlier, and planning had taken place long before the second wave to ensure safe -- sufficient staffing going forward including recruitments, suitability, training, retention, pay equity, benefits, minimum standards of care, increased full-time work versus part-time and casual positions.

And as we know, Quebec moved quickly, and I know there have been issues, but they have

moved quickly with a plan in place. It would have helped to have residents and families included at the discussion and decision-making tables to truly reflect what was happening from the perspective of the resident and families on care needs during the pandemic.

What essential care -- developing the role of essential care partners, visits, communication, and planning for subsequent waves, and, of course, accountability with rigorous unannounced inspections, reporting, and follow-up would have gone a long way to identify standards compliance.

Some items I would encourage you to consider in your recommendations are: 1, at the very heart of long-term care are the residents, not politics or profits. It's about the residents and their safety and care needs always.

2, families are the supportive voice of the resident, and it only stands to reason to encourage residents and families and ensure they have a seat at the discussion and decision-making tables to promote transparency, which is essential to building trust.

3, over half of the long-term care

facilities in Ontario are managed by the private sector. For-profit homes represent a conflict of interest as they can prioritize profit, liability, and shareholder rights over resident care needs.

4, I believe it's unethical to be making profits off the compromised health of people living in longer-term care environments, and this must be stopped.

5, long-term care is the largest form of hands-on care that's not covered under the Canada Health Act, and we need national standards for long-term care.

6, numerous reports have been written over the years by experts in the field of senior and long-term care offering recommendations for care delivery models, best practices, policy reform, staffing, standards of care, data collection. We know what has to be done.

7, long-term care transformation must include both facility- and community-based care. Longer-term care is a continuum often starting with support of family and community services in the home with the potential for the person to move into a facility-based care. Community care must be held to the same standards as facility-based care.

8 -- I'm almost done here -- quality staffing is a critical piece for any delivery of care.

9, our provincial political leaders have demonstrated they do not have the political will to fully act on what is needed to protect vulnerable people using longer-term care. Other options must be urgently pursued for the safety of those using longer-term care.

And finally, I encourage you to take a brave and different path from what has been chosen in the past, one that can transcend partisan politics and be a model of care excellence in the long-term care sector. Thank you.

JESSICA FRANKLIN: Thank you very much, Participant 5.

Participant 6, please feel free to go ahead.

PARTICIPANT 6: Thank you. Communication is something that really needs to be addressed. It was nonexistent, and it's still really not good.

Staff. We need full-time staff with better pay and benefits. They have to stop either running shorthanded or calling in agency personnel.

They all need full-time work. We have to stop the practice of having these low-paid workers going to two and three different long-term care facilities in order to make a living wage.

We have to address cleanliness. And if I get the chance at the end, I will talk a little bit about that on the next round.

They need to go back to reinstate regular inspections. That really needs to be done. And last but the highest of my priorities is to take the profit out of long-term care. As I said, my brother is at Carlingview Manor, which is part of the Revera chain.

I am retired with 37 years in the federal public service. You can't even think how I feel to know that my pension owns Revera, the overwhelming guilt because I'm receiving a monthly pension to the detriment of my brother.

It's time really to end privatization. I think we've seen through all of this that privatization and the for-profit homes really have the highest problems and the highest numbers.

So I am doing everything I can to make Revera public, and I think that needs to be followed by other long-term care facilities. Thank

you.

JESSICA FRANKLIN: Thank you, Participant 6.

Participant 7, please go ahead.

PARTICIPANT 7: This is an all-consuming question for me. My recommendations are very lofty, but I feel that they need to be voiced and heard, and God knows that the entire long-term care system needs to be fixed and that our vulnerable seniors deserve to be cared for in an environment that is safe, healthy, humane, and caring, not just during a world health crisis but always.

1, abolish for-profit facilities because placing profits over people is a repulsive incentive that directly affects quality and the essence of care for this demographic. There needs to be a working system that places human life over shareholders and pension funds.

Hire more nurses, social workers, and psychosocial teams that are regulated, skilled, and trained to ensure that our elders receive the clinical interventions, observations, and around-the-clock monitoring that is integral to their well-being and health issues.

