Long Term Covid-19 Care Commission Mtg.

Ontario Nurses' Association – Second Meeting
on Tuesday, October 20, 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 20th day of October, 2020, 1:00 p.m. to 2:33 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

PRESENTERS (cont'd):
Pat Carr, Team Lead, Labour Relations
Nicole Butt, Manager, Litigation
Marcia Barry, Senior Legal Counsel
Nikolas Baxter, Legal Counsel

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, 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

Dawn Palin Rokosh, Director Of Operations, Ontario Long-Term Care Commission Secretariat

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

COMMISSIONER MARROCCO: If everybody is here, we're all here. We're not in such bad shape that we don't remember that you were here before and that you were coming back to talk to us about matters of more long-term than what we talked about last time. Quite frankly, anything else that you want to talk about since we're here. So go ahead.

MS. BUTT: Great. Thank you very much for allowing us to return. There are two areas we wanted to cover during this session.

We do have more on IPAC but we do want to speak to the difficulties, and I would say almost the impossibility of enforcement, in terms of enforcing the Directives and also enforcing basic occupational health and safety legislation.

And I'm going to start with that, because in looking through the transcripts, you haven't had a whole lot of information on that, I don't think, and I think that our experience may help shed some light on some of the challenges.

I think if we've learned anything over the last few months, is that there is really no effective enforcement mechanism in terms of

enforcing the Directives. And we're not even talking about challenging the Directives, you know, challenging not putting the Precautionary Principle in. We're talking about basically enforcing what is in the Directives.

And we have been really wondering, where do you turn? We don't want to do things after the fact. We want to be able to respond as these issues arise and get them dealt with as quickly as possible, to make sure that the workers are safe.

So ONA has tried a number of things, including inspections under the Occupational Health and Safety Act and Appeals at the Ontario Labour Relations Board.

We also filed an injunction, and we've also resorted to grievance arbitration, and some implementation issues through grievance arbitration.

So I'm going to talk about all of those, but before I do that, I wanted to turn back to a question that you asked last week about whether we ever contacted Local Public Health Officials, and so we actually did.

So when we went back through our records, we did once write a letter to the Medical

Officer of Health for Haldimand-Norfolk, and that was on April the 9th. We raised concerns that we had about Anson Place.

And Anson Place is one of those homes where we called in the Ministry of Labour twice and were not getting any orders issued there to protect the workers.

So we then sent this letter to Dr. Nesathurai and raised our concerns about Anson Place, and said at that time 42 residents out of 61 had tested positive. 21 staff have also tested positive. And we raised a concern that residents and staff were not being cohorted in particular.

Residents were still in the four-bedroom ward rooms, and some of them in the rooms had COVID and others didn't. So we asked the Local Public Health Office to take some action. And we also noted that it was an offence under the HPPA to not comply with directives.

We received a response that same day, so they were very quick at responding, but the response was not -- they thanked us for raising concerns, and said they had been working closely with Anson Place. And then they attached a letter from Anson Place to us, in which Anson Place told

us exactly what they had been telling us for the last few weeks.

They were compliant with Directives. That they were protecting the residents with privacy curtains in the ward rooms, and things look that. So this didn't help us, and so we didn't go down that route, again, we just didn't see it as helpful. So the next step -- sorry, go ahead.

COMMISSIONER MARROCCO: I may be taking you off your point a bit, if I am, just tell me.

Had Anson Place been through SARS? I mean, you know, SARS was different, but SARS was the same in a way. And I'm just curious if they developed any kind of, they had a plan like, you know, what to do in the event of a pandemic or anything?

Were any of those issues addressed by Anson Place or the local -- did it come up in the correspondence?

MS. BUTT: No, I don't believe they had a pandemic plan. Because Anson Place then, we went on and filed the injunction. So I can double check those materials, but I don't believe they had a pandemic plan.

The chain might have had something, but

it certainly wasn't being communicated to the people on the ground.

COMMISSIONER MARROCCO: Did the Ministry of Labour respond to the injunction as well, or was it just Anson Place?

MS. BUTT: No. The Attorney General intervened.

COMMISSIONER MARROCCO: I see, yes. Yes, okay.

MS. BUTT: Yeah, the injunction was really our next step. Before I get there, I do want to talk a bit about the Ministry of Labour inspection system. Because that was what we initially thought would be most responsive to the concerns that were being raised.

And that's because that's the Ministry's entire reason for being, in terms of making sure that the workplace is safe under the Occupational Health and Safety Act. Certainly that workers aren't supposed to be getting sick in the workplace and dying. If anything, it's set up to go in and inspect and make sure the workplace would be safe, would be the Ministry of Labour inspectors.

Unfortunately, that isn't what we saw

happening. The first thing I wanted to point out is that the Directives, Directives 1, 3 and 5, they are subject to the Occupational Health and Safety Act.

So at the very bottom of the Directive, it actually says that long-term care homes, retirement homes are also required to comply with applicable provisions of the Occupational Health and Safety Act and its regulations.

So we had expected that the Directives are sort of a floor, they're not a ceiling. And OSHA is sort of the legislation that governs and that the directors are subject to OSHA as well. But that's not what the Ministry of Labour's position was.

And I did mention this a little last day, initially, the inspectors were not doing any on-site inspections. So when we would phone the Ministry of Labour, or a worker would call with a concern, they would just do a telephone inspection.

So they would speak with the employer, they might speak to a worker rep on the Joint Health and Safety Committee, assuming that the Joint Health and Safety Committee was working and that the members of it weren't off sick.

And they rarely spoke necessarily to the worker who phoned with the complaint. So there was not a lot of complete information being provided to them.

And again, Anson Place -- and I'm using it just as an example -- but the Ministry of Labour was called in on March 30th and on April 8th, and there were telephone inspections. And in the report that they file afterwards, it's called a "Field Visit Report", the inspector noted that workplace parties confirmed that there was screening happening; that all workers are being actively screened. And that this has been taking place for more than three weeks.

So shortly after that, SEIU filed an application at the Labour Board, and I think you heard a little bit about that in their presentation. ONA intervened in that, and as part of the settlement, it was agreed that inspectors would actually go in on site in Anson Place.

So inspections were still continuing to be done by phone in most places, but in two locations, Anson Place and Altamont, the Ministry of Labour agreed the inspectors would actually go on site.

And what we found then, was on the very first inspection, which happened a few days later, nine orders were issued against Anson Place; and three of those related to screening. So where a few days before they had said "workplace parties confirm they're screening", once they were there in person, they were able to see that the screener wasn't wearing eye protection; that they weren't asking the right questions, being that the Ministry of Health was saying needed to be asked. And that they didn't take the -- the screener didn't take the inspector's temperature. So they were able to observe the flaws that were happening. And they never would have known if they weren't there in person.

So, obviously, when we get to our recommendations, one of them is going to be that inspections need to be done in person, it's the only effective way to actually see what's happening on the ground.

Some other concerns we've had, and I've mentioned, they didn't always speak to the worker who made the complaint. And I think that is a fundamental problem. You need to obviously speak to the person who's raising concerns to understand

what they are.

And perhaps our largest concern was that inspectors -- the position they took was that they were only required to make sure that employers were complying with the Directives. So they weren't -- despite the fact that directives were subject to OSHA, the position of the Ministry of Labour was that if the employer was complying with the Directives, they were in compliance with OSHA.

