

Long Term Care Covid-19 Commission Mtg.

Meeting with Ontario Nurses' Association
on Tuesday, October 13, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 13th day of
October, 2020, 2:00 p.m. to 4:00 p.m.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8

9 ONTARIO NURSES' ASSOCIATION:

10 Beverly Mathers, CEO

11 Vicki McKenna, President

12 Cathryn Hoy, First Vice President

13 Pat Carr, Team Lead, Labour Relations

14 Sharan Basran, Senior Executive, Legal

15 Marcia Barry, Counsel

16 Nicole Butt, Manager, Litigation

17 Nicholas Baxter,

18

19 PARTICIPANTS:

20

21 Alison Drummond, Assistant Deputy Minister,

22 Long-Term Care Commission Secretariat

23 Ida Bianchi, Counsel, Long-Term Care Commission

24 Secretariat

25 John Callaghan, Counsel, Long-Term Care Commission

1 Secretariat

2 Lynn Mahoney, Counsel, Long-Term Care Commission

3 Secretariat

4 Derek Lett, Policy Director, Long-Term Care

5 Commission Secretariat

6 Jessica Franklin, Long-Term Care Commission

7 Secretariat

8

9 ALSO PRESENT:

10 Deana Santedicola, Stenographer/Transcriptionist

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1 -- Upon commencing at 2:00 p.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, let me start by introducing the
5 commissioners. I am Frank Marrocco, Commissioner
6 Angela Coke and Commissioner Dr. Jack Kitts. We
7 are the Commission.

8 I have sort of said this to everybody
9 pretty much who has been presenting, but let me say
10 it again. Typically when there is a Commission
11 called, something has happened, and the Commission
12 is looking back at what has happened so that it can
13 explain that to the public.

14 We are a little different because we
15 have been called into existence in the middle of
16 something, and so we have concluded that we should
17 try to say something as soon as we can. We have,
18 you know, still that looking-back process to go
19 through, but if we followed the traditional pattern
20 of an investigation, public hearings and a report,
21 it would be two years or two and a half years from
22 now before we would say anything, and obviously
23 that isn't helpful.

24 So that is where we are at, and we are
25 interested in your observations about -- we are

1 interested in all your observations, but we are
2 interested in your observations about things that
3 we could recommend now which would be useful for
4 the Minister to hear or the Minister of Health or
5 whomever we would distribute our recommendations
6 to. We obviously would make them to the Minister
7 of Long-Term Care for sure, so we are interested in
8 that and that is kind of where we are coming from.

9 We have tended to follow the practice
10 of asking questions as we go along, sort of
11 interrupting and asking questions because we
12 thought it was easier to do that than to try to go
13 back, and so with your permission, we would do that
14 today.

15 And the only other thing is just around
16 3:15 or so I usually take a ten-minute break. So
17 when we get around 3:15, let me know where is a
18 good time to do that, and we'll do it.

19 NICOLE BUTT: Perfect.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 So that having been said, we are ready
22 when you are.

23 NICOLE BUTT: Okay. Thank you.

24 VICKI McKENNA: That is great. Thank
25 you very much.

1 So I am Vicki McKenna. I'm a
2 Registered Nurse, and I am Provincial President
3 with the Ontario Nurses. And with me today is
4 Cathryn Hoy, who is ONA's First Vice President and
5 who is also a Registered Nurse; Bev Mathers, who is
6 ONA's CEO and is a Registered Nurse. We have Pat
7 Carr. Pat is a Manager and Team Lead in our
8 long-term care sector, and she is a Registered
9 Nurse. Nicole Butt is our Manager in our
10 Litigation Team. Marcia Barry is a member of the
11 Litigation Team, along with Nicholas Baxter.

12 And so we are really pleased to be here
13 with you this morning -- or this afternoon
14 actually. I have been thinking about this for days
15 now. And we have a lot to say, and I know we have
16 limited time, but I want you to know that we'll
17 certainly get through as much as we can, but we are
18 bringing the voices and words and stories of those
19 who work in long-term care, who have been working
20 in long-term care through the COVID-19 pandemic and
21 continue to be there.

22 And so generally, just so you know a
23 little bit about ONA, we represent over 68,000
24 primarily Registered Nurses, but we do have
25 representation of some other health care

1 professionals, including over 4,000 in the
2 for-profit long-term care sector, almost 2,000 in
3 the municipal and not-for-profit long-term care
4 sector, and in a few of those nursing homes we
5 represent not only the Registered Nurses but
6 Registered Practical Nurse and Personal Support
7 Workers.

8 Several hundred ONA nurses who work in
9 our hospitals, in public health and the LHINS were
10 also re-deployed to work in long-term care during
11 the first wave of COVID-19, and in fact, some are
12 still working there.

13 And during our presentation, we'll be
14 sharing the following information with you. What
15 were and is the lived experience of nurses and
16 residents at the frontline. What were the key
17 problems that contributed to the spread and
18 devastation of COVID-19. What worked but what
19 didn't work, and what can we do now to prevent
20 harm, illness and death, and I think that is what
21 you were speaking to a few minutes ago. What can
22 we do, what can we get on now, and other things
23 maybe further down the road.

24 So we do have a number of
25 recommendations on how to prevent the tragedy from

1 happening again, but our focus right now is on the
2 short and medium-term sort of recommendations that
3 we believe are most critical now, that we are not
4 only entering but in the midst of -- I believe in
5 the midst of a second wave, and we need to learn
6 from that quickly, the history and lessons of SARS
7 and to act now as quickly as we can.

8 We also have a number of long-term
9 systematic recommendations that we believe need to
10 be implemented in order to ensure that in the
11 future this never happens again, but we would also
12 like to say that we'll welcome the opportunity to
13 speak to you at another time in regard to the
14 longer-term recommendation.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 If I can just interrupt you for a
17 minute. That is quite all right with us. We fully
18 expect to speak to some people more than once, and
19 so we don't have any problem with that. And if
20 there is something that you don't get through today
21 that you feel, we are quite happy to receive
22 something in writing or to schedule a further
23 get-together.

24 So don't feel that -- you know, that at
25 two hours there is no opportunity to give us

1 further thoughts because that is not correct.

2 VICKI MCKENNA: Well, excellent, and we
3 are very happy to hear that, because as we were
4 trying to gather and get all this together and
5 think, okay, we have got two hours, how can we get
6 it all in, so I am really pleased to hear that.

7 So we believe that just overall -- and
8 you are going to hear this throughout our
9 presentation, but we believe that had the
10 recommendations from the SARS Commission, for
11 instance, the Gillese Inquire, and other staffing
12 reports -- and there has been many of those, had
13 they been fully implemented, that workers and
14 residents would have been a lot safer and the
15 impact wouldn't be what we all know has occurred
16 and already beginning to happen again in wave two.

17 Tragically, though, it didn't happen,
18 and health care workers in Ontario were infected
19 with COVID-19 at an alarmingly high rate, much
20 higher than experienced in other countries right
21 around this world. We have done really poorly in
22 regard to health care worker infections against
23 other jurisdictions, and that is something that is
24 quite disturbing.

25 ONA, we were forced to pursue -- and I

1 don't know if you know this at all, but we were
2 forced to pursue legal actions to protect our
3 members' health and safety. We had to file
4 occupational health and safety appeals at the
5 labour relations Board. We had to file an
6 injunction in the courts against four nursing
7 homes. And we had to have an arbitration from over
8 200 grievances that were filed that had to go
9 before arbitrator John Stout.

10 Throughout all of this, our members in
11 long-term care were present. They were in the
12 homes, working every single day. They saw what was
13 happening. They relentlessly advocated for the
14 safety of the residents that they cared for, and
15 their own safety.

16 And because of the safety of our
17 residents and staff -- because the two are
18 intertwined. If the staff are safe and protected,
19 so are the residents. These things are not in
20 isolation. They are totally intertwined.

21 There are nurses and health care
22 professionals in long-term care, they are
23 distraught, they are traumatized over their
24 experiences and the losses that they experienced.
25 Many of our members themselves became sick, are

1 diagnosed -- have been diagnosed with COVID-19.
2 Some were hospitalized. One of our nurses, Brian
3 Beattie, has died. Other members have been off
4 sick due to the physical and emotional trauma that
5 they have experienced by working through the first
6 wave. They are worried. They are very worried
7 about the second wave and what is to come.

8 And these nurses, as I said, want to
9 speak to you. We have conducted a survey, just so
10 you know, where we received over 1,000 nurses
11 responding, and throughout the presentation you are
12 going to see some of that. We put quotes from --
13 we'll put quotes in our PowerPoint presentation.
14 We intend to provide you with a very detailed
15 report of that survey. It just closed last week,
16 so we don't have everything together today, but we
17 will provide you that going forward, and we want to
18 make sure that you have that information.

19 And I can tell you, being involved in
20 this union for as long as I have, to have over
21 1,000 nurses respond on a survey out of this
22 long-term care sector is truly amazing and
23 demonstrates just how profound the experience has
24 been and their thoughts about what happened and
25 what can be the future for long-term care.

1 We have also, just so you know,
2 conducted over 50 one-on-one interviews with our
3 nurses who worked. These nurses work in over 30 of
4 the homes where the worst outbreaks occurred.
5 Their stories are alarming and compelling at the
6 same time.

7 We appreciate that you do plan to hear
8 from them, and we'll maybe figure out the logistics
9 of that, but they are the experts in long-term
10 care. They know what went wrong, and they have
11 ideas on how to fix it.

12 And in the meantime, we put together
13 just a brief video for you. These are four of our
14 nurses who speak about their experiences. All four
15 have been diagnosed with COVID-19 after being
16 exposed in the workplace, and we note that these
17 nurses are all very concerned about being
18 identified and experiencing reprisals from their
19 employers.

20 So we have removed references to their
21 names or their employer. Just so you know -- you
22 may not know this, but nurses don't have whistle
23 blower protection. Many are experiencing reprisal
24 today because they are advocates for PPE, for
25 instance, or for their coworkers and the residents.