We need dedicated and skilled dementia care urgently. There are thousands of seniors who don't have physical medical issues but have dementia, and at times, the only intervention is the use of atypical antipsychotics.

Number 3, Bill No. 203, which is the essential caregiver act, needs to be legislated immediately. The number of essential caregivers need to be increased to at least four people to prevent burn-out and as a backup contingency plan if one of the ECGs becomes ill or unavailable.

This is the foundation on which the long-term care crisis will evolve the quickest and be the most efficient and humane intervention during this current disaster. This is tangible at this junction.

Number 4, increase the number of unannounced Ministry inspections.

Number 5, long-term care facilities need to have a liaison for constant updated communication with families to provide direct and clear answers in a timely manner.

Number 6, PSWs need to have better job security and benefits and pay equity. Affordable and accessible child care should be made available

because most PSWs are marginalized women in this field.

Aging-in-place options need to be addressed ASAP. Families and the populations have witnessed the horror of long-term care over the past year. They are understandably reluctant to place their loved ones in these facilities.

Home care, home support, and assisted living in smaller, manageable facilities needs to become a priority. Families who do not have these crucial supportive measures end up placing their parents or spouses in long-term care where a bed could be available for those seniors who require a higher level of care.

These families who feel that they have no option left to care for their loved ones at home have been forced into a deadly corner. Most families want to support their people in their homes.

As Laura Tamblyn Watts has said:

> "Home care is the least expensive option for the government and the most preferred option for the elderly. Keeping someone in their homes costs far less for the

government than funding a long-term care facility with full-time staff."

My last very utopian recommendation came after a discussion with a friend who is a geriatrician. I had grave concerns about the medical presence, qualitative and quantitative levels in these long-term care facilities. I wanted to know if these were valid, and they were.

The physician care in long-term care facilities is very variable. Some will spend a day or more while others quickly do rounds on their patients every two weeks. This is important because it would not be allowed anywhere else.

All health care professionals, including doctors, in long-term care need to have training in geriatrics and palliative care just like any other specialized medical location.

Continuity of health care workers, including physicians, should know their patients and their families so that care of these seniors can be individualized with regular communication.

Long-term care needs an interdisciplinary approach to caring for our families now and certainly in the future. I did say that I was an overachiever, and here I am.

Thank you.

JESSICA FRANKLIN: Thank you very much, Participant 7.

Participant 8, we'll come to you for your response to question 2. You're on mute, Participant 8.

PARTICIPANT 8: Okay. There. I'm on.

JESSICA FRANKLIN: We can hear you now.

PARTICIPANT 8: Okay. There's an old adage that says that as the leader goes, so goes the rest of the organization. So my -- what would make it better? An administrator/executive director that is the leader in the most senior position in the home accepting his or her responsibility and accountability for quality infection control and management. And this includes the preparation of a detailed pandemic plan and its communication and mock simulation on an annual basis.

I believe that for this to be achieved, all homes must recruit a leader who is qualified by education and experience in health care administration, has the business acumen to manage the home, has the leadership qualities to provide the necessary direction and guidance to staff, and

has the knowledge and experience to oversee quality living and quality dying within the culture of long-term care.

Thank you for this opportunity today.

JESSICA FRANKLIN: Thank you very much, Participant 8.

So, as I said, we're doing very well for time, and because of that, we wanted to offer you an opportunity to just share any final words you would like the Commissioners to hear.

We just ask that you keep them under a minute, and we'll do the same thing that we've been doing, going from Participant 1 all the way through to Participant 8.

Then we'll have some closing remarks from Commissioner Marrocco, and we'll wrap up for the evening.

So if you're okay, Participant 1 -- and, again, if folks do not want to participate in this, that's fine. Just say, you know, "nothing further," and we'll move on to the next participant, but if you do want to share something, you're more than welcome to.

Participant 1, is there any final thoughts you'd like to share?

PARTICIPANT 1: No, just to restate the staffing levels and communication levels I think are so important. I mean, there are those -- you know, there are residents who have family members to advocate for them, but I get concerned about what about the residents that don't have anybody? You know, how are they affected by all of this?

It needs to change. The system needs to change. There's no two ways about it. And, you know, we can study and investigate and do all of these different things, but at the end of the day, the issue is staffing, and it needs to be fixed, you know, and -- yeah, exactly.