And because, as we mentioned last day, the Directives provided some wiggle room in terms of saying, you know, "where possible cohort", there were very few orders that were ever issued.

So from there, ONA filed a number of different appeals, a lot of them were in the hospital sector, but we did file some in long-term care as well. And during those appeals, again, the Ministry's position was made very clear, that compliance with directives equalled compliance with OSHA.

COMMISSIONER MARROCCO: Did the Labour Board rule on that?

MS. BUTT: No, and that's another one of our problems. So we were either faced with a situation of trying to resolve them one-off, one by

one, which we did in some cases. We do have some that are proceeding, it's just that it's a lengthy process. So there's been no response yet on the fundamental issues.

So they were very quick to get a first mediation date, usually within two weeks. But very slow at sort of getting an actual hearing underway to fight the issues. And so we do have one proceeding, but I think the date is still later this fall.

Another thing, and I mean, this is kind of hearsay, but we have been told by multiple inspectors that they had to consult before they could make any orders. That there were a few times where they thought maybe they would make an order on PPE, but they were telling us that they had to get instructions. And we heard that this committee was referred to as WRAC, we don't know anything more about it. But we are concerned if it is true, that they weren't able to independently go and make recommendations based on what their inspection was saying needed to be done.

And certainly, we do know that the Ministry of Labour was giving some instructions. So one of the files that we settled was right after

the injunction decision came down. And so we reached an agreement with the Ministry of Labour that at a minimum they would tell the inspectors that they had to interpret the Directives in accordance with the Morgan decision. So they were providing some guidance, but it was still very limited to, you know, compliance with the Directives is compliance with OSHA.

The other problem we have is that inspections can be very slow. So some of them were being done, you know, within a few days. But again, if it's an urgent issue, it was very difficult to get someone in that day.

But what is really of concern to us that -- so one of our nurses passed away on May 11th, Brian Beattie. And the investigation by the Ministry of Labour there is still ongoing. So it's been five months. We still don't have any kind of final report. We've been following up every few weeks, and we're just told it's in progress. And this means like we can't even proceed to file an appeal at this stage, because it's still open as an investigation. And so serious concerns that, you know, if we're not getting anything done quickly, the workplace just

isn't becoming safer.

COMMISSIONER MARROCCO: Apart from telling you that it's underway, did they give you any reason why --

MS. BUTT: No.

COMMISSIONER MARROCCO: -- it's May, June, July, August -- you know, to write a court decision, you have to write it within six months. They don't have a similar provisions, I guess?

MS. BUTT: No, they don't. They usually release an interim report quite quickly. They did release one, but it just looked at one element of the workplace. And they said they had to come back to do more and that hasn't happened.

COMMISSIONER MARROCCO: Okay.

MS. BUTT: So our main concern is that the lessons of SARS, as they relate to the Ministry of Labour, just haven't been learned.

They're not independent, they don't understand infectious diseases, and there was a failure to protect the health and safety of workers at the time they most needed it.

The other recommendation that was ignored from SARS was there were no proactive inspections done. So back in January, February,

March, when things were gearing up, even in February, when the first long-term care home in BC had the infection, the Ministry of Labour didn't start to do any kind of proactive inspections of long-term care homes. And we're really just reacting to the complaints that they were hearing.

So the Ministry of Labour wasn't effective, the Local Public Health wasn't helpful. And that's what ultimately led us to file the injunction in mid-April. At that stage, we were becoming desperate to help our members. And so we did take a highly unusual step of filing the injunction, we filed it against four homes.

We could easily have filed it against another 20, but we had to focus on sort of the four worst first. And we will provide you with the Court materials, I was going to ask at the very end how you would like to receive them, whether you want hard copies or electronically.

COMMISSIONER MARROCCO: I can answer. If you can provide them electronically, if we want paper copies, we'll do them ourselves.

MS. BUTT: Wonderful. And the Court materials have affidavits as to what was happening at the time in the homes, from some of our members

and I think they would be helpful to you.

Justice Morgan released his decision very quickly, and he was very clear, paragraph 94 that:

> "Where the lives of nurses and patients are placed at risk, the balance of convenience favours those measures that give primacy to the health and safety of medical personnel and those they treat."

And so he was very concerned, and it was clear in his questioning as well, about the health and safety of the workers and the residents in the home.

So he ordered that the responding homes had to provide nurses with access to fitted N95 respirators and other PPE. And clarified that if a nurse assessed that it was necessary, that they were to be provided with that. And he also ordered them to implement the other controls, such as isolating and cohorting residents and staff.

That applied to the four homes in the injunction. We obviously tried to have it implemented more broadly. And as part of that, appeared before arbitrator John Stout a few weeks

later, and put approximately 150 grievances from a number of -- 150 long-term care homes before him.

And so with that, we also have materials from the arbitration that we can provide, and again, there's more affidavits from a larger sample of homes that were put before Arbitrator Stout.

In terms of arbitration, generally the process can be quite slow. So Arbitrator Stout actually freed up time on weekends so that we could get this done. Normally, if I were to contact him and ask for a date, he's booking in 2023. So arbitration is not always that efficient. It takes time to get dates, it takes time to put all the evidence in, like any other legal proceeding.

COMMISSIONER MARROCCO: Can I stop you there for a minute?

MS. BUTT: Yes.

COMMISSIONER MARROCCO: So you file a grievance and you and whoever, agree that he's the arbitrator you want, you can't get him until 2023?

MS. BUTT: That's right. He is busy. There are some who have availability sooner.

COMMISSIONER MARROCCO: The question is, why is that?

MS. BUTT: They tend to be newer. Less experienced, less familiar with the sector. So, yes. Yeah, 2023 at least, if not later.

And the other thing with the grievance is the process. So you file the grievance, you then have to have a step two meeting, and if you're lucky is done within two weeks, but it's usually done within a month. And then there's a chance to respond and then it gets referred to arbitration. And so normally, the earliest you can get even a date would be a few months down the road.

COMMISSIONER MARROCCO: Okay.

MS. BUTT: So arbitration has its problems. But as I said, Arbitrator Stout realized how important this was, booked a weekend and we were able to get an award at the end of that.

And so Arbitrator Stout incorporated Justice Morgan's orders into his decision. He ordered the homes to ensure that they had sufficient supply of fit tested N95s that were readily available. And that has been something that we have been -- there's been challenges in implementation on that.

He also ordered that employees who test positive, were not to work unless they had two

consecutive negative tests 24 hours apart or until 14 days had elapsed after symptom onset, if they were symptom-free.

And he ordered that because it had been a major point of contention between the parties. And again, because the Directives weren't always consistent and clear, that was ordered.

And he also, and I think this is very important. He noted that in addition to all of the AGMPs, the Aerosol-Generating Medical Procedures that were listed in the Directives, nurses should be considering the fact that -- of resident behaviors when they do their point-of-care risk assessment.

So considering that there's a lot of spitting, and the sort of expression of body fluids, I think is how he put it in his award, and that that's something that needs to be taken into consideration in the long-term care sector.