1 So we need to somehow ensure in the system that
2 they can participate in this process now and then
3 going forward we can -- you know, that is something
4 that we can talk about.

5 But we do need to maintain their
6 confidentiality.

7 So, Nicole, can you play the video
8 please.

9 NICOLE BUTT: Sure. Nick is going to
10 play it. We were wondering whether it would be
11 possible to not have the content of the video part
12 of a public transcript, if that part could go off
13 the record?

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 You mean because it would be obvious
16 who the people are on the video?

17 NICOLE BUTT: At least two of them had
18 very specific illnesses that I think would be
19 identifying.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Well, I don't see any reason why we
22 can't -- we won't -- we just won't post the video.
23 Commissioner Coke, what do you think?

24 COMMISSIONER ANGELA COKE: I agree.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Commissioner Kitts?

2 COMMISSIONER JACK KITTS: I agree.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So we won't post the video.

5 NICHOLAS BAXTER: I will be sharing the
6 screen now.

7 THE COURT REPORTER: Just for my
8 benefit, Chief Commissioner, I'm not to transcribe
9 this part?

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Would you just put in the transcript
12 that there was a video played.

13 THE COURT REPORTER: Will do. Thank
14 you.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 All right.

17 NICHOLAS BAXTER: If everyone is ready,
18 I'll play.

19 [Video presentation.]

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 The video stopped, you know that?

22 NICHOLAS BAXTER: Yes, I do. I
23 apologize. I will --

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Oh, that is fine. I just wanted you to

1 know.

2 [Video presentation continues.]

3 NICHOLAS BAXTER: That is the end.

4 VICKI McKENNA: Thanks, Nicholas.

5 So that is just a glimpse, really, of
6 what we are bringing, and as I said, we are
7 bringing those voices and the experiences of those
8 individuals that -- you know, it is their practice.
9 It is what they love to do and what they really
10 truly experience.

11 So Marcia is going to talk a little bit
12 and give you a bit more detail on some of those
13 stories from the frontline. So Marcia.

14 You are muted, Marcia.

15 MARCIA BARRY: Sorry about that. Thank
16 you, Vicki.

17 So as Vicki mentioned, we have been
18 conducting over the past few months interviews with
19 our members, and the stories I am going to tell you
20 now are pulled from the various interviews we have
21 done, and also, as Vicki mentioned, throughout the
22 presentation you are going to be hearing some -- or
23 seeing, not hearing, some quotes from our members
24 from the survey. So as Vicki said, you know, our
25 members have the real frontline experience about

1 what happened and have a lot of ideas about
2 solutions.

3 So one of our goals today was to make
4 sure you hear their stories.

5 [Court Reporter intervenes for
6 clarification.]

7 Is that better, if I just try and
8 project a little more?

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 That is certainly better for me. I
11 don't know about everybody else.

12 VICKI McKENNA: It is better.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Yes, I think that is better.

15 MARCIA BARRY: Sorry, I tend to be a
16 little soft spoken.

17 So I am going to start with a story
18 about what happened in a particular home. However,
19 although it is a story of one home -- no, can't
20 hear? Okay. Hang on.

21 Sorry, technology helps and yet it
22 doesn't.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 Well, I was trying to tell you that we
25 couldn't hear you, but I was on mute, so I'm not

1 really in a much better state than you are.

2 MARCIA BARRY: All right. Can you hear
3 me now? Is that better?

4 Okay. So just give me one moment to
5 turn down because now I can hear you all too loud
6 in my ears.

7 Okay. That should be okay. Okay. So
8 I am going to tell you the story, first of all, of
9 a particular home in the Ottawa area, although I do
10 want to say, having done a lot of the interviews
11 myself with our members, what happened in this home
12 is, I would say, exemplary of a certain pattern of
13 issues and failures that we have seen in a lot of
14 different homes.

15 So the home I want to talk to you about
16 is a 60-bed long-term facility. It is run by
17 Revera, and as I said, it is in the Ottawa area.
18 In this particular home of 60 residents, 53
19 contracted COVID, and the home's staff was
20 similarly decimated.

21 So in this home, all of the beds are
22 classified as C-beds. I think you have had some
23 education about the classifications of beds, but
24 that means that they were built to meet the 1972
25 design standards.

1 One of the things that tends to mean is
2 this home has a lot of ward room beds, which I also
3 know you have heard about. So this home had eight
4 private beds, ten semi-private rooms, and eight
5 ward rooms.

6 So this home was put on respiratory
7 outbreak on March 30th, and on April 2nd, that
8 outbreak was confirmed to be COVID-19.

9 Unfortunately, by that point it was
10 really too late, and the virus was going through
11 the home like wild fire. The first resident with
12 symptoms consisted of COVID-19 had symptoms on
13 March 26th, so a full week before the home was put
14 on a COVID outbreak.

15 Over the course of that first week,
16 again, before the outbreak was declared, at least
17 three staff and two other residents started
18 exhibiting symptoms.

19 So the home would go on to be on
20 outbreak for another two and a half months, and in
21 that time, a large number of staff would become
22 positive for the virus. By April 5th, so three
23 days into the declared outbreak, the nursing staff
24 was down to only two full-time RNs and one casual
25 RN.

1 Those were the only nurses left at that
2 point in time who had not tested positive for
3 COVID.

4 Similarly, the numbers of healthy RPNs,
5 PSW, dietary, housekeeping, all the staff that it
6 takes to run a home had been gutted by the virus.

7 So this home got to the point where
8 they were hiring whoever they could; for example,
9 one of the RPNs one day brought in her 18-year-old
10 son and her father, who were both hired on the
11 spot, and they were put to work partially as PSWs,
12 partially as housekeeping, kind of doing whatever
13 they could in the home to help. Other members of
14 the community, other staff family members were
15 hired into similar roles.

16 Unfortunately, that meant that none of
17 these new hires had any experience in health care,
18 and they were provided with no training or
19 orientation, particularly around infection control
20 and PPE.

21 And unfortunately, this RPN who brought
22 in her family members, both she and her two family
23 members eventually contracted the virus.

24 So one of our members who did not
25 contract the virus and worked throughout the

1 outbreak, she told us, for example, about a
2 particular shift where she was alone with two of
3 these random people, as she describes them, on her
4 shift for the entire south wing. So the three of
5 them had to care for 30 residents, many of whom
6 were ill with the virus.

7 So she described to me how, you know,
8 these two support staff, they were just struggling
9 to feed the residents and change them. That is
10 really the only care they had time to provide while
11 she was attempting to give medications and provide
12 treatment.

13 And that nurse described how she and
14 only one other nurse for a stretch, they just
15 worked twelve-hour shifts, the two of them just
16 rotating, one on days, one on nights, going back
17 and forth.

18 So by the time the outbreak ended here
19 on June 18th, a total of 82 people had tested
20 positive for COVID, 53 of the residents, as I said,
21 and 29 staff, and nine of the residents died. And
22 at the time the outbreak ended, there was still two
23 staff off work remaining in isolation.

24 So I want to go through just some of
25 what we see as some of the particular issues in

1 this home, and again, these are issues that I have
2 heard time and time again from the nurses that I
3 have spoken with.

4 So the first is a failure to enact
5 preventive measures, so screening staff and
6 visitors, screening residents for symptoms,
7 limiting staff to working at only one home. None
8 of these were put in place until there was
9 directives or orders from Public Health to do so.

10 The home didn't implement any social
11 distancing for residents and staff prior to the
12 outbreak. In fact, it actually took a few days
13 after the outbreak for the home to close the dining
14 room and the lounges.

15 And even in the weeks leading up to the
16 outbreak, so throughout March, the home continued
17 to hold staff meetings in a fairly small room where
18 staff weren't able to physically distance.
19 Ironically those staff meetings were often about
20 the COVID virus.

21 So it was actually a staff RN who
22 finally isolated all of the residents into their
23 rooms. This was, again, after the outbreak had
24 been declared, several days after, and she did that
25 despite actually initial resistance from the home's

1 director.

2 So one of the things that was a failure
3 here -- and again, this is a pattern we have seen a
4 lot -- is that the first patient to exhibit
5 symptoms was not treated as though those symptoms
6 were symptoms of COVID. So I have mentioned the
7 symptoms started on March 26th, but no precautions
8 were put in place. So that resident was not -- no
9 infection control protocols, no requirements for
10 PPE were required, and unfortunately, our first ONA
11 member at this home to contract COVID cared for
12 this resident on the day she first showed symptoms,
13 and our RN, our member, was off sick within a few
14 days of the onset of the patient's symptom onset.

15 So that patient was actually not
16 swabbed until after she died. That patient died
17 unfortunately on April 3rd, and she wasn't swabbed
18 because her physician didn't order a swab because
19 she had a history of respiratory issues.

20 So swabbing in the home didn't start
21 until March 31st, so five days after this first
22 patient had exhibited symptoms, and again, that is
23 the day after the home was put initially on a
24 respiratory outbreak.

25 At first they were only swabbing the

1 residents and staff who were already exhibiting
2 symptoms. Again, that is something we have heard
3 time and time again, a failure to do widespread
4 swabbing of the entire home until the outbreak was
5 well underway.

6 So in this home, it wasn't until April
7 13th that the whole home was swabbed, and the local
8 media reported on April 21st that by that time 50
9 residents and 27 staff were now positive.

10 So I have mentioned the failure to
11 isolate. So that first week that the -- I'll call
12 her patient A developed symptoms, the home was
13 actually still receiving new admissions. The first
14 admission was not isolated at all. The second was
15 isolated but isolated to her room. Unfortunately,
16 she had a roommate, and that is a common problem
17 that you are going to hear about from the homes is
18 the inability to truly isolate because so many of
19 these residents have roommates in the room with
20 them.

