Long Term Care Covid-19 Commission Mtg.

Meeting with UNIFOR
on Friday, October 9, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 9th day of October, 2020, 1:00 p.m. to 2:30 p.m.

BEFORE:

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

PRESENTERS:
Katha Fortier, Assistant to the National UNIFOR President, Jerry Diaz
Tullio Diponti, President of Local 2458
Andy Savela, Director of Healthcare UNIFOR
Nancy McMurphy, President of Local 302

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

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

COMMISSIONER FRANK MARROCCO (CHAIR): So are we waiting for -- well, the commissioners are here. Are we waiting for anyone?

KATHA FORTIER: We are all here.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. As soon as Mr. -- well, then let me sort of give you kind of a -- let me give you a sense of where we're coming from, and then --

So typically, when there's a commission created, something has happened, and the government -- the Commission inquiries into what's happened and reports with the idea of explaining to the public what this past event was all about. And typically, it does that by investigating, hold hearings, write a report, and that whole process can take a couple of years.

We're a little different, we think, because we've been called into existence in the middle of something, something that's not over. And so we are, kind of, of a mind that we need to try to make some short-term recommendations immediately before we embark on a more traditional approach at looking back at Wave 1. So we're really very anxious to get any insight we can into

what we can recommended in short order to the Minister to deal with Wave 2 and, you know, Wave 3. And we wanted to avoid a situation where we were simply inquiring into things at the normal pace, and events were simply overtaking us repeatedly because we're into one wave and then another wave, and produce recommendations at a point in time when maybe they're not terribly helpful. So that's the perspective that we have.

The way we've tended to do this is as you're -- we're going along through whatever it is you're saying, as questions occur to us, we just ask them rather than waiting until we get to the end and then trying to go back seems to be kind of inefficient. So we've tended to interrupt with questions if that's -- if that's, all right, that it wouldn't cause you any undue aggravation; that's the way we've normally done it.

The -- probably around 2:15 or so we take a ten-minute break. So if you could let me know around that time when it's convenient, then we would break then for ten minutes or so. So that's basically the introduction. We're ready when you are.

KATHA FORTIER: Great. Thank you very

much. I appreciate that, and I appreciate your time and your reaching out to us to meet with you. As you can well imagine this is -- this has certainly been something that we care very deeply about.

UNIFOR represents about 15,000 long-term care workers in Ontario. That's in retirement homes, nursing homes, homes for the aged. We have -- this has been, again, very into the pandemic but also the crisis beforehand.

And my name is Katha Fortier. I'm Assistant to the National UNIFOR President, Jerry Diaz. And I'm also -- I come out of the healthcare sector. I'm a registered practical nurse, so I'm very familiar with the -- where our members work and the work that they do. I worked in a rural hospital in Northern Ontario, but we also had a long-term care wing in that hospital as well.

So with me today is Andy Savela, who you can see. Andy is our Director of Healthcare. He's also -- he's also -- was an RPN. I think he let his registration slide but also has a background in healthcare.

And then we have Nancy McMurphy. Nancy is the President of Local 302 in London and

surrounding area. Nancy represents a whole lot of nursing homes and long-term care workers. And her background, she's a personal support worker as well.

And finally, Tullio Diponti, Tullio is the President of Local 2458 in Windsor. And between Nancy and Tullio, I think they probably represent somewhere in the ballpark of about 60 nursing homes or maybe a little more. So they're very well versed in the subject and certainly not just -- not just the pandemic and what has happened, but what led to the pandemic as well.

So we've prepared a bit of remarks so we're not going to be repeating ourselves, and so we're going to speak in the order that we've -- that I just introduced everybody in. But -- so I will start, and we're happy if you have questions as we go along.

I sent you some documents yesterday. I realize there was one thing that I forgot to send, and I will get it to you. And last year, that was the -- we did -- had the Ontario Health Coalition do a roundtable report after we did a number of roundtables across the province on the personal support worker shortage. It's called Caring in

Crisis: Ontario's Personal Support Worker Crisis. And so I will make sure that you have that document as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you. Did you want the document that you sent us yesterday on the screen?

KATHA FORTIER: I don't know that I really need that.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

KATHA FORTIER: I'm going to refer to -- I think mostly I just sent you, you know, some of the letters that we've sent to the -- this year on -- on the subject of long-term care and healthcare. And also the -- we've put together a wage document because I think it's really important that the Commission understands what's happened over the last decade in particular to wages in the long-term care sector. So I'll go through a bit of that, but I don't know that we really need it on the screen unless -- well, I guess we could do that if it makes sense.

But what I'd really just like to start with before we get into that is just to go back because I think it's really important that we

understand how long-term care has changed in the last 25 years. And it really is -- it really is crucial that we think about this.

So if we go back to 1995, long-term care homes did not look like they did today. In fact, residents who lived there often drove their own car. They were mobile. You know, they were -- they were reasonably independent.

And in 1995, those people that were the most frail that had the most complex health issues were normally in chronic care hospital beds or continuing care beds in hospitals. Those would be the people, you know, with very complex issues, perhaps brittle diabetics, Alzheimer's, and often -- we often actually had psychiatric hospitals that had psychogeriatric wards that, you know, people got a really intense level of care in.