So we got the decision, and that was in early May. And since that time, we have had many implementation issues. So we're still hearing from homes that they don't have ready access to N95s, and we're having to -- we've had to return to him a number of times to force employers to comply. And

in fact, we are going back before him this week. Not every nursing home was part of the Stout award, so right now we're dealing with one home that isn't part of it. And with respect to that one, we've got a conference call with him this week to then try and set up a date to get something urgently done to respond.

We're just -- I think ONA's main concern is, there's really no way to enforce these. You know, we get these calls all the time from our members saying that, you know, we don't have N95s. Or last night I was denied an N95. And there's really no way to get a quick resolution to that.

We do have a number of recommendations, and again, these are more short term. We have a number of thoughts as well in the long-term about changes in the Occupational Health and Safety Act that might be helpful, but we wanted to focus on sort of short term what could be done.

Nick, do you have the PowerPoint recommendations?

MR. BAXTER: I do I will share them right now.

MS. BUTT: Great.

So the first recommendation is for some

sort of general oversight provision. So we need a system and a process to ensure timely enforcement of the Directives. And as part of that, we believe that the HPPA needs to be amended to provide some whistleblower protection.

One of the things we've been thinking about is, is there a way to establish some sort of hotline that workers can call, and there's someone who answers and can investigate their concerns right away.

We know in other industries, sometimes law firms are set up that do that. I think it's something that needs to be considered, and a lot of our nurses are also facing significant reprisals in the workplace for coming forward. Both in providing the affidavits to the Stout award, and in other cases they've experienced significant reprisals in the workplace.

COMMISSIONER MARROCCO: I know you said that there was no whistleblower protection. But is there not protection under the Occupational Health and Safety Act for a whistleblower? How does that work?

MS. BUTT: There is a provision in the Occupational Health and Safety Act that does say

there should be no reprisals. It's not well enforced.

COMMISSIONER MARROCCO: Okay.

MS. BUTT: I'm not sure Marcia, if you have anything to add to that. But in my experience it's been poorly enforced, and again, by the time we get there -- it's very reactive and our members by that time have been disciplined or terminated, and it's very hard to sort of enforce that.

Go ahead.

MS. MATHERS: It's Bev. Similarly, the Long-Term Care Homes Act has some whistleblower protection. ONA, when we made submissions on the original bill, didn't believe the whistleblower protection went far enough, particularly, in the areas of patient advocacy; and still don't believe it does.

And in fact, the remedies under that act are quite insufficient. And the remedies under the grievance arbitration process for ONA members are certainly more substantive. But all of them, even the ones under the Occupational Health and Safety Act, take a significant amount of time. And if a member is terminated, they have no wages for a long period of time as a result of trying to do the right thing.

MS. BUTT: I did take a look, I don't believe there's anything similar to that under the HPPA, and that's a definite gap.

MS. BARRY: If I can just add to that, I think the aspect of anonymity is important for a lot of the healthcare workers because a reprisal can be difficult to establish, I think a lot of workers are afraid of sort of soft reprisals that are harder to link to the fact that they've taken action under OSHA or under the Long-Term Care Home Act.

So a form of whistleblower protection like a hotline, where complaints can be made anonymously I think would help.

MS. BUTT: The next set of recommendations. So first of all, the MOL should be conducting a proactive inspection, we refer to it as a blitz, in long-term care homes. And that would be including unannounced inspections.

Things that need to be looked at is the internal responsibility system, the functioning of the Joint Health and Safety Committee. Are they meeting regularly? Are they meeting at all? We've heard some homes haven't had a meeting in a long time.

Checking to look and see that all policies and measures and procedures that are required under the Act are taking place. Checking to see that they have a supply of PPE, and that staff have been trained in it. And that homes are acting in accordance with the precautionary principles.

We think even at this stage, even going into the second wave, getting the Ministry in there quickly to do these inspections proactively would be helpful. Especially, as we see homes are -- that didn't have an outbreak in the first wave, are now experiencing outbreaks. And so they don't have the experience necessarily that the other homes have had to build on. So I think this is particularly important.

Next one. And then in terms of actual inspections that are complaint-based. As I have said a few times, they need to be done in person on site. They need to speak to the workers, including the worker who made the call. They need to exercise independent judgment in decision making.

Explain the rationale for not issuing an order, and complete their investigations in a timely manner. Particularly, those being conducted

as the one with respect to the death, they need to be done in a much more timely manner.

The next one I can't emphasize enough. They need to inspect to fully enforce the Act and not just the Directives.

And again, we think that they should be done on site, and that they can wear appropriate PPE to go in. It's safe for our members, it should be safe for the inspectors.

We haven't talked about Ministry of Long-Term Care inspections, because we know you've heard a lot about them. We think they need to be done in-person on-site. There were times we advised our members to call the Ministry of Long-Term Care to report abuse or neglect. For example, when we heard they weren't cohorting. But we don't know what happened with those calls, but we do know those calls have been made and were made.

MS. MATHERS: Well, we know, Nicole. So ONA actually wrote, and did a complaint to Ministry of Long-Term Care for River Glen Haven and Vicki, we finally have the Ministry of Long-Term Care inspectors circle back to us, months later, after they had been into River Glen Haven, and that

was well after their outbreak, and only to tell us that the issues that we have highlighted for them were in fact founded and true.

But the Ministry of Long-Term Care inspectors, like the Ministry of Labour inspectors, were also only making phone calls and inspecting that way, during the outbreaks didn't have shoes on the ground. And it wasn't until after the military report came out, that the Ford Government ordered them back in to do inspections.

COMMISSIONER MARROCCO: Do you think there's a problem around the fact there seemed to be a multitude of inspectors? Ministry of Labour, it seems in order to activate them, it needs to be a worker who is complaining. And if you are a resident and not a worker living in a long-term care facility, that you have to complain to the long-term care inspector, to use a shorthand. And so do you find this -- have you run into this as a difficulty or not?

MS. MATHERS: I was going to say, it's fragmented to be sure. And the interesting thing about it, though, is they have different powers and they look at different issues. So for instance, with Ministry long-term care inspectors haven't

been in doing their proactive inspections which had been stopped, they should have noticed, particularly if they were out there, January, February and in early March, they would have noticed these homes had insufficient infection control plans in place.

Because that is under the resident quality inspection, the big RQI inspections, those are one of the pieces they inspect. But again, those RQI inspections have all but ceased. And I'll let Nicole speak to particularly Ministry of Long-Term Care.

MS. BUTT: What I was going to say, I know that the SARS Commission recommended, and we still think it's a very good idea, that there be teams that are, you know, have Ministry of Labour, Ministry of Long-Term Care, or Ministry of Health inspectors on them, that can sort of proactively go in and inspect and enforce that way. And I think that's something we'd be looking at again.

COMMISSIONER MARROCCO: Okay. Do you know why they didn't do it?

MS. BUTT: No. No. I mean, all I can guess is that after a while people became complacent, and didn't. There's a number -- you

know, again, more systematically, there were recommendations that there be someone from the Ministry of Labour sitting on PIDAC. And in the SARS report it actually says they committed to doing that.

And if you look at the composition of PIDAC right now, they're all doctors working in hospitals or Public Health, and nobody is bringing that sort of worker occupational health perspective forward. So I think a lot of those recommendations just got -- just weren't followed up on.