21 So finally on March 27th staff were
22 directed to stay in their assigned wing and not
23 cross over. However, because this home, like so
24 many homes, is staffed so thinly, particularly on
25 evening and night shifts, that wasn't really

1 possible. So on night shifts, there was only a
2 single RN and two PSWs for the whole building. The
3 RN had to cross over because she was alone. And
4 even the PSWs, in order to reposition and transfer
5 residents, which often requires two people, so they
6 also had to cross from wing to wing.

7 So it was actually an ONA member, an
8 RN, who suggested to the Director of Care quite
9 early on that the residents should be isolated to
10 their rooms. This RN had heard that some of the
11 other homes in the area were doing that. But
12 despite the recommendation, no isolation attempts
13 were made until the weekend of April 4th and 5th.

14 So again, we are several days into the
15 outbreak at this point, and again, they were only
16 at first isolating the symptomatic residents to
17 their room, even if the resident had asymptomatic
18 roommates.

19 And unfortunately they even made
20 exemptions to the isolation rule. So, for example,
21 three residents who complained about being isolated
22 were allowed access to the home and tragically all
23 three of them eventually tested positive.

24 One of the RNs in this home told me
25 that the handful -- so the seven or so residents

1 who did not test positive, by the end of the
2 outbreak, three of them were in private rooms. So
3 I think that really exemplifies the extent to which
4 the ability to isolate and having private rooms
5 makes a big difference.

6 Lack of PPE, so I have mentioned that
7 infection protocols weren't put in place
8 immediately. Eventually staff were provided two
9 masks for their entire shift. They were required
10 to wear a mask, just a simple face mask -- this is
11 not an N-95 -- at all times.

12 But early on in the outbreak there was
13 a notice in the home about what was proper PPE for
14 COVID, but it only mentioned wearing a face mask
15 and goggles or a face shield. It didn't mention
16 gloves, it didn't mention gowns or -- and it
17 certainly didn't mention N-95s. So N-95s in this
18 home only became readily available after the
19 arbitration that Vicki mentioned. That award was
20 issued on May 4th.

21 Finally -- and you will hear more about
22 this later in our presentation, ONA filed a
23 complaint with the Ministry of Labour about the
24 working conditions in the home. An inspection was
25 conducted on April 8th, but it was conducted over

1 the telephone, and despite the fact that the COVID
2 outbreak was clearly running wild in this home, it
3 was decimating both residents and staff, but the
4 inspector found no occupational health and safety
5 violations and issued no orders.

6 Staff were pressured to work sick, so
7 staff were required to return to work when their
8 symptoms were resolved, even if they were still
9 receiving positive COVID tests. And once they were
10 back at work, one nurse specifically asked for an
11 N-95 because she was afraid she might still be
12 infectious, and she was refused.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Can you just -- can you just help me.

15 MARCIA BARRY: Yes.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 So the inspector does the inspection
18 over the phone.

19 MARCIA BARRY: Yes.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 I don't know exactly what that would
22 look like, but did they give any rationale for not
23 making any orders? I mean, do you have a sense of
24 why that was?

25 MARCIA BARRY: So just in terms of how

1 they do it, so typically the inspector would speak
2 to someone from the administration of the home, the
3 Director of Care, the Executive Director. At this
4 point, they were actually both off sick at this
5 home, so it was someone from human resources, so
6 from the Revera head office. Often what we found
7 was they would not speak to whoever had made the
8 call to the Ministry of Labour. So the employer
9 would select a staff person to be the worker rep on
10 the call who didn't necessarily know the issues in
11 the home, and they would simply do a very cursory
12 check for, you know, were there policies in place.
13 They would accept the employer's word that PPE was
14 available. They wouldn't really do an independent
15 investigation into that.

16 And generally, we found there was very
17 thin reasons as to -- if they made no orders. In
18 fact, one of our recommendations, when we get to
19 our recommendations, is that if an inspector is not
20 going to issue orders, that they'll have to issue
21 some reasons why so that we understand why no
22 orders were issued.

23 NICOLE BUTT: If I can just add to
24 that, as just an example at another home, they
25 weren't going in. They were doing the phone

1 inspections, and so they had been called in about a
2 failure to screen, and management told the
3 inspector -- and it is written in the report --
4 that the workplace parties -- that screening is
5 happening and has been happening for the last three
6 weeks, so no orders were issued.

7 And then we went to the Ministry. We
8 filed an appeal at the Labour Relations Board.
9 Part of the settlement was that the inspectors had
10 to go on site, and on their first on-site visit,
11 they issued nine orders because they were able to
12 actually observe. So they made three orders on
13 actually the screening process. They said they
14 weren't wearing eye protection during screening.
15 They didn't take their temperature, and they
16 weren't asking the proper questions.

17 So it was only once they actually got
18 there and actually started to see what was
19 happening that I think the inspections became at
20 all meaningful.

21 MARCIA BARRY: Uhm-hmm.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Okay.

24 COMMISSIONER JACK KITTS: Ms. Barry,
25 you alluded to it in your previous remarks about --

1 I think you said the Director of Care and the
2 Executive Director were both off sick?

3 MARCIA BARRY: That's correct, yes.

4 COMMISSIONER JACK KITTS: From the
5 beginning?

6 MARCIA BARRY: From fairly early on.
7 They actually, unfortunately, both worked with
8 symptoms for the first week of the outbreak, and
9 then eventually stayed off work.

10 COMMISSIONER JACK KITTS: So my
11 question is then about the other leadership. There
12 would be a Medical Director, and there would be an
13 IPAC lead in the home. Where were they during
14 this --

15 MARCIA BARRY: This home didn't
16 actually have an IPAC director, and the Medical
17 Director wasn't coming into the home after the
18 outbreak commenced.

19 COMMISSIONER JACK KITTS: Okay. Thank
20 you.

21 MARCIA BARRY: No problem.

22 So the last thing I wanted to say about
23 this particular home or the last sort of, I guess,
24 point where we see things going wrong is the
25 failure to cohort.

1 So this is something you might have
2 already seen that ONA has felt quite strongly about
3 is that once a home has an outbreak and has a
4 number of positive residents, it is really
5 important to get those residents cohorted so that
6 positive and negative residents are separated for
7 infection control and also for staffing, so that
8 you can have staff cohorted and have some staff
9 working with the infected residents or the positive
10 residents and some staff working with the
11 uninfected.

12 So in this home, it wasn't until really
13 mid to late April that there was an attempt to
14 move -- separate the positive residents from the
15 residents who were still negative.

16 And unfortunately, it was really too
17 late. There was still, in the room, in the wing
18 that they reserved for the uninfected residents,
19 infections continued to pop up, and eventually, as
20 I have mentioned, the vast majority of residents --
21 I think it works out to 87 percent of the residents
22 in this home were infected.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 Did anyone in that home complain to the
25 local Medical Officer of Health?

1 MARCIA BARRY: We did not try that.
2 One of the issues for us in this home -- so just to
3 give you a little bit of an overview about ONA's
4 structure. So typically in every one of our
5 bargaining units we have an elected leader, a
6 bargaining unit President, and she unfortunately
7 was one of the nurses who was sick. She contracted
8 COVID on April 7th.

9 So she was no longer in the home. We
10 didn't have sort of -- we were struggling to get
11 information about what was happening in the homes.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Yes. No, I don't mean that critically.

14 MARCIA BARRY: Yes.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 It is just the local Medical Officer of
17 Health is supposed to have some authority when
18 there is an infectious disease outbreak, and so
19 does the Ministry of Labour. We all understand
20 that.

21 But I was just curious about the
22 interaction, if any, with the local Medical Officer
23 of Health, or whether he or she was missing in
24 action.

25 MARCIA BARRY: Yeah, that

1 unfortunately -- those aren't details that I am
2 aware of.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay. That is fine.

5 MARCIA BARRY: Yes. So I did want
6 to --

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Oh, excuse me, Ms. Barry. Ms. Coke.

9 COMMISSIONER ANGELA COKE: Marcia, I
10 just wanted to ask the question, were any of these
11 residents decanted, moved to other places?

12 MARCIA BARRY: No.

13 COMMISSIONER ANGELA COKE: Okay.

14 MARCIA BARRY: However, that is
15 actually an excellent segue, Commissioner, because
16 I wanted to tell you a few stories on some places
17 where we actually think things went right, and the
18 last of these stories I am going to tell you is
19 about something called the Windsor field hospital.
20 You may or may not have heard about that already.
21 But that is exactly what was done there, and it
22 frankly saved a home that was starting to go, you
23 know, into a very bad outbreak, and we think it is
24 an excellent model when infections get to the
25 extent that they have gotten in some of these homes

1 in the first wave.

2 So the first home I wanted to tell you
3 about in terms of where things went right is the
4 Halton Homes for the Aged. So Halton Homes for the
5 Aged is a municipal home. There is three
6 facilities; Allendale in Milton, Creek Way Village
7 in Burlington, and the Post-Inn Village in
8 Oakville.

9 So Halton, as you may know, is in the
10 GTA. It is an area where geographically there was
11 a fairly high prevalence of COVID in the community,
12 but these homes actually did quite well, as did
13 most homes in the municipal and non-profit sector.

14 So of the three homes, Allendale had a
15 single case, one resident. Post-Inn village had
16 two, one resident and one staff, and Creek Way had
17 none.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 So roughly -- I am not asking for
20 precise numbers, but like how many residents would
21 there have been in these places?

22 MARCIA BARRY: These are all fairly big
23 homes. I believe each of them is around the
24 100-bed mark but --

25 BEVERLY MATHERS: No. No, no, no.

1 Each of these homes are probably between 160 and
2 240 beds. They are big homes.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay. Thank you.

5 MARCIA BARRY: Okay. Thanks, Bev.

6 So what these homes did well, so first
7 of all, they closed to all but essential visitors.
8 They implemented universal masking for staff. They
9 restricted staff from working at multiple
10 facilities, and they did all of that long before
11 there was directions issued on those. They were
12 doing that back in early to mid March. A lot of
13 the homes didn't do it until the orders came down
14 in late March and April.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 And I'm sorry to keep interrupting.