What happened throughout the '90s were the -- certainly, the late '90s -- were thousands of those beds were closed. The chronic care hospital beds declined greatly in hospitals and as well as psychiatric hospitals also closed which closed down some of those psychogeriatric wings.

Now, those people didn't just disappear. They moved into the long-term care

system. That was -- Harris was the premier. You'll remember the Restructuring Commission that rolled through the province that closed those hospitals beds, and you'll also remember that there was a huge increase in long-term care beds and new builds. Those new builds were mostly to the for-profit sector. That's where we really saw the growth in for-profit long-term care in Ontario.

Before that, we probably had about 40% of the homes being for profit, and 60% not-for-profit. Not-for-profit could mean municipal or regional run. It could be -- mean that it was run by a hospital. It could mean that a long-term care facility was run by a not-for-profit agency like a church organization or a religious organization; some of them still operate to this day.

So we really saw the shift to for-profit operators in the province during that five-year period. And again, we also saw during those five years that the complexity of the residents that they were caring for in nursing homes grew quite rapidly. And we've seen that just continue to skyrocket really. I mean, the complexity in a nursing home, it just today doesn't

look anything like it looked 25 years ago.

Also in 1995, the government decided to remove a minimum measurable standard of care in long-term care. Now, let me sort of just explain what that means. At the time, the minimum measurable standard of care was 2.25 hours. But again -- and what that guaranteed was, you know, in a formula for a long-term care facility, you had to work out your staffing so that nursing and personal care was delivered to each resident for an average of two-and-a-quarter hours per day. That was the minimum.

And it's a bit complex because, you know, straight ratios are a little bit difficult to do because, you know, the ratios could change per shift. You obviously wouldn't need as many staff on a nightshift as you would on a dayshift.

So there's some variables, but the minimum measurable standard of care meant a couple of things: First of all, that you had to provide certain a level of staffing, that that was actually a requirement; and when an inspector went into a facility to do an inspection, they could actually look at the formula and make sure that you were providing enough hours of care per resident per

day. And if you weren't, you had to do that. You had to improve your staffing levels. So, you know, that was -- removing that minimum standard, we feel, was -- was a grave mistake. It actually should have been kept in place, and it should have -- it should have actually grown because again, right now, obviously, a four-hour minimum measurable standard is what is recommended.

I'm just going to touch now on the wage brief that I give you. And I really want you to sort of see in particular over the last decade how wages -- real wages in nursing homes, in long-term care facilities has, first of all, not kept up with inflation, and secondly, been a deterrent. It's pushed people away from working in homes when, you know, your work does not keep up with inflation.

So I just want to start -- first of all, you may know this. I might -- I'm probably stating the obvious, but long-term care workers in the Province of Ontario are covered under the Hospital Labour Disputes Arbitration Act. It's illegal for them to go on strike. And so if a collective agreement isn't negotiated, they go before an arbitrator.

During, you know, the previous decade

before that, we bargained a lot of collective agreements, and they actually didn't go before an arbitrator. And we bargained some settlements that were -- that were very progressive. I think Tullio and Nancy will both remember being at a Rivera bargaining table, bargaining, you know, 2.6, 2.75, and 3% in wage increases, getting a drug card for our members which was, you know, this was a workforce often of, obviously, mostly women, but, you know, these were things -- a drug card was important in that, you know, they didn't have a lot of expendable income and being -- and, you know, having to pay for -- they had a drug plan, but when you had to pay for your medications up front, that was a huge burden on a lot of our members.

So, you know, through the previous decade, we were making real progress for these workers. We were actually, you know, feeling like, you know, we were -- we were doing something.

The work wasn't easy. It never was, and it's challenging, and it takes a real special person to do that work, but, you know, the compensation was reasonable.

Over the last decade --

COMMISSIONER FRANK MARROCCO (CHAIR):

Can I just ask you, at that time, from '95 on, was it the same regime in the sense that you couldn't go on strike; if you couldn't reach an agreement, you went before an arbitrator? Was it --

KATHA FORTIER: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- always like that throughout this period?

KATHA FORTIER: Yes, it's been -- it's been like that -- probably I believe, since the '70s, it's been illegal for healthcare workers to go on strike.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. But specifically, personal support workers, that's workers in long-term care homes were captured by that?

KATHA FORTIER: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

KATHA FORTIER: We would actually -- sorry. Did you have another question?

COMMISSIONER FRANK MARROCCO (CHAIR): No, I don't. Oh, sorry.

COMMISSIONER JACK KITTS: I was just going to -- I think we heard from somewhere else that personal support workers weren't considered

essential workers up 'til some point; is that true or not?

KATHA FORTIER: I would say that that's not true. If they -- again, the Hospital Labour Disputes Arbitration Act clearly covers long-term care facilities in the Province of Ontario and has done for decades.

So I guess, in the definition of essential, not having the ability to strike, personal support workers haven't had the ability to go on strike for decades.

Now, there might be some exceptions because Homecare is not covered under the hospital -- under HLDAA, is what we call the -- affectionately call the Act. So Homecare personal support workers did have the ability to go on strike.

