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.

BEFORE:

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

PRESENTERS:

ONTARIO NURSES' ASSOCIATION:
Beverly Mathers, CEO
Vicki McKenna, President
Cathryn Hoy, First Vice President
Pat Carr, Team Lead, Labour Relations
Sharan Basran, Senior Executive, Legal
Marcia Barry, Counsel
Nicole Butt, Manager, Litigation
Nicholas Baxter,

PARTICIPANTS:

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

Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Jessica Franklin, Long-Term Care Commission Secretariat

ALSO PRESENT:
Deana Santedicola, Stenographer/Transcriptionist

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

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

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

NICOLE BUTT: Perfect.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

NICOLE BUTT: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

further thoughts because that is not correct.

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

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

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

ONA, we were forced to pursue -- and I

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

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

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

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

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

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

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

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

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

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

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

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

But we do need to maintain their confidentiality.

So, Nicole, can you play the video please.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

You mean because it would be obvious who the people are on the video?

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, I don't see any reason why we can't -- we won't -- we just won't post the video. Commissioner Coke, what do you think?

COMMISSIONER ANGELA COKE: I agree.

COMMISSIONER FRANK MARROCCO (CHAIR):

Commissioner Kitts?

COMMISSIONER JACK KITTS: I agree.

COMMISSIONER FRANK MARROCCO (CHAIR): So we won't post the video.

NICHOLAS BAXTER: I will be sharing the screen now.

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

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

THE COURT REPORTER: Will do. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

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

[Video presentation.]

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

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

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

know.

[Video presentation continues.]

NICHOLAS BAXTER: That is the end.

VICKI McKENNA: Thanks, Nicholas.

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

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

You are muted, Marcia.

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

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

what happened and have a lot of ideas about solutions.

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

[Court Reporter intervenes for clarification.]

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

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

VICKI McKENNA: It is better.

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

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

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

Sorry, technology helps and yet it doesn't.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I was trying to tell you that we couldn't hear you, but I was on mute, so I'm not

really in a much better state than you are.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

director.

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

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

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

At first they were only swabbing the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MARCIA BARRY: Yes.

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

MARCIA BARRY: Yes.

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

MARCIA BARRY: So just in terms of how

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

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

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

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

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

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

MARCIA BARRY: Uhm-hmm.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

MARCIA BARRY: That's correct, yes.

COMMISSIONER JACK KITTS: From the beginning?

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

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

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

COMMISSIONER JACK KITTS: Okay. Thank you.

MARCIA BARRY: No problem.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

MARCIA BARRY: Yes.

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

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

MARCIA BARRY: Yeah, that

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. That is fine.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, excuse me, Ms. Barry. Ms. Coke.

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

MARCIA BARRY: No.

COMMISSIONER ANGELA COKE: Okay.

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

in the first wave.

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

BEVERLY MATHERS: No. No, no, no.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

MARCIA BARRY: Okay. Thanks, Bev.

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

COMMISSIONER FRANK MARROCCO (CHAIR): And I'm sorry to keep interrupting.

MARCIA BARRY: No, that is fine.

COMMISSIONER FRANK MARROCCO (CHAIR): Did they ever give you a reason about what they were saving the masks for?

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Commissioner Kitts.

MARCIA BARRY: Yes.

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

MARCIA BARRY: Absolutely.

COMMISSIONER JACK KITTS: Who did that?

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

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

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

MARCIA BARRY: Absolutely.

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

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

COMMISSIONER JACK KITTS: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We would like to --

COMMISSIONER FRANK MARROCCO (CHAIR): I did have one question.

MARCIA BARRY: Yes, absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Have you heard of any other places that have copied that field hospital model?

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

MARCIA BARRY: Yes.

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Thank you.

MARCIA BARRY: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In order to solve the staffing crisis,

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

BEVERLY MATHERS: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Because it seems difficult to just focus on one particular type of worker in an environment that depends upon multiple types of workers.

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Right. Okay. Thank you.

BEVERLY MATHERS: You are welcome.