17 MARCIA BARRY: No, that is fine.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Did they ever give you a reason about
20 what they were saving the masks for?

21 MARCIA BARRY: So what we often heard
22 about -- so in homes where masks were locked up, we
23 heard about staff theft being an issue, and we just
24 generally heard that they were saving them for
25 provincial supply, that provincial supplies were

1 low and that, you know, there wasn't enough to go
2 around.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay. Commissioner Kitts.

5 MARCIA BARRY: Yes.

6 COMMISSIONER JACK KITTS: In the homes
7 that did well, they did things before a
8 directive --

9 MARCIA BARRY: Absolutely.

10 COMMISSIONER JACK KITTS: Who did that?

11 MARCIA BARRY: So it would be the -- in
12 some homes, it was the Director of Care. Halton
13 Homes for the Aged, it was at a corporate level
14 that these measures were put in place.

15 The next home I am going to tell you
16 about is actually a private home in the Bobcaygeon
17 area where it was a Director of Care who took all
18 the initiative herself.

19 COMMISSIONER JACK KITTS: Okay. So the
20 Director of Care has a key role.

21 MARCIA BARRY: Absolutely.

22 COMMISSIONER JACK KITTS: Back to the
23 Revera home that you spoke about first in Ottawa,
24 how did that finally sort out? Did corporate come
25 to town or --

1 MARCIA BARRY: Yes, yes. So there was
2 someone from Revera human resources who was -- and
3 I believe they put in place kind of an interim
4 Executive Director for the home who was going into
5 the facility while the DOC and the existing
6 Executive Director were off sick.

7 COMMISSIONER JACK KITTS: Thank you.

8 MARCIA BARRY: So in Halton, so in
9 addition to taking the initiative early, PPE was
10 always plentiful, there was no restrictions,
11 including no restrictions on N-95.

12 And the Halton homes actually
13 guaranteed, so any part-time or casual staff who
14 agreed to work at Halton and give up their second
15 job to do so were guaranteed hours. And in fact,
16 apparently there was actually shifts where they
17 were above complement for staff because they made
18 good on that promise.

19 In addition, you know, the home was
20 just good on infection control measures. They were
21 quick to isolate residents. They were good with
22 education. You know, really everything was done
23 much better.

24 So the second example, as I mentioned,
25 is this home -- it's called Case Manor Care

1 Community. It is only a kilometre away from
2 Pinecrest. Pinecrest, as I'm sure you know and
3 recall, was the first Ontario home to really make
4 the news in terms of its devastating outbreak.

5 Now, Case Manor Care Community had some
6 other advantages. It is a newer home. It has no
7 ward rooms. It has mostly private and semi-private
8 beds. But as I have mentioned, it was the
9 leadership and the Director of Care who really made
10 a big difference at this particular home. The
11 Director of Care is actually a former staff nurse,
12 so she is someone who knows the home really well,
13 knows the residents really well, knows the staff
14 really well, so communication was excellent.

15 In addition to the normal daily huddles
16 for the registered staff, the DOC put in place
17 daily COVID meetings for all staff and actually the
18 Executive Director would attend these as well. So
19 you know, anyone from dietary to house cleaning,
20 whoever, could come and learn about policies, have
21 their questions answered, and these meetings were
22 done with proper social distancing.

23 PPE was in ample supply in this home,
24 and again, what the nurses tell me is that is
25 because of the DOC. They describe her as a bit of

1 a hoarder. She stockpiled it. They actually had
2 enough that they were able to donate to Pinecrest
3 when Pinecrest was in desperate need, and they
4 still had enough supply for themselves.

5 And the staff report that they felt
6 free to use anything they felt was necessary,
7 including N-95s.

8 One of the things this home is doing,
9 which again you are going to see reflected in our
10 recommendations, is -- so this home didn't have an
11 outbreak. They did have a false alarm in April
12 where they had some residents test positive. They
13 turned out -- it turned out to be a lab error, but
14 any resident who has passed away from other causes
15 since March, the DOC has been holding -- and, you
16 know, to give some credit to -- this is a Sienna
17 home, to give some credit to the corporation, they
18 are allowing her to do this.

19 So she is keeping private rooms empty
20 to use as isolation rooms. So there is currently
21 eight empty private rooms in the building. So they
22 have got the capacity now for any new admission.
23 Any resident in a semi-private room who develops
24 symptoms, anyone who is re-admitted after a
25 hospital stay, they have the ability now, because

1 they are keeping these beds empty, to truly
2 isolate, and when I say truly isolate, I mean
3 isolate from other people so that the resident is
4 alone in the room, because one of the ironies of
5 the first wave is when these homes talked about
6 isolating, they meant isolating residents to the
7 rooms but so many of them have roommates, so they
8 were not truly isolated.

9 Things at Case Manor are not perfect,
10 like so many homes, and you are going to hear a lot
11 from us today about staffing. You know, they are
12 struggling with staffing. The one facility rule
13 has really thinned out their staff, but, you know,
14 all in all they are in quite good shape.

15 So the last story of things that went
16 well that I want to tell you is in the Windsor
17 area, as I have mentioned, the Windsor field
18 hospital. So ONA represents members at Heron
19 Terrace, which is one of the worst hit homes in the
20 Windsor area. The home had 69 confirmed cases and
21 25 confirmed cases among staff.

22 So they were hit pretty hard with
23 staffing, with so many staff off sick, and they
24 were starting to really struggle. However, on
25 April 18th, 32 COVID-positive patients were

1 transferred from Heron Terrace into the field
2 hospital run by the Windsor Regional Hospital. So
3 that field hospital, you may or may not know, it
4 was set up in a rec centre at a local community
5 college. It had capacity for 100 patients. 50
6 beds in that field hospital were used during the
7 first wave. All of them were transferred from
8 local nursing homes that were in outbreak.

9 And one of the things that was really
10 extraordinary about the field hospital is the
11 staffing ratios. So the field hospital was staffed
12 with staff from Windsor Regional Hospital and also
13 some staff from Hotel Dieu. So in a nursing home,
14 an RPN might have 32 residents assigned to her. An
15 RN might have 60, 70, 80 residents assigned to her.

16 Whereas at the field hospital, there
17 was a charge nurse and seven primary care nurses
18 for every 25 patients. So that is a patient care
19 ratio that is frankly unheard of in long-term care,
20 and those residents got a level of care that they
21 just never would have gotten in the home.

22 One of our members who worked in the
23 field hospital described it to me as one of the
24 highlights of her nursing career, and a nurse from
25 Heron Terrace told us that she believes that the

1 field hospital is the main reason that that home
2 got out of outbreak.

3 So that is my portion, unless the panel
4 has further questions about those stories and
5 examples.

6 We would like to --

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 I did have one question.

9 MARCIA BARRY: Yes, absolutely.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Have you heard of any other places that
12 have copied that field hospital model?

13 MARCIA BARRY: No, that is the only one
14 I have heard of is the Windsor area.

15 BEVERLY MATHERS: There is an example
16 in Kitchener where Forest Heights decanted a number
17 of ill residents to an empty unit at Freeport, at
18 the Freeport side of the Grand River Hospital, and
19 that contributed to them getting out of outbreak.
20 I mean, they had a devastating outbreak as well,
21 but contributed to them finally turning a corner.

22 And that decision was made, as we
23 understand it, because Grand River deemed it unsafe
24 to have their own staff go into that site and
25 decided to move the patients to care for them to a

1 site where they had control of the occupational
2 health and safety.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay.

5 COMMISSIONER JACK KITTS: Can I just
6 ask a question of Ms. Barry.

7 MARCIA BARRY: Yes.

8 COMMISSIONER JACK KITTS: This may not
9 be fair. It may be for the Windsor hospital, but
10 the question is, in wave one, the decanting of
11 patients from the hospital freed up staff in the
12 hospital and space.

13 Do you think that in wave two there
14 will be as many staff or sufficient staff to manage
15 a similar outbreak?

16 MARCIA BARRY: I think it depends. I
17 mean, obviously it depends to some extent on what
18 happens in the hospital. So the staff who were
19 transferred predominantly were staff in the float
20 pool, oncology nurses and OR nurses. So because,
21 you know, surgeries were generally closed during
22 the first wave, there was, I guess, some overflow
23 nursing staff that were used to staff the hospital.

24 So, you know, as of right now,
25 hospitals aren't cancelling non-emergency surgeries

1 and in fact are trying to get through the backlog.
2 So, you know, I do think that is a question that
3 bears discussion with hospitals.

4 Certainly, when I spoke to our
5 bargaining unit President at Windsor Regional, she
6 told me initially she was concerned that it was
7 going to contribute to workload issues at the
8 hospital, but again, sort of found things
9 pleasantly surprising in terms of how it worked in
10 the first wave.

11 COMMISSIONER JACK KITTS: Thank you.

12 MARCIA BARRY: Sure.

13 So I am going to turn it over to Bev
14 now who is going to start with some of our
15 observations and recommendations, and we are
16 starting with the topic of staffing, so it is a
17 timely subject.

18 NICHOLAS BAXTER: And I will be sharing
19 my screen, so everyone stay tuned.

20 BEV MATHERS: Thank you, Nick, and
21 while Nick is starting to do that, I want to talk a
22 bit about staffing, workload, retention and
23 funding.

24 And we want to start by speaking about
25 the staffing crisis in long term care, which has

1 been a long standing and a well-recognized problem
2 for decades in long term care, but which has
3 absolutely been exacerbated by the COVID-19.

4 So first, the number of RNs working in
5 homes was greatly reduced by the requirement that
6 they could only work in one health care facility,
7 and then many of those RNs who chose those
8 facilities became ill.