COMMISSIONER JACK KITTS: Oh, in Homecare. Okay. Thank you.

KATHA FORTIER: Yeah. Yeah, so just a matter really of where you worked, but long-term care does not have and has never had the ability to strike.

And I get back in those days, they were -- they were -- we were healthcare aids, not

personal support workers. The educational requirement changed as it probably should have because the complexity changed, but they've never had the right to strike.

The point I would like to really make with this is that in the last decade, we've -- and this would be, you know, for all unions, SEIU, CUPE. You know, we do a lot of work together. As unions, we probably represent the majority of the long-term care homes in the province. And, you know, we've certainly worked together on this, and even on bargaining. We've -- you know, had -- certainly had conversations with each other.

But the reality has been in the last decade that nobody has been able to negotiate a collective agreement, that they have been set by arbitrators. Once one large nursing home group gets a settlement, then every arbitrator in the province will not stray from that pattern, and that the last decade has -- has really shown that the wage increases have just fallen below inflation.

I do -- there's a piece in this around municipal homes, and that comes into relevance for a few -- for a few reasons, and I'll go into them a little later, but we do talk about the average

wages for a number of classifications in a municipal home versus a long-term care home. And you'll see that there's a significant spread, that they're likely 2 to $3 more. The wages are 2 to $3 more an hour in a -- in a long -- in a municipal home versus a private home.

You know, this, I guess, for some people, maybe $3 an hour doesn't sound like a lot, but for, you know, a woman working in the long-term care system, I would -- I would argue that that's very significant. That's, you know, a big cart load of groceries for them every week or shoes for their children. These are -- these are significant amounts.

So -- and I'd also like to just raise something as well where we talk about wages, and it's the increase in part-time work, in casual work, and wage progression itself because you'll notice on the -- on the charts that we gave you, there's a start rate, and then there's -- I don't think we've printed the one-year rate, but you can assume it's somewhere in the middle. And then we have the two-year rate, which is generally the higher rate. It takes two years to get there.

But -- oh, nobody ever phones my house

phone, sorry about that, but --

COMMISSIONER FRANK MARROCCO (CHAIR): You know, don't worry about it because my phone rings almost every single time I'm on one of these calls. And one of these days, I'm going to just -- anyway, I'll spare you that, but you're not alone with this phone.

KATHA FORTIER: It's a telemarketer. It's somebody -- want my ducks, or, you know, I'm sure it's just one of those calls. I don't know why I have a house phone anymore.

But anyways, I just want to talk about progression and what happens to new workers in the long-term care system.

First of all, they're unable to get a full-time job. It can take you years, perhaps a decade to get a full-time job. And so you don't even move along the progression for working for an employer. One year actually translates to 1,800 hours in most instances. So that means that they have to get 1,800 hours working for that one specific employer.

Most personal support workers and other workers that work in nursing homes don't actually have the opportunity to just have one job. They

work two jobs or sometimes three jobs. They work for multiple employers. So getting to that progression to get from the start rate to the two-year rate might actually take them six years.

So I just want to make sure that you sort of understand that it's not just everybody with two years is making the top rate because that's certainly not the case. And, you know, of course there's a real trend from employers to not have to provide benefits and sick pay. So they like to keep people part-time and casual and working multiple jobs. It works for them, just as --

COMMISSIONER FRANK MARROCCO (CHAIR): So then you can't get the top rate until you have worked 3,600 hours, is that -- is that the idea?

KATHA FORTIER: Yes. Yes. And that might take you six years to do that --

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

KATHA FORTIER: -- if you're working for three different employers.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there -- in your view, is there a place for part-time workers in -- in the system? As of --

you know, as opposed -- I recognize what the system is now, but in terms of what you're saying, there's too many, or there shouldn't be any? Or --

KATHA FORTIER: Well, there are -- I mean, there's always been part-time workers in healthcare, that's just a given. It's been very clear that that's part of the system, but the ratios have just seemed to increase dramatically.

So, you know, I would say that there are homes where 70% of the workforce is now part-time, where probably that -- that numbers could easily be reversed, that you could actually have more full-time workers. There's a reluctance on the part of employers to create this full-time work because once they're full-time, they have -- they have -- they're able to get the benefits, and they're able to get the sick time, paid sick time.

And by the way, neither of which, nether the sick time nor the benefits are as good as what you would find in a hospital or what you would find in a municipal home. There's some staggering differences there as well, particularly around pensions, but also all of -- all of the benefits as well and sick time. Sick time in hospitals is particularly more generous, and in

municipal homes.

So we've given you three charts on that document as well, and they're -- it's the historical wages for two groups of for-profit operators. One is the Schlegel Homes. This is a for-profit operator. These are the actual rates that we -- that we have in our collective agreements. And the other is the Extendicare Chain where we bargain essentially with ten homes at a central table.

And you'll see what we've done. I'm going to put my glasses on to look at this. But you'll see what we've have done is we've actually compared the wage increases that they've received to the wage increases -- to the rates of inflation and what those differences would have been if they actually kept up with inflation.