MS. MATHERS: I think, too, in Ministry of Labour, there is a shortage of inspectors who have been trained on healthcare and trained on infectious diseases investigations. And I think that became obvious.

I know at one point we had inspectors into one of our sites in London, and it was an industrial health and safety inspector. Yeah, it was an Industrial Ministry of Labour inspector that was in, who knew nothing about infectious disease spread.

MS. BUTT: OSHA generally doesn't address infectious diseases at all. And that's again something long-term we're thinking of

recommending, would be some sort of legislation in OSHA specifically addressing this type of situation. Because even simple things like getting notification of a worker's illness.

It's very clear under the Act that if someone dies, or is critically injured, which includes your life being placed in jeopardy, that notice has to be given immediately.

Well, the position taken by the Ministry of Labour is that if there's a death, fine, that's covered. But, you know, if you are hospitalized and on a ventilator, that isn't considered a critical injury and those notices don't happen under that section.

So there's a whole lot of things that just aren't understood and taken into consideration under OSHA, that I think long-term needs to be looked at.

Did you have any more questions sort of on the enforcement side of things?

COMMISSIONER MARROCCO: I don't think we do.

MS. BUTT: Okay. Then we wanted to continue, last day we had more we wanted to say about what was happening in long-term care homes,

specifically, with respect to leadership and communication and IPAC more, and so maybe we'll turn over to that.

Cathryn, I think, are you up next.

MS. HOY: Yes. So I'm going to try to be quick, because I know there's a lot to get through.

Our members have pointed to two main issues, in addition to the staffing crisis that they believe contributed to the severity of the outbreaks in long-term care.

A failure on the part of the leadership to proactively prepare, communicate and failure to implement the common IPAC and Health and Safety measures. So I'll talk about a few of these issues and then I'll turn it over to Vicki to talk about IPAC and Health and Safety.

When we looked at many of the worst hit homes, leadership was simply absent physically. While the RNs were walking into very dangerous circumstances to care for the residents, many of them were just walking out. Including the administrators, the director of care, the physicians, funeral directors, and other supports.

Many administrators, director of care

and other managers just disappeared on daycations or leaves, or they stayed in their offices and rarely ventured onto floors.

So an example is Scarborough Health Network, noted at their Extendicare Guildwood. The administrator, the assistant administrator, the director of care and program manager were off for extended periods of time. And the infection control lead, and quality lead just stopped coming to work.

So while replacements were sent, there were gaps in leadership because the new leaders did not know the home, the residents, the family or the staff, and that's very problematic.

So in other cases, while leaders remain physically present in the home, they failed to lead. We heard from many, many nurses that they were the ones proposing the measures to the director of care administrator. Sometimes their ideas would be implemented, but many times they were not.

So for example, in early March, it was suggested that they set up an extra handwashing station, and a set aside space in the home to be used for isolating residents. Her suggestions were

not implemented, and she was told that she was fear mongering. That's just terrible.

Furthermore, communication, many homes particularly those worse hit by the outbreaks was just abysmal. We heard from many staff members, from different homes that they were not even being advised when residents were tested positive for COVID, instead, they actually learned from families that someone had tested positive.

So in turn, we know that communication from the homes to the families were problematic. And I just want to share, I have a brother in long-term care. An agency worker came to work in his home due to the staffing shortages, and that agency worker was found to be positive for COVID.

So the practice of using agency nurse that could hop all over the place, put my brother at risk, as well as each one of the residents he lives with, and the residents at the next home that that agency worker would go to. So communication is key here. Because that home did not communicate with the family, who I am the family, I was put at risk. I dropped off his monthly care package, so I made contact with the home.

So if I had had a communication, I

would not have been at that home. So for me going to that home, they put me at risk, and every single person I came into contact with. So lack of communication seems simple. But it has a domino effect, especially in this environment.

So I want to stress, because you've heard about staffing. Agency is not the answer. Homes should be staffed with their own staff and communication is key.

So in addition to changes in direction, corporate policies, we're not always communicated to the frontline. Those that work on evenings and nights, they received even less information.

Now this isn't true of all the homes, we did hear of some inspiring examples of strong leadership and how it really did make a difference to the staff. And we can actually learn from these examples going into the second wave, or we are in the second wave.

Some measures that worked included daily huddles and a communication binder for staff to review; very simple.

So one of our recommendations is the administrators, DONs, so director of nursing, assistant director of nursing, should communicate

with families and substitute decision makers.

Our members have told us that they spend an incredible amount of time on the phone with families. This is critical work, but with staffing so, so short, it has fallen on the frontline nursing staff to do.

So during any outbreak, the director of nursing and the administrator must be present, full-time, amongst altering times of day they are in the home to provide leadership and direction at times other than Monday to Friday during the daytime. Staff work 24-7, communication needs to be across shifts.

The role of the medical director needs to be clarified, so that it is clear that they are expected to attend the home in-person during an outbreak.

Licensees are required to immediately notify all employees when a resident or employee tests positive for COVID-19 to stop the spread.

A flagging system must be developed to indicate which residents have COVID-19. This includes a sign on the door to the room, a sign above the bed, and a wristband, so that if a resident wanders, staff are aware of the resident's

status. Flagging systems are currently used for so many different methods, so this is just in addition.

Daily huddles on every shift should be held to discuss new or updated policies, procedures, and measures. Huddles should also include new and emerging treatment and care protocols, particularly for emerging diseases. Example, the COVID that we're experiencing now, how to provide supportive care. Information should be documented in a binder or on an electronic platform, so that it can be shared with staff working on evenings and night shifts, and everyone knows where it is.

The care plan for all residents needs to be updated immediately, to reflect the resident's wishes regarding enhanced care and alternate care settings.

Just because a patient is DNR, does not mean that their illness should not require medical management.

So another example is Windsor Field Hospital, Windsor-Essex County Health Units Medical Officer of Health, described contacting every family to discuss their wishes. Updating care

plans in advance would save so much time, and allow affected residents to be transferred and isolated much more quickly and efficiently.

I'm going to turn it over to Vicki shortly, but I just wanted to add something because I think examples speak so loud. So you heard us speaking about staffing, you're going to hear it again later. So I also had a mother in long-term care until August. I want to share with you, there was one registered nurse on nights, 130-plus residents.

They are not only that registered nurse, they are the manager, they are the staffing clerk, and they are the maintenance person. They shovel snow, actually, in the wintertime. And day shift is not much better.

And that was a home for the aged, and nursing homes are staffed far less. My mom was palliative. So I stayed in that home for eight days, 24-7. And for her passing, she required extra, extra care for eight days. I can't say enough about how wonderful the staff were. But, they were overworked, they were double shifted, they had no days off, and many shifts had staffing shortages. The number one priority, in any care,

but long-term care should be meeting the care of the residents, and not increasing dollars to shareholders. Staffing, and the right staff, not just bodies, should be our foremost thought in long-term care.

So I just want to ask you one thing, and I say this with the utmost respect. Tomorrow morning when you all get up, I want you to set your phone for six minutes. That's how much time each of you will have to get up, get showered, get your hair done and all other aspects of personal care. And I'm talking dressed and out the door from start to finish. I'm sure you're going to find it a challenge. Now imagine that you're bedridden, probably in soiled briefs, or you just have issues with mobility. Can you imagine getting ready in six minutes? Because that's all the time that is given to the staff, for people like my brother and mom, who need to get up. So treasure your six minutes tomorrow, and I'd love to know how it works out.