9 Secondly, the workload itself was much,
10 much greater in all of these homes. So, first of
11 all, it takes time, extra time, to don and doff PPE
12 between every resident and interaction, and it is
13 incredibly important that the time is spent so that
14 the nursing staff can't contaminate themselves and
15 then become infected.

16 Feeding and providing care to residents
17 who are isolated in their room takes extra time
18 because there is no longer everyone can sit at a
19 big dining table, and the trays have to be
20 delivered and people have to be individually fed.

21 Feeding and providing care to residents
22 who are isolated in their rooms also takes extra
23 time. It takes more time to look after the
24 residents who become sick with COVID-19, and
25 isolation is incredibly hard on the residents, many

1 of whom we have heard have become depressed, and
2 those who have cognitive or dementia, often we see
3 those conditions deteriorate while they are
4 isolated.

5 And then without warning, we saw our
6 staff or the RNs have to take on the work of both
7 the funeral directors as well as the coroners in
8 many cases.

9 So, first, I want to talk about the
10 general staffing crisis. So since at least 2001,
11 numerous reports have been written confirming what
12 staff who work in long-term care have known, that
13 long-term care is grossly inadequate, their
14 staffing, and given the acuity and care needs of
15 the residents which has grown year over year.

16 Certainly this has been reported for a
17 significant amount of time. So we heard in the
18 Gillese inquiry a great deal about the staffing
19 crisis in long-term care, and on the slides you'll
20 see a couple of Justice Gillese's comments.

21 So two moments from that inquiry stand
22 out for us. In one case an RN testified that on
23 the day shift there was a ratio of one RN to 32
24 residents, and if that RN didn't take a break and
25 wasn't otherwise interrupted, they would spend most

1 of 15 minutes with each and every resident. Of
2 course, that couldn't happen. There is no time
3 when they wouldn't be interrupted from their other
4 duties and that includes significant amounts of
5 time required to chart, to do family conferences,
6 to do admission assessments, medication
7 reconciliations, supervising PSWs, RPNs, and I
8 could go on and on and on.

9 On the night shift, there was one RN
10 for 99 residents, and that would mean at the most
11 an RN could spend up to 4.5 minutes per resident,
12 again, assuming there were no interruptions from
13 other units, they didn't take a break, and there
14 was no other work being performed.

15 A staffing study that was released this
16 summer that we have just gone through during COVID
17 confirmed that there is a need to urgently address
18 that staffing crisis in long-term care homes and
19 that a minimum daily average of four hours of
20 direct care is required.

21 This is the very same recommendation
22 that was contained in the 2008 Sharkey Report and
23 in the 2012 Donner Report , and yet these have not
24 been implemented.

25 In order to solve the staffing crisis,

1 homes must be able to recruit and retain qualified
2 Registered Nurses. The Gillese Inquiry heard
3 considerable evidence about why long-term care
4 homes, especially in the for-profit sector,
5 struggled to keep their staff.

6 Not only is the workload and
7 responsibility of RNs significant, there are far
8 fewer resources available in long-term care homes
9 than in a hospital, but also the for-profit homes
10 pay RNs less than the municipal homes and
11 hospitals.

12 We also heard in the Gillese Inquiry
13 that they would often get RNs used to working in
14 long-term care and then RNs would immediately, as
15 soon as there was a vacancy in a municipal
16 long-term care home, jump ship and go to there
17 where there were more RNs, and they were paid the
18 same as hospital nurses.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Ms. Mathers, if I can just interrupt
21 you for a minute. Did ONA ever -- going to do a
22 holistic model -- I am going to get all the numbers
23 wrong, but a model of what the staffing should look
24 like. Let's say, if you have 100 residents and so
25 many PSWs, so many Registered Practical Nurses, so

1 many Registered Nurses, so many in the -- did ONA
2 or anyone else, but did ONA ever turn its mind to
3 that?

4 BEVERLY MATHERS: Yes.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 Because it seems difficult to just
7 focus on one particular type of worker in an
8 environment that depends upon multiple types of
9 workers.

10 BEVERLY MATHERS: Right, and we have
11 looked at it from a holistic point of view.

12 We say that at least -- and this goes
13 to the acuity of the residents as well. But we say
14 there should be 20 percent RNs, 25 percent RPNs,
15 and 55 percent PSWs, and that for every 120
16 residents, there should be a Nurse Practitioner.

17 And that then -- if we talk to this in
18 terms of percentages, then the model would be able
19 to vary based on a 100-bed home versus a 60-bed
20 home versus some of the bigger builds that have 300
21 or 400 beds.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Right. Okay. Thank you.

24 BEVERLY MATHERS: You are welcome.

25 COMMISSIONER JACK KITTS: Just to

1 follow up on that, would the acuity of the patients
2 factor into or is it pretty homogeneous across
3 homes?

4 BEVERLY MATHERS: Well, I -- so I'll
5 say this. I have been doing this, and I have been
6 involved in many of these studies since the late
7 1990s, and it used to be that the old model used to
8 rate residents A through G. A used to be, as our
9 nurse in the video said at the beginning, that tea
10 and toast granny who just couldn't manage a home
11 and was getting malnourished at home, to the G that
12 was the most acutely ill.

13 And what happened through time is the
14 Ministry stopped reporting those variations, and
15 what we see really now is all the residents are --
16 the A's from the '90s don't even exist in long-term
17 care homes. They are at home still. They are not
18 even really in retirement homes unless they can
19 afford it. But really there is not that much
20 variation in acuity anymore, and that doesn't
21 matter whether their primary illness that causes
22 them to require the most care is either medical, a
23 multi-system, or whether or not that is dementia
24 and/or cognitive impairment.

25 It is pretty homogeneous, and I know

1 this is one of the things we would like to come
2 back and talk to you about in terms of funding in
3 the long-term for homes, but we think the existing
4 funding model, our nurses spend a huge amount of
5 their frontline time charting, so that the homes
6 can be funded based on the currency of my model,
7 and we think that model shouldn't exist anymore and
8 that they should just be given a flat rate per diem
9 because of the -- really there is so little
10 variation now in the acuity of the residents.

11 COMMISSIONER JACK KITTS: Thank you.

12 BEVERLY MATHERS: Okay. So what
13 happened with staffing during COVID? Well, you
14 have heard a bit about this, so, you know, it has
15 become very clear just how thinly staffed long-term
16 care homes are and just really how few full-time
17 staff they have.

18 Our members reported during COVID that
19 their workloads doubled, tripled and quadrupled
20 with completely unmanageable conditions. The low
21 level of staffing coupled with increased
22 responsibilities, such as contacting families,
23 assessing residents multiple times through the day,
24 administering medications, providing palliative
25 care, bagging deceased bodies, meant that residents

1 were not getting the appropriate level of care they
2 needed and certainly deserved.

3 And we are not diminishing any of those
4 important tasks. There just simply wasn't time.

5 As we said, we surveyed our members,
6 and the survey data, which is now on your screen,
7 demonstrates just how badly staffed these homes
8 were. Most disturbingly, 43 percent of respondents
9 noted they did not have an RN in the building at
10 all times. 11 percent stated that their home
11 failed to meet 24/7 standards more than four times
12 a month.

13 On the next slide, we were told by one
14 nurse about his struggle with staffing. On one
15 night he found he was the only RN on night shift
16 for a 174-bed home. When he called the Director of
17 Care, he was told that he had to figure it out how
18 to manage and that he would be responsible for that
19 night giving medications throughout the home, and
20 that is all he should worry about, not any of the
21 other care needs.

22 The home was in outbreak. Residents
23 were dying every day and on every shift, and this
24 RN knew there were residents that were unlikely to
25 live through that night.

1 Staffing levels have not recovered from
2 the first wave. We know -- our members in many
3 homes tell us that there was barely enough staff to
4 cover the schedule. Many -- and we hear this from
5 others, that there are a number of sick nurses,
6 PSWs, who have not recovered from COVID yet and
7 have not returned to work.

8 Now, if anyone gets sick or has to take
9 an emergency leave, the homes are going to be right
10 back into crisis, even without another outbreak.

11 So our --

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 What occurs to you, if anything, about
14 something that would immediately improve the
15 staffing dilemma or tragic situation, or is it too
16 late to do -- you know, for example, if they
17 implemented the 20, 25 and 55 tomorrow, would it
18 make a difference, or is that more of a long-term
19 solution?

20 BEVERLY MATHERS: I think it could make
21 a difference if it was coupled with full-time jobs
22 to fill those, and we are going to come to this in
23 a few minutes, but it would also have to come with
24 some relief on some of the wage and benefit issues.

25 But I think there is opportunity.

1 There are nurses that recently retired from
2 long-term care who might come back even on a
3 temporary full-time basis.

4 We have heard -- and I know Nicole
5 interviewed this nurse. We have heard from one of
6 our members, a very active member, she offered to
7 go back, and she had just retired from Forest
8 Heights Long-Term Care in Kitchener. She offered
9 to come back and help them out if they would
10 provide her with an N-95 mask because she is older,
11 and they told her they didn't need her that badly,
12 that they weren't going to give her an N-95 mask.

13 So there are some things that could be
14 done immediately, we know that, that would help
15 bring some nurses back into the setting, but it is
16 going to need to be a package, because if you are
17 going to need to get some of the recently-retired
18 nurses to come back, they are going to need to feel
19 protected.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Okay.

22 COMMISSIONER JACK KITTS: Just to add
23 on to that, so if suddenly the hours of care went
24 to four hours, do you have any idea how much
25 staffing that would require to fulfil that

1 directive?

2 BEVERLY MATHERS: I believe, on
3 average, because I know that the recommendation is
4 for direct care, so worked hours, it would be about
5 a 30 -- I believe it is about a 30 percent increase
6 overall to staffing, and for RNs, it is probably
7 more realistically about 40 percent.