So we go back to August 1st, 2011 for the Schlegel Group. Schlegel in particular has a very low start rate far lower than an Extendicare home. So, as an example, the start rate in a Schlegel home today is $18.84 an hour. In an Extendicare home it is higher. It's $20.83 an hour. So you can see it's a significant difference. Some of that might be because the

Schlegel homes are newer. They've -- they work -- they opened more recently, probably within the last 12 to 15 years, and they opened -- of course, it's non-union facilities, so they were paying those rates. So it was sort of the basis. You have to bargain up. Whereas Extendicare and other homes were around for a longer period of time.

But just to give you an example, right now at a Schlegel home, the top rate for a personal support worker is 21.04 an hour. And had they at least kept up with inflation, they would be at $22.20 an hour.

The Extendicare rate right now is $22.21 per hour, and this is -- I'm talking the top rate, the two-year rate, and if it kept up with inflation, it would be $23.11. And then if we look at the last comparison which we gave you, which was an average municipal home, an average municipal home, this is our Brucelea Haven. It's in Tullio's local, and Gateway Haven, they're municipal homes. And that compares with a personal support worker rate right now currently of $25 an hour.

And we've laid out what all of those increases were. And actually, they've been well -- not well above, but above inflation. So if their

rates had kept up within inflation, it would be $24.61 an hour.

So the reason that I compare the municipal homes, and we explain it on the final page, is because of proxy pay equity.

So proxy pay equity was brought in in the early 1990s, and it was done specifically for workplaces like a nursing home where you simply did not have male comparators to do a real pay equity plan. In fact, in most nursing homes, there's one male comparator. It's the maintenance person, and that just does not allow you to do a proper pay equity plan for anybody in that facility.

And so that was recognized by actually the Bob Rae government, and so they put in some legislation on proxy pay equity.

And so what proxy pay equity did was allow you to -- for these types of workplaces, was allowed you to compare to similar work with a group of workers that actually had a pay equity comparator.

So again, I go back to municipal homes because municipalities not just run the nursing -- run a home for the aged. They also -- they also operate, you know, all sort of things. They have,

you know, all of the things that a city or a municipality would have to do. So you have an array of male comparators to do pay equity with.

So in 1994, a pay equity plan was determined at the time, and I guess just as a bit of a background, our UNIFOR homes were part of the Service Employees International Union. We left the union in 2000 to join what was then the Canadian Auto Workers Union and is now UNIFOR. But we were part of that original plan.

And what the plan said was that the comparator in 1994 was a municipal home and that they made $1.50 an hour difference. And that $1.50 an hour had to be paid out. So we were still part of that plan even though we weren't members of SEIU going into the early 2000s. And I believe that plan completed the payout. It wasn't very -- it wasn't very generous. So you can imagine $1.50 over ten years is 15 cents a year. But they did get that pay equity during that time.

Now, as you can see since then, the rates in a municipal home have grown -- that gap has gotten even bigger than the original $1.50 an hour. So the two unions, SEIU and ONA, have been in various disputes with the employer. We've

supported ourselves and CUPE because we're not named in the agreement even though we worked part of the agreement, essentially, getting the same increases. We are interveners with the Equal Pay Coalition, so we're involved in those as well.

So we did have a successful appeal last year, and what is -- what is -- the crux of the appeal is that these employers should have had to maintain proxy pay equity. That they -- you know, they didn't actually have to maintain it. We know that that wage gap between a municipal home worker and a nursing home worker has grown, and it hasn't been addressed, and we feel it should be.

So we were successful in court last year that they were ordered to maintain proxy pay equity, and the employers have -- this is the for-profit employers represented by Bass & Associates, have appealed that decision. And so that was just heard in court just this week, the employer, the for-profit operators appeal not wanting to give pay equity to those workers.

And in fact, for some reason that is yet to be explained to us, though we did meet with the Minister of Long-Term Care last week, and they did tell us that they would give us an explanation,

but the Attorney General has -- of Ontario has intervened in this case on behalf of the employers. So, you know, you've also got government actually working to stop nursing-home workers from getting the pay equity that they deserve.

So I just thought that that was an important piece for the Commission to understand. And if there's any questions on that, I'm happy to take those, and if not, we will move over to Nancy McMurphy for her remarks.

COMMISSIONER FRANK MARROCCO (CHAIR): I don't think we have any questions, so...

NANCY MCMURPHY: Okay. Thank you very much. I want to thank you as well for giving us this opportunity for come and speak with you today. As Katha mentioned, I was a previous long-term care worker for many, many years. So this is something that's very near and dear to my heart.

I'm one of ones that's still fortunate enough to remember a time when you left at the end of your shift feeling a sense of pride because you knew that you had improved someone's life. And sadly, that's not the case for staff any longer. They're walking out doing a mental checklist of who they didn't provide adequate care to, or who they

didn't provide care to based on the number of staff that were there that day.

So Katha has asked me if I would focus my attention on specific staffing concerns and issues. And with your indulgence, I'm going to read my comments because honestly, I just don't want to forget any of the points that I wanted to touch on because I think, you know, sometimes we -- we get so engrossed with this conversation that we can just go off on a tangent and completely miss very important aspects that need to be addressed. So I'm just going to read my remarks, and please feel free to stop me at any point in time.