So I'm going to pass it over to Vicki, and I thank you for your time.

COMMISSIONER MARROCCO: I think you can assume it didn't work out well.

MS. HOY: Yeah, it didn't work out well. But I think sometimes you really need to put things into perspective, to understand how hard the staff work and how short they are.

And these are the people of Ontario that have given to all of us, and I truly believe they deserve more.

MS. MC KENNA: Absolutely true, Cathryn, thank you.

I want to talk a bit about IPAC, and I know we keep talking on and off about it, but I want to spend more time on it. And we are hard on this issue, because it is critical. It is imperative that IPAC is a big, what I'm hoping will be a major recommendation. And this is a short-term situation that needs to be remedied. This is something that needs to be done right away.

So I will say this. That overall, the change in leadership within the homes, they fail to proactively prepare and to implement basic infection control measures. Such as screening, isolating, cohorting, providing PPE. You've heard that, and we'll talk about it off and on.

It was really difficult to understand, because long-term care deals with outbreaks all the

time. And if you have a loved one, or a family member, or a friend in long-term care and you've visited them over the last number of years, you will often -- I myself going there, arrive to find a sign on the door to say, we're in outbreak. This is the situation.

You know, so I actually, in my years in nursing when this all started, I thought, okay, you know, long-term care, they'll be on it. They're going to be prepared, they'll be planning everything, you know, things will be in place.

But I'll say that when the news broke in January, and the outbreaks in Washington State and BC began in February and in early March, we at the long-term care homes were slow to react. It seems like they froze. They were waiting to be told what to do by Government, instead of applying IPAC principles proactively and early.

They weren't prepared to take the steps to prevent the virus from entering the home or to address it once it was there. And there are some best practices, there are some really good examples of where that did not take place, where nursing home administrators stepped up early in staff. They did things before Public Health told them they

needed to do, or before the Government told them anything, they knew what to do. But many, many others did not.

So here are some of the key issues. Training. Most IPAC training seems to be done via e-learning, or given when there's a policy to read. Now across the homes, our members reported in the survey that we did, where we had over a thousand nurses who work in long-term care respond.

33 percent of them said they only received a policy to read.

30 percent said they received a webinar or had some e-learning modules to do.

5 percent said they received absolutely no information or training at all.

21 percent said they received in-person training with practice on the donning and doffing of personal protective equipment.

And that we all know, I know as a nurse, that the donning and doffing practice and drilling is a skill and it is something that has to be practiced, and it isn't a one-off.

Staff were required to work while they were sick and infectious or return to work after they had two negative tests, or after the 14 days

after symptom onset.

In the homes that have outbreak, 17.5 percent of the nurses who tested positive for COVID said they were required to return to work while they were still symptomatic.

36.9, almost 37 percent say they were required to return to work before receiving two negative tests as was the direction.

And 22.7 say they were required to return to work before two weeks having lapsed since their first positive test.

So that is in a quick nutshell, some of the situations, and what our nurses are reporting from the frontline.

So Bev, do you want to talk a bit about cohorting.

MS. MATHERS: Thanks, Vicki. One of the other challenges we dealt with is failure to isolate and cohort residents.

So beginning in early April, we received numerous reports that homes were not complying with Directives 3 and 5, and that specifically, they were not isolating and cohorting residents.

We brought evidence in the injunction

to support that homes were not doing that. And this was continued even after Justice Morgan ordered homes to cohort. And in fact, I'll pick on the Anson Place again, because well, sadly it is so easy to pick on.

But the reality of the situation is, Justice Morgan ruled on Anson Place and yet weeks after his award, our night nurse and a PSW who hadn't seen a manager in weeks, took it upon themselves, also on a nightshift, to cohort the residents. And decided if they were terminated because of it, it was probably just as well, because the environment was unsustainable.

At Scarborough Health Network, they were assigned to come in and support Sienna Altamont. In their interim report, Scarborough Health Network said that cohorting was not completed until after they were in the home and that it was done on July -- sorry let me say that again. It was done on June 15th and 16th.

So that was weeks and weeks after the beginning of the outbreak at Altamont. In our survey, 20 percent of respondents said that residents exhibiting COVID symptoms are not isolated, and 40 percent of respondents stated that

staff cohorting was not implemented either.

So I'll move then to talk about cohorting of staff, and say that many homes also did not cohort staff. While it's true we're focused on the RNs, this also was not done with the PSWs.

At times this was simply a function of the fact that they were so critically short-staffed they simply couldn't assign staff to only work with residents who were diagnosed with COVID-19. But even where they did try to cohort staff, that it was virtually impossible for RNs. If the home only has one RN, it becomes then impossible to cohort them with only the negative or positives with only one in the building. And we see this on many evenings and nightshift where they can't do it.

So, you know, the unfortunate thing about not cohorting both staff and residents is, we have learned just how easy it is to spread COVID, and how not cohorting has likely contributed to the spread of COVID in these homes. And with that, I'll turn it back over to Cathryn.

MS. HOY: So the homes did not have sufficient supply of PPE, gloves, gowns, goggles, shields, surgical masks, and N95 respirators.

So this meant that at times, staff are not wearing PPE, or they were wearing the same PPE in between residents, which is totally contrary to infection control measures. Or, they were actually making their own. And if you're on Facebook, I'm sure you've seen it, some of our members literally had to wear garbage bags.

So we will provide you with a copy of the survey report, but it's very clear from the survey that in homes without outbreaks there were definite supply issues with all types of PPE.

26 percent reported supply issues with the impermeable gowns; almost 35 percent with face shields; almost 70 reported restrictions on their use of N95s; and 30 percent saying that they were explicitly denied N95s.

So the nurses face constant battle each and every day just to get an N95.

They were told they can only wear them if they were performing AGMPs. Many employers took the position that AGMPs were not performed in long-term care.

Just a sidenote, I asked for the suction machine for my mother, but I was told it was locked up, it was an order from the Ministry of

Health. My mom needed that suction machine, so who do I question? Was it a proper order, or did they not have N95s, or did they not want to give N95s?

So when a hospital took over, they reinforced this messaging. Homes locked up N95s, so they could not be accessed by our nurses when needed. And this was particularly problematic on evenings and night shifts.

When the DOC did come to work, but they went home, they had the keys. So other homes did make N95s available, but not necessarily in the sizes needed by the staff. So if a worker was provided with a N95, and it's the wrong size, it will not seal and it will not provide the airborne protection that they need.

So even now we're still receiving frequent reports that nurses cannot access the N95s when needed, or that they're being provided with one N95 to last the entire shift.

Tests for N95s was not conducted for staff prior to the arrival of COVID-19. We know of several homes that are still doing their first round of fit testing in the second wave. At least one home has advised its staff a few years ago that they would have to pay for fit testing themselves.

Many others are now redoing the fit testing, because the new models of N95s have been introduced in the workplace.

So I will hand this over now to Nicole.

MS. BUTT: Thank you. What I wanted to speak about briefly right now is to provide a recent example of how this is still happening.

So this happened during the first wave, but it's still a concern. And I did mention we're going before Arbitrator Stout this week, but I wanted to give a few details about what we're being told is happening right now in the second wave.