JESSICA FRANKLIN: Thank you very much, Participant 1.

Participant 2, any last, final thoughts?

PARTICIPANT 2: I just want to say that at the end of the first wave, if we had recruited, trained, and deployed even people trained to the old -- the existing standards, which we all think are insufficient, if we had done that, we would have been in a better position.

The second wave would have occurred anyway, but we would have been in a better position

for the second wave, and we weren't. And I still cannot explain to myself why that happened.

And I just wanted to say thank you for -- to the Commission and the Commissioners for the interim recommendations which did signal that this is a very urgent requirement. And I really appreciated to see the interim recommendations come out in support of improvements and change in long-term care. Thank you.

JESSICA FRANKLIN: Thanks very much, Participant 2.

Participant 3, any last words to share?

PARTICIPANT 3: Nothing groundbreaking, but I've always been a proponent of not watching -- or not listening to what they say. It is watching what they do. Sort of like following the money. You know, talk is pretty cheap. Action says it all.

And one of the things that I've noted when I go visit my wife is the level of happiness in the building is down, down, down. And the person beside my wife, she wanders out to the hallway, and she says, "I'm so lonely. I'm so lonely." And she has focused all her efforts on trying to get out of the building.

And I'm sad because of that, so -- and I'm not in power to help her in any way. But the -- it's not permitted now, so... Anyhow, thank you.

JESSICA FRANKLIN: Thank you very much, Participant 3.

Participant 4, any last words to share?

PARTICIPANT 4: Just quickly, you know, I really think monitoring and reporting at the accountability framework level needs to be taken out from -- out of the Ministry's role and responsibility.

We need a whistle-blower kind of function, and I know that the Patient Ombudsman Paul Dube does the best they can, but he just doesn't have the tools in his tool belt to really speak for long-term care.

And I think long-term care itself just needs some very -- some whistle-blowing legislation so that people can talk like we've been doing today.

And I'd like to thank you too, like the other people have said. You know, this is a tough task that you have, and we understand that it's a tough task. Thank you for your focus on this

issue.

JESSICA FRANKLIN: Much appreciated, Participant 4.

Participant 5, any last words to share?

PARTICIPANT 5: Yeah, thank you. First of all, I'd like to thank the Commissioners and the team for allowing -- giving us all this opportunity and for all of the work that you have been doing. It's been no small feat reading through the transcripts on the website. You've been listening to some very heartbreaking presentations.

And I think that's a big thing because part of it is that families have really lost -- families and residents have lost their voice in this. They have not been heard. They have not been listened to.

It has been excruciatingly difficult, very, very painful, and so this work that you're doing is incredibly important. And just offering people a chance to be heard is a very important piece of this, an important piece of the healing as well.

What I would like to say, though, is in addition, I would like to say that there is a lot of inconsistency in how long-term care is delivered

across our region and also right across the province.

And so being part of the Champlain Region and hearing the excellent care and successes that are going on in some of the long-term care homes, and then taking a look in other long-term care homes, the quality and the care delivery is just not there.

And I think the -- you know, that's one of the tenets of the Health Act, is that we have equitable and we have equity in care delivery. And it is important that we strive to provide that for people living in long-term care right across the sector.

So I'll leave it at that, and, again, thank you again for all your work.

JESSICA FRANKLIN: Thank you for those insights, Participant 5.

We'll turn over to Participant 6 for any final words you'd like to share.

PARTICIPANT 6: Thank you, and I wanted to -- I also want to thank the Commission for allowing me to be here.

I raised a couple of times about cleanliness is something that really needs to be

looked at. I want to share a post-COVID. My brother started getting very severe migraine headaches during COVID, and he still continues to have these.

October 29th he had a severe headache that went on for a number of days. He'd asked to see the doctor, and I called and asked for the doctor to see him.

On November 2nd, he was sick to his stomach, and no one related it to the fact that he had a migraine, so they put him in a different room of isolation.

On the bed was a rough blanket and a rubber sheet. The person that had been in that room died. There were diapers on the -- clean diapers on the windowsill, but in the bathroom was the person's razors and two combs in a cup that had been used and were not clean.