So prior to the pandemic, we were absolutely in a crisis. COVID-19 has only worsened the situation. If I could say there is one positive aspect about the pandemic, it's that it's brought a much-needed public awareness to just how dire the situation is in long-term care.

The funding mechanism that we have currently is obviously not working. What we see now and specific to nursing is the nursing of personal care envelope. And the funds are directed to an extensive list of staff, services, and even products are included in that envelope.

In order to provide quality care, there has to be a commitment of designated hands-on providers. With the current envelope system, the decision relies on individual operators and their budget.

So a couple of examples that I can give you have of what was happened over the last number of years with this type of funding is we will have operators that by June of each year, they decide that they're simply not going to replace the first or second sit call (phonetic). They just want to make sure that there's enough money in the budget to get them through to the end of the year.

We also have frequent situations where we will have an injured worker that's returned to work in a modified role. But they're being counted as part of the compliment of care providers for the shifts. They're counting them despite the fact that these individuals can probably only do a small portion of their normal routine because of their injuries that they're suffering from.

So with the current staffing ratios that we have already being so taxing, these types of decisions are making an already impossible job more than overwhelming. As a result of COVID, many

staff are now also dealing with mental health issues; they're dealing with depression; they're dealing with increased anxiety. And many of them are going through a horrible grieving process because of the loss of the residents.

If there isn't an investment in proper frontline care, I guess my question is what kind of message are we sending to the residents, to their families, and to the staff that we're trying to retain and recruit into these jobs.

Currently, it's not uncommon to see an assignment of 1 PSW to 12 residents on days or on afternoons, but on the nightshift, you can often see that it's 1 to 32 residents. These numbers would be reflective only on shifts that they aren't working shorts. So with the ever-increasing resident acuity and the diversity in the resident population, these ratios are not only unsafe to provide high quality care, but it's absolutely impossible.

Between an aging population and the ongoing shortage of beds for residents that are suffering from serious mental illness, staff are frequently subjected to both verbal and physical abuse. They're forced to rush the care which

causes anxiety for the residents and agitation of course.

So what we would like to see would be a minimum of -- pardon me -- a maximum ratio of residents to staff of 1 to 8 for days and afternoons and 1 to 12 for the nightshift.

I think that's a good starting point, and quite frankly, we'd like to see the numbers reduced beyond that. We have homes right now where we have designated Alzheimer wings. And so you're going to be facing higher behavioural issues regularly. And we think a realistic ratio for those environments would be 1 to 6.

Far too commonplace are shortages of two to three staff on any given shift and on any day of the week. It used to be that these shortages occurred most frequently on the weekends, and I'm sure everyone can relate to that. But that's no longer the case. Now, it's every day of the week.

Many of our homes are reporting being between five to ten PSWs short in a 24-hour period. Most negatively impacted are private-for-profit facilities, and even more challenges are occurring in our rural settings. Of course, I'm sure you can

understand why.

The shortage is of the result of many things. You're going to have your sick calls, your family emergencies, bereavement leave, workplace injuries. But many times, the shortages are occurring simply because there's not adequate staff to even cover the shifts when a schedule is being prepared.

As bad as the numbers were before COVID, they have absolutely grown worse. Workers have continued to leave the sector, and more recently we're seeing shortages in all classifications.

I know for some, the decision was made out of fear, anxiety, concern for the safety of their family and themselves. When we've had an opportunity to do an exit review with staff, the reasons for leaving were really quite consistent. They speak of excessive workloads that have led to complete frustration that they cannot provide the necessary care the residents need and that they deserve. There's a fear of being unsupported in the roles that they're doing. They are fearful of accusations of resident neglect simply because there aren't enough hours in the day to do the work

that needs to be done.

They're struggling with inconsistent and unrealistic schedules. As we know, many saw a reduction of stable hours because of having to choose one workplace, and every single worker that we speak to speaks out about burnout and total exhaustion.

I would add to that that we also have to look at the fact that daycare is very problematic in a 24/7 environment, and that has, of course, also worsened with COVID.

Many employers have attempted to find solutions, but the solutions that they are working on just aren't working for the homes, quite honestly. So employers are relying on agency staff, in some cases, to fill vacancies. These individuals come into the building with no knowledge of the residents or the work routines, and they honestly create more work for the staff sometimes because the staff are feeling like they're having to orientate them each time they come into the building.

The cost associated with agency staff is much higher, and so you can understand that's insulting and demeaning for dedicated employees

that have worked at the home for a number of years and someone walks in the door, but they're making several dollars an hour more than them and yet only performing a portion of the duties because, again, they don't know the job routines. Using agency workers provides very little continuity of care to the residents or to the workplace.

We also have seen recently the introduction of resident care aids. So these individuals are not trained. They are not qualified PSWs, but they are utilized to provide non-nursing roles of the PSW. They don't provide hands-on care. So the portion of the job that many PSWs would look forward to is what these individuals are doing. And I say that because if you've had an extremely stressful shift, sometimes if you just take that time away to go and make a few beds, you know, porter a couple of residents to the dining room, that just gives you the opportunity to regroup both mentally and physically because you're dealing with very high-intensity residents.

I would add that we've had to remind several of the employers the scope of these jobs as they are frequently attempting to expand the roles

due to the ongoing staff shortages.