So, first of all, a small home is having its first outbreak right now. Nurses have told us that first they were being provided with only two surgical masks and one N95 for a full shift. They are not cohorting staff. And last week a nurse told us that she was denied an N95. That the ADOC and a manager from the hospital that has been brought in to manage, both told her she can only have the N95 if she was doing an AGMP; which is clearly not what the Directive says. And so she was denied that N95.

We then wrote a demand letter, telling them that they had to cohort. That they can't be

denying N95s, in accordance with Directive 5. And a few days ago, we received a response from a senior manager at the hospital, who's been seconded to support the home. And this is a problem that we see a lot. The hospitals are helpful, but they don't always understand the context of long-term care.

And her e-mail to us has made us extremely concerned. So she indicated that they've had a meeting with staff to review required precautions for routine care of COVID-19 residents, which as you are aware, is droplet contact precautions.

And she clearly explained to the staff that the evidence is that this is an illness that's predominantly transmitted through droplets. And, you know, this is discouraging members who are hearing this message and might want to do their PCRA and decide they need to have the N95.

She also shared with the staff that the increase in healthcare worker cases are predominantly due to community contact; through contact with friends and families; or because workers are not being truthful about their symptoms; or they're not complying with infection

prevention and control protocols in place.

So again, there's this sense that, you know, it's not the fault of the home, it's the fault of the workers who are, you know, getting this in the community and bringing it into the home.

She also claims that N95s are in short supply, which is contrary to what the Government has been telling us repeatedly, recently. And she says that most vendors are no longer willing to provide these to long-term care homes in order to divert supplies to facilities that are high-risk environments due to the frequency of regular aerosol-generating procedures, like the ICU, emergency and surgical, and trauma suites.

So we're very concerned about what's happening in this home, but we also think it's happening in other homes. This is consistent with the messaging that we've heard over and over again.

It's not consistent with the Precautionary Principle. It downplays the risk to staff in long-term care, where the majority of healthcare worker infections have happened. And the reality is that long-term care is a high-risk environment. Around the world that's been

recognized.

So we're in a situation now -- sorry, it also disregards what Arbitrator Stout recognized in his award that residents exhibit those behaviors like spitting and coughing that can endanger our members. And that's actually been, you know, it's been recognized by Stout. Certainly, the new directive speaks to proximity to the members, or to the residents as being something to be considered in doing the point of care risk assessment.

And so we've got a situation where members are being denied N95s, but they're also being actively discouraged and being made to feel guilty for asking for them in the first place. Fundamentally, that is a problem and it puts every ne in the home at increased risk.

So we've set up a conference call, as I said with Arbitrator Stout. But again, we don't know how quickly these issues can get resolved. And in the meantime, you know, this goes to enforcement. Our members are still going there to work every single shift, and they're in trouble.

This is a situation where, you know, I think last I heard, they had close to 30 residents and staff who were sick.

MS. MC KENNA: It's Vicki. Yeah, I just have to come in to say, you know, when you hear these stories, it's no surprise that Ontario has some of the highest healthcare worker infections and long-term care resident transmission and death.

When you look across the country and in other jurisdictions around the world. We are not in good stead here. And it's situations like this, that it's no big surprise that workers are getting ill, the residents are becoming ill, and you know this is -- we had Directive 5, we've been through this with Government, Public Health was involved, the Chief Medical Officer of Health, and still we continue to reach, you know, to get to resistance like this with employers. And it's just -- it's unacceptable and it's outrageous. Anyway, sorry, I couldn't sit still any longer.

MS. BUTT: I think, fundamentally, the problem is that by continuing to reinforce it's just droplet and contact, when there's certainly a divide between experts. At a minimum I think it's fair to say there's a divide, and it's not universally accepted that transmission can't be airborne. That by not putting that in writing to

the workers, they're not hearing that they should be wearing those N95s, and that's why the Precautionary Principle is so fundamentally important.

We wanted to just quickly go through a few recommendations that we have on IPAC and then speak very briefly at the end about a recommendation on mental health, and then we're finished.

Vicki, did you want to start?

MS. MC KENNA: Yes, I'll try and be brief. We'll provide certainly more detail in the recommendations for all to review.

It is, in our view, every home must have a registered nurse who has infection control practitioner status, that is their title; that they are trained and they are certified.

There are programs out there, there's programs at Centennial College in Toronto, at Queen's in Kingston, they're everywhere. There are novice infection control prevention programs that are available and easily accessible. And ideally, the specialist would also agree to, at some point be certified, so they would hold the proper certifications and have access to the updates and

be in the know on what the most recent and updated information is.

And there was a recommendation of exactly this for infection control practitioners that they passed to the Central Park Lodge Inquest in 1999, so this isn't new. This is not a new recommendation.

IPAC practitioners should have the authority to make effective decisions about infection, prevention and control in the workplace. They shouldn't be beholden to an administrator or director of care when it comes to decisions about infection control.

We also believe that training is really important and mentioned it earlier, but all staff must receive comprehensive training. They've got to know the basic IPAC thinkables. It should be done in person, it should include training. And training that includes testing on drilling, and donning and doffing of the personal protective equipment. And it has to be reviewed on a regular basis, at least annually, no matter what.

The training, as I said annually, but you never know when an infection may occur, just like we're in the midst of right now. When that

happens, they need to make sure their staff are updated and trained at the moment, in the ready so that they're ready to go.

There should be training and disease process, especially at new diseases and infections that are causing outbreaks. We should ensure that our management staff can regularly attend training, licensees must pay for the cost of training and cover staff salaries during training and backfill shifts.

So the staff training, you know, needs to be supported both at the frontline staff, the administrative staff, and this also leads to -- we won't get into it at this very moment, but similar recommendations that came out of the long-term care inquiries, that have come out of other inquests where training seemed to be deficient in the administrative side, in particular, on long-term care, but also the support staff training and updating.

In order to keep viruses out of home, the Directives, we believe, must mandate. We must have mandates that are clear.

So Bev, you're going to talk a little bit about those.

MS. MATHERS: I will, thanks, Vicki.

So that admissions and readmissions to homes, these residents must be tested within 48 hours prior to the admission or readmission. And residents who leave the building or grounds, should be isolated for 14 days upon return.

And this is really about keeping the virus out of the homes. It is about the iron ring we keep Government talk about, but never really enforce.

In hot zones, admissions should simply cease and residents should not be permitted to leave the grounds.

Staff and residents should be tested every two weeks in a manner that is the least intrusive.

For instance, sputum testing instead of NP swabbing. And results must be received by the homes in 48 hours. Therefore, homes must receive either priority testing or the new fast testing mechanism.

I will say to you that ONA and the nursing homes have actually been writing to Government and requesting this, as well as Vicki and I raising this with the Minister of Health,

Christine Elliott, since early September.

And to date, we have no response at all to our questions about rapid testing or less intrusive testing.

Agency staff, staff obtained through Government, health human resource matching tool, students, private family, caregivers, sitters, companions, essential caregivers and family tests, visitors must also be tested, and they must demonstrate proof of a negative test before they enter the home.

We know that in some of the homes that in fact the infection has come in, either via a student, through an agency staff, or through private caregivers. And this simply can't be allowed to happen, and there shouldn't be a double standard in who gets tested and who gets exempt.