8 NICOLE BUTT: Does the Nova Scotia
9 Nurses Union study quantify that?

10 BEVERLY MATHERS: The Nova Scotia
11 Nurses Union study didn't quantify that per se,
12 Nicole, because their staffing levels are currently
13 different than ours, but I do know that there was
14 some work done by the Canadian Centre For Policy
15 Alternatives. Sheila Block did that research, and
16 we could provide that to you where she actually
17 costed out where going up to four hours of care,
18 what that would cost to do it immediately.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 That would be helpful actually if you
21 could send us that.

22 U/T BEVERLY MATHERS: Nicole, could you
23 just make a note of that, and we'll pull that
24 after.

25 VICKI MCKENNA: I am wondering, Bev and

1 team, we are at around the 3:15-ish mark. Before
2 you start into the recommendations, should we take
3 a quick break, as was suggested at the beginning?
4 Is this a good time?

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 They are silent on it, so let me
7 answer. We'll take the ten-minute break now.

8 VICKI MCKENNA: Okay. Excellent.

9 BEVERLY MATHERS: Thank you, and then
10 I'll come back and talk about the recommendations,
11 and we'll move on.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 All right.

14 BEVERLY MATHERS: Okay. Perfect.

15 -- RECESSED AT 3:16 P.M.

16 -- RESUMED AT 3:26 P.M.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 Well, I think we are ready.

19 BEVERLY MATHERS: Okay. Then I will
20 carry on. Thank you.

21 So recommendations on staff,
22 recruitment and funding.

23 So number one, immediately require
24 every licensee to ensure that long-term care homes
25 are staffed in accordance with the requirements

1 established in the Long-Term Care Homes Act and its
2 regulation and all obligations in the Collective
3 Agreement.

4 So we are very concerned with the
5 relaxed standards introduced in the midst of the
6 first wave, and by that we're meaning the
7 directives.

8 It is even more important...

9 [Court Reporter intervenes for
10 clarification.]

11 So it is even more important during a
12 pandemic when the residents are more acutely ill,
13 more at risk, and to have an RN in the building, at
14 least one in the building 24/7 and to be fully
15 staffed, and the directives gave the homes waiver
16 on those requirements, and we saw the homes take
17 advantage of that.

18 So that would be our first
19 recommendation.

20 The second recommendation is there
21 should not be any layoffs while Bill 195 is in
22 effect, despite changes to CMI or occupancy. So
23 this is not the time to reduce staffing levels.
24 All homes are at risk. We see that now, even in an
25 early part of wave two, how susceptible the homes

1 are.

2 We have received layoff notices now
3 from several long-term care homes over the past few
4 weeks, and that includes one of our homes where we
5 represent PSWs. One of the homes has actually
6 given layoff notice for PSWs. In our minds, this
7 is unconscionable.

8 Our third recommendation is that the
9 Ministry of Long-Term Care must provide temporary
10 wage increases for RNs and RPNs so that they are
11 receiving the same pay as nurses in the hospitals
12 and the municipal sectors.

13 This temporary wage is to last until
14 the pandemic is over and should end at the same
15 time as increases to the PSW wage, and this would
16 be followed by a permanent wage increase after the
17 pandemic.

18 So it is similar to really what the
19 government did for the PSWs. In increasing wages,
20 the government noted that a higher increase was
21 provided to PSWs working in long-term care as
22 opposed to hospitals precisely to take away the
23 competitive edge from hospitals.

24 The same is entirely true for RNs and
25 RPNs, and in fact, this was one of the driving

1 forces in why some of the nurses chose to work in
2 the hospitals versus long-term care when they had
3 to select a single employer.

4 We now see where the government's
5 temporary increase for PSWs is really making no
6 sense. So at Southbridge, Port Perry, prior to the
7 wage increase for PSWs, PSWs made between \$20 an
8 hour to \$22.31 an hour. That \$3.00 an hour
9 increase brings that number up to \$23.02, and up to
10 a maximum of \$25.31. This now means that the PSWs,
11 there is really now no wage differential between
12 the PSWs and the RPNs. The RPNs start at \$23.30 to
13 a maximum of \$27.40, and yet the education and
14 skills differential is significant.

15 And this Port Perry home is the one I
16 talked about that has issued notice of layoffs to
17 PSWs.

18 Our fourth recommendation is that the
19 Ministry of Long-Term Care should immediately
20 increase the funding per home to ensure there is
21 4.1 hours of direct care or worked hours provided
22 by RNs, RPNs and PSWs. I am not going to belabour
23 this point because we addressed this in a question
24 just before the break.

25 And you will see, when we provide you

1 with the opinion from the Canadian Centre For
2 Policy Alternatives, the costing they have done is
3 based on the 4.1 hours of direct care, which is a
4 number that has been recently circulated as a
5 better number based on research.

6 Number 5, during any outbreak, homes
7 must up-staff RNs, RPNs and PSWs, and the Ministry
8 of Long-Term Care must provide funding so this can
9 be implemented immediately.

10 We know there is an increased workload
11 in the case of outbreaks. We know that staff have
12 to be cohorted. That means they can't go back and
13 forth between residents. And so the workload goes
14 up, so staffing has to go up.

15 Our sixth recommendation --

16 COMMISSIONER JACK KITTS: Ms. Mathers,
17 could I ask a question on number five, please.

18 BEVERLY MATHERS: Yes.

19 COMMISSIONER JACK KITTS: If the
20 funding was provided, are there sufficient RNs,
21 RPNs and PSWs out there that would be able to work
22 on short notice in a second wave?

23 BEVERLY MATHERS: So we believe that if
24 there was an increased number of full-time jobs, if
25 the RNs, RPNs and PSWs who selected one home

1 actually got -- had their hours increased to
2 full-time hours that they have lost, if some of
3 them want overtime and are willing to work it, we
4 believe that if working conditions were improved,
5 we would see people come back.

6 COMMISSIONER JACK KITTS: So --

7 NICOLE BUTT: Sorry, some of the homes
8 have staff that they are just not calling in. So
9 they have people who are part-time that they could
10 bring in on schedule and they don't, and that has
11 been a problem.

12 BEVERLY MATHERS: Yes.

13 COMMISSIONER JACK KITTS: So it is not
14 just the money. There is a number of other
15 conditions that are required; is that correct?

16 BEVERLY MATHERS: Yes, absolutely.
17 Workload is a huge component, as well as access to
18 PPE, which we'll come to, but it is -- we believe
19 it is a basket of improvements, but workload,
20 access to PPE and wages and benefits overall, it is
21 a basket, and you will see that as we sort of wind
22 our way through this.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 So this is a fairly basic question, but
25 I think maybe you are assuming something about my

1 knowledge that you shouldn't.

2 The province funds, and a portion of
3 that funding is directed to wages and that portion
4 has to increase; is that what -- and does that
5 apply whether it is a private home or a municipal
6 home or otherwise not-for-profit?

7 BEVERLY MATHERS: So that is -- so how
8 the homes are straight up funded is based on four
9 different envelopes of funding, and yes, there are
10 some. Three of the envelopes can only be used for
11 what they are designated for, so nursing and
12 personal care, food, and programs and support.

13 So all of those envelopes can only be
14 used for that, and then there is a very complex
15 scheme about what that can be used for.

16 There is a fourth envelope called
17 "other accommodation". That envelope, the
18 municipalities and the charitable homes re-invest
19 some of the money that the for-profits take out for
20 profit. The not-for-profits take that money that
21 would otherwise be directed for profit, and they
22 re-invest that back into staffing, which is why for
23 the most part the charitable homes and the homes
24 for the aged, the municipal homes, have better
25 staffing to begin with.

1 So yes, it is there, but it is what --
2 some of it is about what motivates.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay. So if a private home is telling
5 us that they should increase the envelope for
6 nursing and nursing staff, that also means that out
7 of that fourth envelope, that is where they are
8 finding their profit and the return on investment
9 to their investors and so on, which is why they
10 don't --

11 BEVERLY MATHERS: Absolutely.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 They don't re-invest a portion of their
14 profit in improving the staffing.

15 BEVERLY MATHERS: Yes.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 I am just trying to understand what
18 ONA's position would be on that and actually it
19 sort of helps me understand this a little better.
20 Thank you.

21 BEVERLY MATHERS: You are welcome, and
22 I think it also goes to why in some cases some
23 homes had stockpiles of PPE and some didn't.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 The same idea.

1 BEVERLY MATHERS: The same idea.
2 So our sixth recommendation is that
3 immediately cease requiring Registered Nurses to
4 perform the role of funeral directors and the
5 coroner during an outbreak.

6 Funeral directors can safely attend in
7 the home wearing personal protective equipment for
8 airborne precautions, as can the coroner, and
9 this --

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 So let me stop you there for a minute.
12 So the funeral directors were saying we won't come
13 into the homes, and we won't remove the body, so
14 therefore either you remove the body or the body
15 stays in the home. That is really what the nurse
16 was confronted with, that rather incredible
17 reality.

18 BEVERLY MATHERS: Yes, it was a huge
19 component feature. The funerals homes determined
20 it was unsafe for them to enter the home, and yet
21 our --

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Presumably, though, they accepted the
24 money to conduct the funeral at the end of the day.

25 BEVERLY MATHERS: Yes, absolutely.

1 And I don't know if you recall this,
2 but one of the factors -- and I know Nicole and
3 Marcia and Nick have been interviewing our nurses,
4 but one of the things our nurses found the most
5 traumatic is, you know, from some of those homes
6 that were in the worst outbreak where the press and
7 families were camped outside those homes, was
8 pushing that funeral home stretcher past the press,
9 past the families, out to the waiting hearse with
10 the body bag on it.

11 Some of our nurses continue to lose
12 sleep over that and have been very traumatized by
13 the effects of doing that for residents they have
14 cared for and for a number of them for a very long
15 time.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 So that even when you get outside, you
18 have to push the hearse to the -- or you have to
19 push the body to the hearse?

20 BEVERLY MATHERS: Yes.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 They don't even -- like they weren't
23 coming at least to meet you at the door.