He had no clothes. They brought him down. He was in the room for four days before they -- before he went back to his own room with the same clothes to stay in day and night. No towel. On day three, they brought him a small hand towel and no change of clothes.

The joke of this is not funny, but a

couple of his friends would go down and visit him and say there was absolutely no one around. They moved him from the room he had been in that was -- originally he was in supposed isolation into this room, but they had not sanitized the room. They had not cleaned the room after this other individual died.

There really needs to be some kind of a focus on the cleanliness and the amount of times -- they're short of cleaners as well as all the other staff.

That's it. Thank you for listening to me.

JESSICA FRANKLIN: Absolutely, Participant 6. Thank you for sharing that.

Participant 7, please go ahead with any final thoughts.

PARTICIPANT 7: Thank you for the opportunity to speak on behalf of our loved ones. It's uplifting in a way to be able to voice our concerns to people who get it. They get the nuances of long-term care, you know, exactly what you're going through.

It's vital to have this type of discussion with -- almost with strangers because,

let me tell you, you bring your family out, you bring your friends, and everybody who listens, who has listened to me for the past year since the pandemic began.

It's especially important to talk like this if you have a fractious relationship with a facility and a company. It's important for me to have said all that I said today because I don't know when I'll ever get to say it again because certainly the facility and the companies don't listen.

So I thank you for this opportunity and to all the Commissioners for lending us your ear this evening. Thanks a lot.

JESSICA FRANKLIN: Thank you very much, Participant 7.

Participant 8, any last words to share?

PARTICIPANT 8: Am I on? Okay. Thank you. Actually just that I would like to see family councils mandatory within long-term care.

And secondly, I would like families to have an opportunity to be involved whenever the inspectors come on-site. I think that would really enhance the communication of the quality issues that one is aware of in the homes.

So that's an opportunity that I think should be important to family members. As I say, if we go back to regular inspections, it would be easy to notify families of that.

And I just want to say again thank you to Commissioners as well for this opportunity today, and thank you for the respect shown this afternoon in the moment of silence. That was very much appreciated. Thank you.

JESSICA FRANKLIN: Thank you very much, Participant 8.

And thank you to all the participants for sharing those final thoughts. I know I'm extremely humbled by the fact that none of this was prepared, and you've just come with such thoughtful, considerate, and, you know, clear sharings. So thank you very much for that. It adds to our work tremendously.

I'm going to turn it over now to Chief Commissioner Marrocco to give some closing remarks, and then we will close the evening.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, it's -- the thanks really has to go from us to you. We are going to do our level best, and it's essential that we understand what is really

happening in long-term care.

The stories are varied. There are some stories that are uplifting. We heard one earlier this afternoon. But for those people caught up in it, we didn't have to be doing this very long to understand the problems around communication, training, staffing.

And we're going to do our level best to write as intelligent a report as we can. And you can be sure that it will be -- we will put as much into it as you put into it today.

And so on behalf of all of us, thank you for your time. There is a website. The transcripts are there if you want to see what we're up to. You'll see that we're not taking any holidays in there. Thank you all very much. Bye bye.

JESSICA FRANKLIN: Thank you, Commissioner Marrocco.

So just to let participants know, as Commissioner Marrocco said, there is a website where the transcripts will be posted within the coming days.

Also, if there's anything that you didn't get to cover that you would like to share

with the Commission, please know that you can send us a written submission, and there's information on how to do that on the website. We're accepting those submissions. We ask that you send them by January 31st.

And once again, thank you for the courage, the bravery, the resilience that you shared with us tonight. We are, you know, in sincere appreciation of your time and just wish you a very good evening moving forward. Thank you very much.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye, everybody.

-- PROCEEDINGS CONCLUDED AT 5:39 P.M. --

REPORTER'S CERTIFICATE

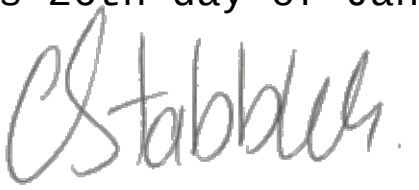
I, CARISSA STABBLER, Registered Professional Reporter, certify;

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

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

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

Dated this 26th day of January 2021.



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