And while we understand there are challenges with testing, the fact of the matter is our homes should be of the highest priority.

Our next set of recommendations are part-time employees who choose to work in a single long-term care home should be provided with full-time hours. They should not be penalized and lose income because they can now only work in one

home.

Licensee operators must not offer shifts to agency or full-time employees at overtime until all those part-time employees have been offered all of the available hours.

We continue to hear horrible stories of our members who continue to lose income as a result of the emergency orders. Agency workers should be permitted to only work in one healthcare facility while provisions of Bill 195 remain in place, and/or the World Health Organization declares an end to the pandemic, whichever is the latter.

We don't think agency workers should be treated any differently than the permanent employees of the homes.

Moving on to the next regulated health professionals and other healthcare employees diagnosed with COVID-19, will not return to work until they have either received two negative tests, or until 14 days have elapsed from symptom onset; if they are symptom-free.

We are very concerned that on October 1st, that Public Health Ontario changed the guidance to healthcare facilities again, and are now allowing employees to go back into healthcare

facilities, ten days after symptom onset.

We don't know why that happened. There was no public announcement about it. There is no change in the science that we are aware of, and there's been no explanation. But why would we put residents at risk of catching an infection from a healthcare worker, who knew they were positive, but their employers are now changing the policies and forcing them back to work again after ten days.

Every home must identify and prepare rooms that are available to be used for isolation. We are recommending that there be at least one private room available for every 32 residents. And this would preventatively deal with -- they could be treated as infirmary beds, it could contain symptomatic residents with early isolation, it allows cohorting of staff as well.

Currently the inability of homes to isolate symptomatic residents was a major cause of spread in the first wave. We're seeing that continue in the second. And in addition to these isolation rooms for symptomatic or positive residents, we are again saying that anyone who is newly admitted or readmitted to a home also be isolated for 14 days. We just think that these are

commonsense approaches to preventing the disease spread.

We are worried that in some cases, there is -- and we understand the pressure that hospitals are under to free up beds, we do. But we cannot, as we did in the first wave, push people out into the long-term care homes and leave the homes without any flexibility in their beds.

Our next recommendation is that a resident should not be placed in a room with more than one other resident. This includes not only one admission, only new admissions and readmissions, but also those who are currently occupying ward rooms.

Ward rooms should be converted into semiprivate rooms as soon as possible through attrition. And that doesn't mean to us, attrition in that very room. But it could mean attrition in another room that could be converted into a semiprivate room, and with some juggling in the home, that attrition couldn't happen sooner.

We did learn in the first wave, that curtains do not provide a protection from COVID. I'm not really sure why that had to be a lesson, but it was. And we have heard that in order to get

around the provisions of Directive 3, at least one home has considered moving residents who are currently in semiprivate or private rooms into a ward room so that new admissions or readmissions can be placed there. And this is contrary to the intent of that directive.

Ward rooms are just simply not safe during a pandemic. And in fact, as the homes are rebuilt moving forward, semiprivate, three-person, four-person rooms should be eliminated entirely.

Residents should not be placed in rooms with more than one other resident. I think I have covered this already.

Moving on then, the Ministry of Long-Term Care must provide funding to ensure that employees who quarantine or isolate due to an exposure are paid for their time off, and that part-time and casual employees receive sick pay. Otherwise, sadly, it leads to some employees lying, and coming to work sick so that they can pay their bills.

Isolating and cohorting residents and staff must be mandatory.

The current directive still state that isolating and cohorting is to be done only when

possible, and we believe this needs to change now.

Our next recommendation is that every long-term care home must have an adequate supply of personal protective equipment, including: Gloves, gowns, goggles, face shields, surgical masks, and NIOSH approved fit tested N95 respirators or equivalent or better protection.

At a minimum, an adequate supply of PPE would be a three-month supply. We know the Ministry in their fall announcement, announced they were providing two-month's supply. It truly needs to be three months to get us through these phases and they have to have plans about how they're getting more.

PPE must be readily accessible to all health professionals and other healthcare workers in the homes. They cannot be locked up, they have to be available.

The home will provide weekly updates on its supply during the pandemic to Joint Health and Safety Committees and trade unions.

This weekly update will include the number of each type of PPE, including the relevant model numbers of N95 masks. After the pandemic the home will report on its supply at every Joint

Health and Safety Committee meeting.

We must ensure that our workers have access to the type of N95 masks or equivalent that fit them and that they have been fit tested for.

And that any time a home receives a new model, that those N95s then have to be fit tested again, so that we can ensure that the airborne protection that the masks are supposed to provide are indeed providing.

The next recommendation is that the Provincial Government should create and maintain a Provincial stockpile of PPE. Data should be publicly available, in realtime, including the type and numbers of PPE in stock and expiration dates.

We heard this past weekend that there is a shortage of a particular stock of N95 masks, the type at the home that Unity is helping with -- Unity Hospital is helping with now in Toronto, there is a shortage of masks. To which we have been told by Government, is not true. So we're not understanding where the gaps are, and why there are still inadequate supplies of PPE around.

And then the final recommendation we want to make under IPAC and Health and Safety, is that the field hospital model which was so

successful in Windsor, should be used province-wide. In the alternative, long-term care homes must move residents into hospital or a dedicated facility for treating COVID-19.

I have to say, and I sat through much of the testimony at the Wettlaufer Inquiry, and I have to say again, that this notion that our seniors go to long-term care homes to spend the end of their life, does not mean that they should go there to spend the end of their life and catch a disease, or have something else happen to them that expedites the end of their life. And that there's no quality of care, or respect, or dignity for them in those last days.

Not all of these residents should have died, that died from COVID, should have died from COVID. They should have been transferred to hospital to be cared for. And our nurses are simply devastated by that. And I have to say that it really has been unacceptable, that this notion existed that no one was to be moved to hospital.

And with that, I will turn it over to Vicki to talk about mental health.

MS. MC KENNA: Okay. Thanks, Bev.

I'll just speak quickly about this. It

is a really important issue and it's not -- I know it's one that is often heard in the media and in reports just generally.

But the effects of COVID-19 on people's mental health is significant. And it is really clear, I believe, from the video that we showed last week, how COVID-19 has significantly traumatized the registered nurses that you heard on that date and many, many others.

We've heard from the nurses that they've had to require time off for adjustment disorders, really, depression, anxiety, posttraumatic stress they're being diagnosed with now. And this is all as a result, and we believe, directly from their experiences working with patients with COVID-19 and in facilities of long-term care that are ill prepared.

Not only did our nurses get sick, but we've heard stories of how they had, you know, how they had given COVID-19, or transmitted it inadvertently to family members, to their spouses, to their children, to their parents.

The trauma that these nurses are experiencing is real, and we have to address it. And for that reason, we're making the

recommendation about providing them with the mental health support for those workers. Many of them who work are part-time, they have no benefits, they have no paid sick leave.

So mental health support needs to be and must be provided to employees who worked through the pandemic, including counseling to be available to employees for a period, we believe, of up to two years; and that's something that should happen now.

Our recommendation is that it be done through WSIB. And any long-term care worker who worked during the pandemic should have a claim to be able to be activated and approved. Providing the benefits through WSIB is appropriate, we believe, as the mental health injuries that occurred in the healthcare workers clearly fall in the scope of workplace injury, in our belief, and, therefore, under WSIA.