The other issue that we've seen happening is that the PSWs are applying for these positions just to get away from the unrealistic workload of the resident care. So we're not really resolving the problem. We're just making the problem even more difficult.

The Canadian Institute for Health Information shows that it's imperative to address the shortages. There are approximately 40% of PSWs that leave the job the year after their graduation. There is roughly another 25% with two or more years' experience that are leaving yearly.

We also see the issue of an aging demographic not only in the residents but in an aging workforce. So roughly 25 of the PSWs that are currently working in long-term care are over the age of a 55. These statistics don't provide for a stable workforce. We know that many of these individuals are being offered part-time or casual employment.

Prior to the pandemic, we found that in order provide for the family, workers were forced to secure two, maybe three positions with different employers. And that dramatically reduces their

availability for call-ins with any one of those particular employers. The inconsistent schedules provide a very poor work-life balance. And again, the conditions are just not attracting workers into our sector.

I'll just touch on one question that was posed to Katha previously. I agree with her suggestion that we flip the 30/70 to 70/30%. We absolutely need to have part-time workers in this sector because, honestly, they are going to cover shortages for sick calls. They may help to beef up the staff so that staff can have statutory holidays off or that they could have vacations. So there is a need, but there is not as great a need as what we're seeing occurring.

The recently announced PSW wage enhancement, I'm confident that that was intended to be -- it was intended to be a bonus for our PSWs. But the reality is, it's very, very problematic. It's problematic first of all because it's temporary.

But secondly, as we see it, the band-aid fixes aren't going to aid us in recruiting or retaining staff. The announcement created a huge amount of divisiveness between workers in

other classifications. They're not looking at as an issue of retaining PSWs, but they rather are looking at it -- they see it as a disregard of the contribution that they provide in the jobs that they do within these homes.

We have one home, actually, in our local that with this PSW enhancement of the $3, they are now making 27 cents an hour more than an RPN in that particular home. So we're having to try and address that with the operators.

As of yesterday, London Middlesex Health Unit, which is the area that I'm in, reported there's now six long-term care facilities in declared outbreaks. And to me, that's frankly terrifying. We have to be concerned that how is this -- how is this going to impact staffing moving forward? You know, the staff are already terrified. They're already exhausted. And now we see more and more of these outbreaks occurring. It has to -- it has to pose a great deal of questions as to what we're going to do.

So if anyone has any questions, I would certainly be happy to answer them for you, but that's just an overview of what's going on with the staffing currently.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have a sense of why the personal support workers have been -- I was going to say traditionally -- but undervalued in terms of their contribution to the healthcare sector? Do you have a sense of why that is?

NANCY MCMURPHY: No. You know what? I honestly don't because the work that they're performing is frontline work.

COMMISSIONER FRANK MARROCCO (CHAIR): I understand.

NANCY MCMURPHY: You know, they're providing probably 85% -- meeting 85% of the residents' needs in any given shift. So why they are being undervalued in such a manner, I think part of the problem that we're seeing right now is that there are a lot of allegations of abuse and neglect, and I'll tell you right now, not one of us in our union condone abuse of a resident.

But what is really frustrating for these individuals is when they're being accused of abuse or neglect, honestly, as I said previously, because they don't have time to do the work.

So if you don't answer a call bell in a prescribed period of time, that can be considered

neglect. But if there's no one else on the wing with you to answer the call bell, and you're with another resident, you can't leave that resident that you're with for fear that they may have a fall and then you have neglected that resident that's resulted in, perhaps, an injury to them.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

KATHA FORTIER: I would just like to add to that. You know, part of the challenge is, is that personal support workers have spent a lot of time compensating for the cuts and for the increased work and the increased workload, the increased acuity of their residents. They start work early every single day. They work through their breaks. They stay late. It's not unusual to find people that come in an hour early for their shift to start their shift, and they're not paid.

They're -- they -- you know, and but the reality is, is that those residents become their family. I mean, you know, we've been hearing a lot about -- from families who are so distraught that they can't get in, that their access is limited to their loved ones. And that's absolutely fair.

But there's a whole section of people who live in long-term care, for whatever reason, who don't have any family or family lives too far away, or they just don't visit. I mean, you know, this loneliness aspect of it -- and -- it is really crucial, and it's not new. There are -- there are a lot of people in long-term care that don't have a support system other than the staff.

You know, I know that you talked about when I had the initial conversation -- now they're testing my fire alarm system.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we were even until they tested your fire alarm system.

KATHA FORTIER: Okay. The test may be over. I apologize. The joys of working from home. But, you know, they've compensated. And not only have personal support workers and other workers in these homes -- they sometimes -- they replace the family. You know, they go to funerals of their residents. They bring them a coffee from Tim Hortons every day. They bring them clothes. They bake for them. You know, there's -- you know, when I think about, you know, the 1,952 residents that have died, I mean, you know, it's so

devastating. But you know how devastating it was for these staff as well.

And because this is a workforce that's mostly women and mostly come to work because they care, you know, it's easy to take advantage of that.