24 BEVERLY MATHERS: No, they were not.

25 There are quite a number of pictures around of

1 nurses pushing the stretchers with the bodies in
2 them out like 20, 20 metres, 30 metres out beyond
3 the doors.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Okay.

6 BEVERLY MATHERS: Our seventh
7 recommendation is that the Ministry of Long-Term
8 Care must provide immediate funding to homes which
9 the homes will be required to use to create more
10 full-time positions, with benefits to attract and
11 retain staff.

12 And I think I have probably spoken
13 enough about that, but just to say that going into
14 COVID, we had some homes that may have only had --
15 some homes had zero full-time RNs and a number of
16 them only had one or two.

17 And with that, I will turn it over to
18 Vicki.

19 VICKI McKENNA: Thanks, Bev.

20 Yes. So we have lots to say, so I am
21 going to move fairly quickly because I am kind of
22 concerned about time, but at the same time, I know
23 you might give us more at another point.

24 So I want to talk a lot about
25 government actions, and we have a set of

1 recommendations revolving around government action
2 or inaction in some cases, specifically as it
3 relates to applying the precautionary principle and
4 more generally about directives.

5 So I will just say sort of a title is
6 the precautionary principle wasn't applied.

7 And in regard to the SARS Commission --
8 and all of you I know are familiar with that, when
9 Justice Campbell, he emphasized the importance of
10 the precautionary principle in the SARS report. He
11 recommended that the precautionary principle be
12 expressly adopted as a guiding principle throughout
13 Ontario's health, public health and worker safety
14 systems. That was, you know, just one of his major
15 recommendations that he made.

16 And a quote from him I think that you
17 might find interesting is that:

18 "The point is not who is right
19 and who is wrong about airborne
20 transmission. The point is not
21 science, but safety. Scientific
22 knowledge changes constantly.
23 Yesterday's scientific dogma is
24 today's discarded fable. When it
25 comes to worker safety in hospitals"

1 - and he was referring of course to
2 the SARS situation then - "we should
3 not be driven by the scientific
4 dogma of yesterday or even the
5 scientific dogma of today. We
6 should be driven by the
7 precautionary principle that
8 reasonable steps to reduce risk
9 should not await scientific
10 certainty."

11 And until this precautionary principle
12 is fully recognized, mandated and enforced in
13 Ontario's hospitals, workers will continue to be at
14 risk.

15 And importantly, he also recommended
16 that had the health and safety of health workers be
17 taken seriously.

18 So I would just say that the
19 precautionary principle was not applied during the
20 pandemic, and with respect to COVID-19, Ontario
21 initially, I will say this, accepted airborne
22 precautions should be taken. Right off the hop,
23 that was, Okay, we are going to, you know, accept
24 airborne precautions, and in a meeting on February
25 16th, the Chief Medical Officer of Health admitted

1 that the science on transmission was mixed.

2 Then on March 12th, the Chief Medical
3 Officer of Health issued Directive No. 1, and that
4 stipulated that droplet and contact precautions
5 were recommended for the routine care of patients
6 with suspected or confirmed COVID-19, that airborne
7 precautions were required when there was
8 aerosol-generating procedures, and if they were
9 planned or anticipated, with patients who were
10 suspected or confirmed.

11 The Chief Medical Officer of Health
12 noted in that directive that it was based on a
13 better understanding of the epidemiology of the
14 virus.

15 Well, however, just so you know, the
16 footnotes in the technical brief that was attached
17 to that directive, all the studies that they were
18 referring to were dated between 2012 and 2016 and
19 were not specific to COVID-19 at all.

20 So it was clear to us and our members
21 that the government didn't learn the lessons from
22 SARS, and future directives, such as the one on
23 March 30th, Directive 5, and subsequent revisions
24 provided that nurses should do a point of care risk
25 assessment and determine that an N-95 was required

1 based on their professional clinical judgment.

2 Although moderately better, it was
3 still a far cry from really acting in accordance
4 with the precautionary principle.

5 Then in July, 239 scientists sent a
6 letter to WHO, to the World Health Organization,
7 stating their belief that COVID-19 could be
8 transmitted by air. Most recently the CDC
9 recognized the same. And while a new version of
10 Directive 5 may ensure some better access to N-95s
11 for staff, the fundamental problem is that
12 Directive 5 does not advise workers that COVID-19
13 is airborne or could be airborne, that this is
14 misleading when an N-95 is necessary.

15 And according to the precautionary
16 principle, we should be using N-95s as protection.

17 So we strongly believe that if
18 long-term care staff had been freely able to use
19 the NIOSH-approved N-95 fit-tested respirator mask
20 or equivalent or better, always keeping the
21 concerns of conservation and supply in mind of
22 course, that many, many lives would have been
23 saved.

24 So we of course recommend on the
25 precautionary principle and that is that the

1 precautionary principle must guide the development
2 and implementation of monitoring measures,
3 procedures and guidelines, processes and systems to
4 ensure worker health and safety because, you know,
5 if the workers are safe, so are the residents and
6 patients they are caring for. It is just as I
7 mentioned earlier. This is fully intertwined and
8 to be truly consistent with the precautionary
9 principle.

10 Airborne precautions should be worn by
11 regulated health professionals and other health
12 care workers when providing care to suspected,
13 probable or confirmed residents in long-term care.

14 And, you know, that is -- you know, we
15 believe that if that overarching principle would
16 have been in place, we wouldn't be -- we wouldn't
17 have experienced what we did and what we fear we'll
18 see ahead.

19 So I will leave it at that, and Bev is
20 going to talk about some more of the concerns about
21 some of the directives in long-term care.

22 COMMISSIONER JACK KITTS: Vicki, before
23 we go on, could I ask a question?

24 VICKI McKENNA: Sure. Yes.

25 COMMISSIONER JACK KITTS: Could you

1 turn it back to the previous slide, please?

2 VICKI McKENNA: Uhm-hmm.

3 COMMISSIONER JACK KITTS: So this amend
4 Directive 5 to be truly consistent with the
5 precautionary principle. Airborne precautions
6 should be worn by regulated health professionals
7 and other health care workers when providing care
8 to suspected, probable or confirmed residents in
9 long-term care.

10 VICKI McKENNA: Uhm-hmm.

11 COMMISSIONER JACK KITTS: Is that the
12 same directive to health care professionals and
13 other health care workers in the hospitals?

14 VICKI McKENNA: That would be our
15 position, yeah.

16 COMMISSIONER JACK KITTS: Okay. So
17 this is not the directive. This is your position
18 for long-term care?

19 VICKI McKENNA: Yeah. Well, there is a
20 recently revised Directive 5 that Bev might get
21 into, I am not sure if she does or not, is somewhat
22 better than the first directive -- or the second
23 Directive 5 which was better than the first
24 Directive 5.

25 Anyway, it goes on. But the admission

1 or inclusion of the precautionary principle is what
2 is missing for one thing, absolutely is very much a
3 problem and is not really truly integrated in the
4 directive as it should be.

5 But yes, the same as is really what
6 your question is, hospitals, long-term care, with
7 people who are suspected, probable or confirmed,
8 absolutely.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 Do you think there is an adequate
11 supply of these N-95 masks now?

12 VICKI McKENNA: Yes.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Okay.

15 VICKI McKENNA: I do. The government
16 assures us and continues to assure us. I will say
17 that I was anxious -- not just myself personally,
18 but there was anxiety, a little bit, in the
19 beginning because of the inadequacy of the planning
20 quite often -- or quite honestly, and the pandemic
21 provincial supply wasn't there.

22 And what was there, much of it was
23 expired, and you probably maybe have already heard
24 that, and we'll hear more about that. Some
25 employers never rotated their stock. Their stuff

1 was -- you know, we really were anxious and
2 worried, and the supply chains were a nightmare. I
3 do believe that, but somehow we managed to get
4 through that but not in the way that we should
5 have. The protections obviously were clearly
6 missing, particularly in long-term care.

7 But the government assures us that
8 supply is not a problem, that they have it,
9 employers can get it, the regional tables have it.
10 There should not be any issue. And they keep
11 assuring us of that every time we meet around PPE.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 So your position is, if you apply the
14 precautionary principle, then regulated health
15 professionals and other health care workers would
16 be wearing N-95 masks while they are working?

17 VICKI McKENNA: Yes, if they are
18 working with suspected, probable or confirmed
19 residents, yes, and if they had -- the other piece
20 of this of course is borne into this or woven in is
21 the environmental controls, right, so the cohorting
22 of people, for instance.

23 If you are caring for a certain
24 population or number of residents who are
25 suspected, probable or confirmed, and they are only

1 in one area, you only have certain staff needing or
2 wearing the full PPE, but if you don't employ the
3 environmental controls, you don't cohort, then, you
4 know, people are freely moving about, well, then
5 you have got to garb up everybody. You know, there
6 is a couple of pieces that kind of fit together
7 there and that is about, you know, being good
8 stewards and those kinds of things as well.

9 But yes, yes, if they are suspected,
10 probable or confirmed, absolutely, they should have
11 respiratory protection because you can't stay
12 beyond six feet. You can't care for people from
13 afar. You know, you just can't.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Yes, I get that part of it.

16 VICKI MCKENNA: It doesn't work like
17 that very well.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 I am a little not up to speed where I
20 should be, but I have got that particular piece of
21 it in my head.

22 VICKI MCKENNA: Yes, I will just say
23 sort of on a side note, some of our nurses have
24 said to us, you know, people, if you can believe
25 it, would say to us, Well, don't get that close to

1 them. They would have administrators that would
2 say that, and they would say to them, Well, have
3 you been here recently? Like do you understand
4 what we do? Of course we have to be close to
5 people, you know.

6 So I wasn't being, you know -- I know
7 you would recognize that, but surprisingly some
8 people don't that are actually in the field of
9 long-term care.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Okay.