COMMISSIONER JACK KITTS: Just to

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

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

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

It is pretty homogeneous, and I know

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

COMMISSIONER JACK KITTS: Thank you.

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

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

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

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

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

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

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

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

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

So our --

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

But I think there is opportunity.

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

directive?

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

That would be helpful actually if you could send us that.

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

VICKI McKENNA: I am wondering, Bev and

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

COMMISSIONER FRANK MARROCCO (CHAIR): They are silent on it, so let me answer. We'll take the ten-minute break now.

VICKI McKENNA: Okay. Excellent.

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

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

BEVERLY MATHERS: Okay. Perfect.

-- RECESSED AT 3:16 P.M.

-- RESUMED AT 3:26 P.M.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we are ready.

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

So recommendations on staff, recruitment and funding.

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

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

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

It is even more important...

[Court Reporter intervenes for clarification.]

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

So that would be our first recommendation.

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

are.

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

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

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

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

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

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

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

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

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

And you will see, when we provide you

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

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

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

Our sixth recommendation --

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

BEVERLY MATHERS: Yes.

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

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

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

COMMISSIONER JACK KITTS: So --

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

BEVERLY MATHERS: Yes.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

knowledge that you shouldn't.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

BEVERLY MATHERS: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

BEVERLY MATHERS: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

The same idea.

BEVERLY MATHERS: The same idea.

So our sixth recommendation is that immediately cease requiring Registered Nurses to perform the role of funeral directors and the coroner during an outbreak.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

BEVERLY MATHERS: Yes, absolutely.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

BEVERLY MATHERS: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

BEVERLY MATHERS: No, they were not. There are quite a number of pictures around of

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

VICKI McKENNA: Thanks, Bev.

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

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

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

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

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

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

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

- and he was referring of course to the SARS situation then - "we should not be driven by the scientific dogma of yesterday or even the scientific dogma of today. We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty."

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

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

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

that the science on transmission was mixed.

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

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

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

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

based on their professional clinical judgment.

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

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

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

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

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

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

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

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

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

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

VICKI McKENNA: Sure. Yes.

COMMISSIONER JACK KITTS: Could you

turn it back to the previous slide, please?

VICKI McKENNA: Uhm-hmm.

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

VICKI McKENNA: Uhm-hmm.

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

VICKI McKENNA: That would be our position, yeah.

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

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

Anyway, it goes on. But the admission

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

VICKI McKENNA: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Yes, I get that part of it.

VICKI McKENNA: It doesn't work like that very well.

COMMISSIONER FRANK MARROCCO (CHAIR):

I am a little not up to speed where I should be, but I have got that particular piece of it in my head.

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

VICKI McKENNA: Yes. So Bev, I think over to you.

BEVERLY MATHERS: Thank you, Vicki.

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

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

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

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

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

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

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

facilities?

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

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

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

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

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

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

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

It was really a very difficult

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

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

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

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

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

with the directives.

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

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

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

So recommendations.

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

and this is something we have repeatedly said to government.

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

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

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

BEVERLY MATHERS: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): And my question is a bit unrelated to what you just said, so please pardon me. But in relation to staffing, do you see a need for any part-time staffing? We have been told, Well, we need some part-time staffing for lots of reasons, and so you can't do away with it entirely or you shouldn't.

What is ONA's position on that?

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

COMMISSIONER FRANK MARROCCO (CHAIR): If you wait longer, it will be 4:01 and 4:02.

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

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

NICOLE BUTT: Awhile.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

NICOLE BUTT: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

NICOLE BUTT: Thank you very much.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

NICOLE BUTT: Uhm-hmm.

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

VICKI McKENNA: Yes, we would be happy to do that, absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

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

NICOLE BUTT: Okay.

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

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

VICKI McKENNA: Thank you very much.

NICOLE BUTT: Thank you very much.

COMMISSIONER FRANK MARROCCO (CHAIR):

Thank you. See you again.

-- Adjourned at 4:03 p.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 13th day of October, 2020.

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