It also ensures that all workers in long-term care would have access to benefits, which are generally not provided to part-time and casual employees, and even full-time employees they are limited in long-term care.

So I really do want to thank you very

much for the time you've spent with us. Registered nurses are required to work in dangerous circumstances without proper protection.

They were required to do their very best, and they did. With skeletal staff, tasked with providing care to acutely ill residents with almost none of the supports that they would have had, had they been in a hospital.

They've become ill in unprecedented numbers. One sick healthcare worker is one too many in our view. And in this case, thousands have become ill, and the second wave is only just starting.

We have to do better. We can do better and do it now. And it's time to make those choices. And to prioritize the lives of residents, and the safety of nurses and healthcare workers who provide that care for them.

So I know Nicole has a few wrap up points. I know we kind of broke our goal, but this is so, so important to us and the people that we represent, the nurses. And they want you to know how much they love working in long-term care, and the residents are like their families, as you've heard them say. And they are desperate for some

support and systems to be put in place so they can properly care for people and to protect them and of course we want them protected as well.

Nicole?

MS. BUTT: Before I finish up, were there any questions or anything --

COMMISSIONER MARROCCO: I did have one question.

We were told that it's -- I don't know if "traumatic" is the right word. But it's difficult moving someone to a field hospital from their room, or their residence.

And, you know, if a person is sympathetic to that hospital model, did the nurses think that it's -- I mean, what's your experience with people who, like in that Windsor model, we were all told it was successful, but was this a real issue moving the people or not?

MS. MC KENNA: I'll just say first off, best I know and what I have heard from the field, no. But what I will say is, anytime you move a resident in long-term care who's been in a room for a period of time, it's upsetting, it is. We're not going to pretend it isn't. It is a different environment. And particularly if dementia is part

of the condition that you're dealing with, even more so probably.

But what I also heard is for the residents who didn't have to move, right? They only moved COVID positive patients out. And those people were very ill, those people were very ill when they were moved. So I didn't hear that the residents had as much difficulty as they would have, you know, that they were ill. Is what I'm saying.

They were so ill, that in most cases they, you know, the movement really didn't have the same impact, had it been, you know, their usual day-to-day and they were getting shifted to a new room, that's disruptive. And it probably, once the people started to recover, then they realized they weren't in their usual location, there was probably, you know, some difficulty maybe at first.

But some of the nurses that worked in that field hospital, told us, it was the -- it's been the highlight of their career to be able to spend time with people. They were up-staffed, and those residents had more staff around them than they ever would have had in a nursing home.

And actually I didn't, you know, at

least not from what I know, and Nicole and Marcia may have heard differently in your interviews with staff, but I did not hear that.

MS. BUTT: I think you also need to consider what the alternative is, because they were very sick. And being very sick alone without the care you need is going to be infinitely worse than the disruption of being moved out.

COMMISSIONER MARROCCO: I understand that. I just wanted to ask the question, because obviously you have some experience with this, just to satisfy myself that I asked. I get it.

MS. BARRY: If I could add one final point. I think the staffing makes the big difference. And one of the things I was told about the field hospital was actually every resident who was transferred was provided with an iPad to communicate with their family.

When you compare that to the very thinly staffed homes and those very heartbreaking stories that we've heard about people, you know, dying alone with no family around, I think as Nicole says, we're balancing the lesser of two evils. And certainly there would be some disruption in the move, but I think when you sort

of consider for those residents who did pass, you know, they were able to die with some contact, better contact with their family and some more dignity than in the homes that were just so badly understaffed at that time.

MS. MC KENNA: I think, too, what the nurses said. Because at every bedside there was an iPad, the resident, the individual may not have been able to actually use the iPad, they had that access to the family for them right there, that they could just pick up and use with them. Because many residents in long-term care (poor audio - connection difficulties) --

COMMISSIONER MARROCCO: Yes, all right.

MS. MC KENNA: -- the nurses were able to make that connection with the staff, and they set aside the funds and had iPads at every bedside, purely for patient communication with their family for the resident to be able to communicate, or the nurses to assist that communication.

That was something that I think, I at least heard from many, many, families and you know throughout, how desperate they were. And Cathryn herself has had a personal experience with family and being able to contact. I think it's critical.

I think that's, you know, those personal touches, those piece are hugely important to people when they're ill no matter where they are, I think, but in this case for sure.

COMMISSIONER MARROCCO: Thank you. Anything further?

MS. BUTT: The only thing I wanted to ask about was sort of your next steps and sort of timing.

So we're going to send you tomorrow a copy of our PowerPoint and a written document with our recommendations. And some of the other materials we've talked about throughout. But I wasn't sure in terms of, we do have probably some written submissions on long-term things we'd like to provide to you and we didn't know the timing looked like for you.

COMMISSIONER MARROCCO: The long-term, we'll turn attention very shortly to long-term, but we don't have -- we don't have that short time horizon.

We're not feeling quite the same way about that as we were about the short term. I wouldn't concern yourself unduly about that. If you can get it to us in the next little while, it

should be fine.

MS. BUTT: The next question is the plans for speaking to staff directly. I know on your website they say they can provide a written statement, but is there going to be an opportunity to speak?

COMMISSIONER MARROCCO: As I understand, there was an issue around confidentiality.

MS. BUTT: Yes.

COMMISSIONER MARROCCO: And I think, I don't want to speak too quickly, but I think it's going to be resolved. And I think we're going to have control over what's confidential and what isn't. But rumors are one thing, until we see it in black and white, that's another.

But I think that's going to happen shortly. And if that's the case, then we'll be able to consider as a commission, the three of us, any requests for confidentiality.

But I'm a bit more optimistic now that we're going to get a timely answer than I was when you were here the last time.

MS. BUTT: Great.

COMMISSIONER MARROCCO: And I speak for

the three of us who have talked about this, we do want to give people the opportunity to talk to us in confidence, if that's what they want to do.

Notwithstanding the fact that we're trying to be as transparent as we can in terms of what we're hearing and so on. But that's necessary. We think it's necessary, and we're trying to work it out.

MS. BUTT: Perfect.

COMMISSIONER MARROCCO: But I think we'll be okay.

MS. BUTT: Okay, that's wonderful. Thank you. I think that was everything we had.

COMMISSIONER MARROCCO: Thank you very much. Thanks for all the work and the presentation was a work of listening to it. I can imagine how much work you put into it, but it's very much -- it's very helpful for us, and you do represent people with very practical experience.

To the extent that your submissions, or argument or statement is consistent with something we're thinking, it gives us a certain confidence that it's grounded in reality, and not in theory, and that's important to us. So thank you again.

MS. BUTT: Great thank you. Very much.

-- Meeting adjourned at 2:33 p.m.

REPORTER'S CERTIFICATE

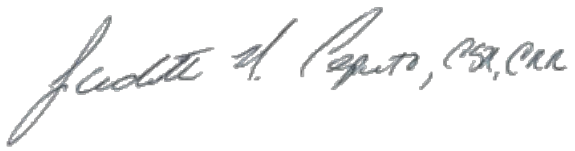
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

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 21st day of October, 2020.



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