Tullio's local had an experience once where we had a retirement home where the employer stopped paying the workers, and they went to work anyway.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there any counselling or anything offered? Has there been any counselling or anything like that for the workers who have been through Wave 1, you know, just to try to deal with so many deaths? And, you know, anyway, has that happened?

NANCY MCMURPHY: Some of the homes are --

ANDY SAVELA: Maybe I can add something -- I can add something to this and add, you know, a lot of our workplaces, we've negotiated EFAP programs and things of that nature. Some of them are very good programs and some not so good at all. But we're really finding that this is becoming an issue, and this week we've been on

numerous calls that our union is going to be doing webinars on compassion fatigue, burnout, and trying to just bring to people different avenues and opportunities for them to try and deal with -- you know, with emotional things that they're having to.

TULLIO DIPONTI: Can I say something?

COMMISSIONER FRANK MARROCCO (CHAIR): Just -- sure. But, Commissioner Kitts, did you want to ask a question?

COMMISSIONER JACK KITTS: There was a separate topic, so go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): Sorry. Go ahead.

TULLIO DIPONTI: So Nancy laid it out really well, and I appreciate what she talked about. When you talked about being undervalued, the PSW, I think the whole industry is undervalued. It doesn't matter who works in those facilities, whether it's a dietary worker, RPN, caretakers, PSWs, and all that.

So I think we've got do look at the whole industry, how they're being undervalued. And then when you talked about the mental issue of it, just imagine, when we were going through this pandemic in the first wave, and the funeral homes

couldn't go into the homes to pick up the bodies that passed -- unfortunately passed away. Now, they put the burden on our members. And like Katha said, they become the family members. They're the ones -- and they've done this before; they clean them up and all that -- now they had to put them in body bags.

Yeah, do we need mental health? Do we need some mechanism in there to help these workers deal with what's going on? We definitely do. But I just don't want to make it as if it's just a PSW issue. This is an industry-wide issue, and whoever works in this industry have always felt they're undervalued.

And like Nancy said, especially now with this just targeting one sector of that -- those homes, the PSW, only giving them the raise, it just magnified the problem.

COMMISSIONER JACK KITTS: Yeah, just building on that, I guess my question builds on that. So we've heard they're undervalued. They're subject to verbal and physical abuse, workload is excessive. They're unsupported. They're burning out and exhausted.

And I think, Nancy, you said that the

current wage fixes aren't going to work or they're not the solution; band-aids aren't the solution. Can you tell us what you think needs to be done as soon as possible to help out in Wave 2?

NANCY MCMURPHY: Absolutely. So we strongly encourage that there is a mandatory four hours of care per resident per day introduced immediately. We want to make sure that these residents can be given the care that they need and that they deserve.

We feel that it's vitally important that we see full-time jobs being created and full-time jobs with benefits. This is going to entice, we believe, individuals back into the sector.

We also would like to see, obviously, a fair wage schedule. When you look at the differences that Katha has laid out between municipal homes and private long-term care homes, it's pretty significant the wage difference.

And you know what? I've worked in the sector for so many years, and as Katha said before, it's not all about the money. Absolutely it's not because these individuals, some of them have worked for 20, 25 years. They're bringing in clothing and

personal hygiene products to the residents that they know that they need. They've stuck it out. But the workload has just increased to the point that it's beyond their capacity.

You have to understand that we now have residents in some of these facilities that might be as young at 21, 22 years old. And they're there because they may have suffered a traumatic brain injury, and there are no assisted living beds available in the community.

Then you have residents that are suffering from serious mental illness. And then you mix into that your elderly population that are suffering from the dementias, and that's just a recipe for disaster.

COMMISSIONER JACK KITTS: Just one supplemental. If mandatory care were implemented tomorrow or next week, would there be sufficient staff to meet that mandate?

NANCY MCMURPHY: I don't know that there would immediately, but I think it would go a huge way to drawing people back into the sector. If they knew that they were going to be able to perform the job safely and the way that they should be performed, I believe that it would bring people

back into the sector.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Commissioner Coke.

COMMISSIONER ANGELA COKE: You spoke before also about the issue, the temporary wage increase for the PSWs, the issues that that may cause with the RPNs; in terms of it, I guess the relativity gets shifted.

Are there other classifications or group that that problem is taking place in the homes, or is that mainly the group that is creating the issue there?

NANCY MCMURPHY: I think it's being felt by all classifications, quite frankly, because they're feeling devalued. The RPN, it's because of the, you know, they've taken into consideration they are registered. They're a registered practical nurse. And when a PSW is making 27 cents more an hour than them, then that's -- you know, that's very problematic.

But all classifications, because I mean, let's be frank, you can't have a home operating properly if you don't have a good cleaning staff that are looking after the infection

control, if you don't have a strong dietary department that are providing proper nourishment for the residents, if you don't have the registered staff that are going to be assessing the needs of the resident on a daily basis as well as administering medications. So it is an entire team in order to make the homes properly run.

COMMISSIONER ANGELA COKE: Thank you.

KATHA FORTIER: I think we'll go to Andy next for his remarks and then to Tullio.

TULLIO DIPONTI: Andy's on mute.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, you're on mute.

ANDY SAVELA: There I go.

Thank you. But I'm happy to also be able to be involved in today's discussion and offer some comments on, you know, the things that we're seeing in long-term care.