12 VICKI MCKENNA: Yes. So Bev, I think
13 over to you.

14 BEVERLY MATHERS: Thank you, Vicki.

15 And I think too for us, one of the big
16 pieces are if the health care workers stay healthy,
17 then they are not even at risk of spreading it to
18 the residents, COVID to the residents.

19 And so that is one of the reasons too
20 why we advocate for the precautionary principle is
21 because it helps minimize spread.

22 So in terms of the directives
23 themselves, we want to start out by saying that the
24 long-term care direction came far too late. So I
25 know that Vicki and I were meeting with the

1 Ministry of Health even in January of this year and
2 asked them how they were planning for COVID in
3 Ontario.

4 And while we recognized that Minister
5 Elliott is not the Minister of Long-Term Care, we
6 did meet with her in January, and we were talking
7 to her about the health care system as a whole. We
8 asked her questions about how they were going to
9 protect long-term care, as well as home care and
10 hospitals.

11 We have rarely met with the Ministry of
12 Long-Term Care. We did meet with Minister
13 Fullerton in the middle of February, but that was
14 to discuss the staffing study. And during that
15 meeting, when we raised issues of COVID with her,
16 herself, as well as her staff, were unprepared and
17 didn't have responses to our questions about the
18 readiness of long-term care to protect against
19 COVID.

20 Following that, ONA and the other
21 unions repeatedly raised concerns about long-term
22 care, and by mid-March, the government was advised
23 about our concerns with PPE supply in long-term
24 care. And one of the issues we raised was why are
25 long-term care staff working in multiple

1 facilities?

2 One of the recommendations from the
3 SARS Inquiry and Justice Campbell was that health
4 care workers needed to minimize the number of
5 workplaces they worked in, and we were asking the
6 very same thing about the lessons learned from SARS
7 and how they were going to apply that to COVID.

8 It is unfathomable to us that during
9 this entire period of time hospitals were still
10 actively moving patients into long-term care, and
11 while we appreciate that hospitals were trying to
12 decant patients and free up acute care beds, there
13 was little thought about what the impact would be
14 on the long-term care homes themselves.

15 So, for instance, even as late as April
16 9th, hospitals were still sending residents to
17 long-term care. They would test the resident while
18 they were still in the hospital, but the results
19 wouldn't be back prior to the resident being moved
20 into long-term care, and the assumption was made
21 that those residents -- those brand new residents
22 in long-term care would in fact be isolated.

23 But did anyone really stop to think
24 about whether or not those homes had the ability to
25 isolate those residents given the setup of homes

1 and how would staff be able to deal with that
2 isolated resident who may in fact be positive while
3 they were also providing care to 30 other residents
4 and trying to ensure if that resident was positive
5 that they weren't cross-infecting people.

6 So after not providing much guidance
7 then to long-term care homes, suddenly government
8 then issued a flurry of guidelines, orders and
9 directives, and we saw from government and the
10 Chief Medical Officer of Health alone and the
11 Ministry of Long-Term Care, there was direction and
12 directives issued on March 22nd, March 23rd, March
13 27th, the 30th, and then April 8th, 10th, 14th,
14 15th, 16th, 17th, 21st, 24th, 25th, 26th and 29th,
15 and then again in May on the 1st, 2nd, 11th, 12th,
16 21st and 23rd.

17 On top of that, there was also
18 direction coming from local Public Health Units,
19 operators of the homes themselves, and directions
20 from the Directors of Nursing and the
21 administrators, and on the ground for our members
22 was constantly shifting, and our members were
23 trying to keep up with it all the while trying to
24 deal with homes that were in outbreak.

25 It was really a very difficult

1 situation for our nurses who are looked upon as
2 leaders in those homes by the PSWs and the RPNs,
3 and for the homes themselves to try to stay on top
4 of constantly changing rules.

5 And all the while, there was very
6 little consultation going on with any of the
7 frontline representatives.

8 Then the directives were open to
9 interpretation, and in some cases weren't very
10 directory at all. In the beginning, the directives
11 were worded very weakly and were used sort of as
12 guidance to homes. For example, in the early
13 guidance, Directive 3 that went out on March 22nd,
14 it said "where possible limit the number of work
15 locations".

16 So putting aside the question of why
17 wasn't it even mandatory by March 22nd, the problem
18 is using words like "where possible" creates so
19 much wiggle room for employers not to comply.

20 And then even when the directives
21 seemed clear, there were other government documents
22 in other parts of government that were trying to
23 interpret those directives and make it easier in
24 some cases for the homes to understand. The
25 problem was the interpretations were not consistent

1 with the directives.

2 So as an example, Public Health Ontario
3 was doing education finally for long-term care in
4 late May and June on how to prevent spread of COVID
5 in long-term care homes, but the education they
6 were providing wasn't consistent with Directive 5.

7 In addition, the order relaxing
8 standards such as documentation, staffing and other
9 requirements under the Long-Term Care Homes Act, a
10 sector that is and was highly regulated for a
11 reason, to ensure quality care to residents, was
12 given at a time when it wasn't the time to relax
13 standards.

14 And I think too there was all sorts of
15 weird push and pull going on in the directives.
16 So, for instance, the directive said you could only
17 work in one long-term care home, but the directive
18 didn't apply to agency personnel; it didn't apply
19 to anyone coming to work at a home out of the
20 health human resource matching portal. So it still
21 left the homes open to spread.

22 So recommendations.

23 Ensure that directives, orders and
24 guidelines and supporting interpretive documents do
25 not conflict and are consistent with one another,

1 and this is something we have repeatedly said to
2 government.

3 Number 11, all directives, past and
4 present, should be available on the government
5 website. We have been noticing that the prior
6 directives have been disappearing off the
7 government website, and there is not, like, a
8 historic site on the government website.

9 And number 12, directives should
10 clearly indicate that they represent minimum
11 standards and requirements, not maximums.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Can I just stop you for one second.

14 BEVERLY MATHERS: Yes.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 And my question is a bit unrelated to
17 what you just said, so please pardon me. But in
18 relation to staffing, do you see a need for any
19 part-time staffing? We have been told, Well, we
20 need some part-time staffing for lots of reasons,
21 and so you can't do away with it entirely or you
22 shouldn't.

23 What is ONA's position on that?

24 BEVERLY MATHERS: There is a need to
25 have some part-time staffing. There will always be

1 a need to backfill vacation, occasional sicknesses,
2 statutory holidays, but the level -- there used to
3 be a directive from Ministry of Health and from the
4 nursing secretariat it was called at the time, and
5 I know Vicki will remember its current name because
6 I never do.

7 But they said that the goal for
8 staffing health care facilities was 70 percent
9 full-time, 30 percent part-time and --

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 That is what I was going to ask next,
12 so 30 percent part-time is reasonable?

13 BEVERLY MATHERS: We think so, and we
14 agreed with the notion of 70/30 back when that
15 directive was put out, and I will tell you that
16 long-term care is lucky if it is 30 percent
17 full-time and 70 percent part-time right now.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Okay.

20 NICOLE BUTT: And I would just very
21 briefly add that Commissioner Gillese in her
22 recommendations did recommend, as part of the issue
23 of dealing with agency, that there be some
24 part-time staff who could work as well that you
25 could pull from.

1 So, you know, that is something else
2 that we did agree with.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay.

5 NICOLE BUTT: In terms of timing,
6 because I see it is 4:00, almost 4:00. It is 4:00,
7 and we have --

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 If you wait longer, it will be 4:01 and
10 4:02.

11 NICOLE BUTT: That's right. I am just
12 wondering, we still have a lot that we wanted to
13 discuss, particularly around what happened with the
14 homes, concerns about leadership leaving and not
15 being available. All of the IPAC issues we have
16 touched on, but we wanted to talk a little bit more
17 in detail about the problems that they had in
18 getting the training that they needed to use it and
19 then also the enforcement piece of it, so the
20 Ministry of Labour, the injunction.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 All right.

23 NICOLE BUTT: So we are kind of in your
24 hands, but --

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Well, I guess there is one of two ways
2 of doing it.

3 I don't want to rush you. So, you
4 know, do you have a sense of how much longer it
5 would be, or would it -- go ahead.

6 NICOLE BUTT: Awhile.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Yes. Well, then I think we are better
9 to reschedule, and so I suggest you arrange with
10 Ms. Drummond to come back and complete the
11 presentation.

12 I must say, whether it took a long time
13 or not, it is certainly worthwhile listening to,
14 and if there is something of an immediate nature
15 that you think can be done, if you could
16 communicate that to us sooner rather than later,
17 even though you are coming back, that would be
18 helpful.

19 NICOLE BUTT: Sure.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 And then we'll just reschedule, and I
22 am sure -- you know, we will do that. We will make
23 that arrangement with you.

24 NICOLE BUTT: Thank you very much.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 The only other thing is this and maybe
2 you can help us with this. You have a website.

3 NICOLE BUTT: Uhm-hmm.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Could we put a link on your website to
6 our website so that if your members are trying to
7 figure out what we are up to, it is easy for them
8 to find us?

9 VICKI MCKENNA: Yes, we would be happy
10 to do that, absolutely.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Thank you.

13 All right. So then we will stop, and
14 we will look forward to seeing you again.

15 NICOLE BUTT: Okay.

16 VICKI MCKENNA: Thank you very much,
17 and as you said, if there is some immediate
18 recommendations, we'll send those to you and with
19 some rationales, so some contexting from our
20 perspective as well, so we can do that.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Thank you. That is very helpful.

23 VICKI MCKENNA: Thank you very much.

24 NICOLE BUTT: Thank you very much.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Thank you. See you again.

2

3 -- Adjourned at 4:03 p.m.

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1 REPORTER'S CERTIFICATE

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

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

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

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

13
14
15
16 Dated this 13th day of October, 2020.

17
18 

19
20
21 _____
22 NEESONS, A VERITEXT COMPANY

23 PER: DEANA SANTEDICOLA, RPR, CRR, CSR
24
25

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