But I just want to start by telling you I was very happy to hear at the beginning of this call today that the Commission was, you know, considering some short-term recommendations put in place, you know, as soon as possible because frankly, you know, with the second wave approaching and -- and we're -- I'm getting calls from our

members who work in, you know, homes that are declared an outbreak, and frankly, some of them for the second time, it's -- you know, in all honestly, they seem to be looking for a lifeline. And there's not much that we can say at this point other than point to the work we're trying to do in terms of getting some of the things we're talking about today addressed.

So I'll just say that, you know, when the pandemic hit the sector, there was already a crisis with respect to the workforce in long-term care. The vast majority of the facilities, particularly those operated in the for-profit sector, had already an unstable workforce and a severe shortage of staff.

Katha talked about the report that we're going to forward to you that we commissioned the Ontario Health Coalition to write on our behalf. And we shared that with Minister Fullerton and her staff pre-pandemic when we had the opportunity to meet with her just before the pandemic really broke.

I want to say about that report we're going to forward you that it did stem from roundtable discussions that we held across the

province. And I think it's important to know when you read that report that we were very inclusive in terms of people who participated in those roundtables. We had all classifications of worker in long-term care facilities, residents, and family members, family councils. We had for-profit and not-for-profit operators participate, educators, physicians, and politicians.

So we feel that report captures, you know, a wide range of views and opinions. And I think, you know, when you read it, you'll see it clearly supports some of the things that we're recommending that need to happen today.

I think it was Nancy who talked about the long-term care workers having to choose a primary employer when the outbreak starting hitting facilities. And this really unfortunately exacerbated the staffing crisis.

The majority of long-term care workers, you know, have to piece together a number of part-time and casual jobs to make a living wage and support their families. And, you know, in many circumstances, being limited to work only -- only one employer led to workers and staff frankly finding them jobs in different sectors. And in all

honestly, a lot of them have left and don't intend to come back, and more, I believe, are weighing those options, particularly now as we go back into -- to outbreak.

Frankly, also, I can tell you that many workers left the job right when an outbreak was declared in their facility, and it was not really only related to the extra burden on -- you know, which caused the unstable workforce, but also to the lack of access to the appropriate PPE, personal protective equipment.

And lots of facilities -- and again, it seemed to be a worse of a problem in the private sector. You know, our workers, members reported PPE being kept under lock and key. And, you know, the problem with that is when you're on a time crunch and you're looking to get the appropriate PPE so you can perform your duties with the PPE being under key and, you know, supervisory staff would be responsible for that run off their feet as well, it just caused a problem with people getting access to the PPE that was needed.

And in all honestly, you know, there were debates on the floor on, you know, what PPE was needed and, you know, the things the Medical

Officer of Health had outlined in his directives, Directive 5. It became so bad that if you can imagine, we literally had our members in the one workplace who took pictures of themselves and reported that they had wrapped themselves in garbage bags to keep themselves safe.

Employers must be held accountable to comply with the directives put forward by the Medical Officer of Health to give workers the safety that they need. And in particular, we're hoping that employers will follow the newly amended Directive 5 that we participated with many in -- in coming to consensus on. I think it's more clearly written and provides more appropriate protection to a broader classification of workers. I think this will ease some of the anxiety and whatnot in the workforce.

So I'll end my comments there. I think we've touched on a lot, but I just want to close by saying that it's very important that long-term care workers who are going to speak to the Commission are able to go and tell their stories without fear of retribution from their employers. It's paramount that they get more protection so that they can, you know, speak openly and frankly with

the Commission.

And with that, I'm happy to answer any questions as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, and let me just say, just on that last point, we have -- we want to amend the terms of reference to make it crystal clear that we can grant that confidentiality and that only we can take it away. There's some ambiguity in the terms of reference, and that's under discussion. So we're alive to -- we understand that problem.

ANDY SAVELA: Thank you.

KATHA FORTIER: We appreciate --

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts.

COMMISSIONER JACK KITTS: Yeah, just on a point of clarification, when you -- when you spoke about the impact of one site -- working at one site only on the workers, I want to be clear. Are you thinking or saying that perhaps we could find a way to have them work at more than one site and keep the patients and other residents -- the residents and other staff safe, if you could find a balance? Or I made a mistake?

ANDY SAVELA: I'm thinking that, I

mean, right now, I think, you know, there's a recognition that perhaps another look had to be taken at, you know, who is entering the facility and under what circumstances.

You've heard the -- or you will if you haven't, the concerns raised by family caregivers and people who do that thing. And, you know, in all honestly, there were -- it was frustrating for our members because, you know, here they were having a restricted income because they could only work at one employer, yet the staffing shortages were so, you know, difficult that we had agency staff who, frankly, their role was to go into any facility they're needed on any given day to enter a workplace.

So it just didn't seem to make a lot of sense for people. I'm sure that, you know, we could put our minds and come up with procedures and processes that would keep workers safe. But the fact that the people who counted on income from numerous employers to make ends meet, being restricted to just one job through no fault of their own really had a profound impact on staffing.

KATHA FORTIER: I would just like to add to that. B.C. acted far earlier than Ontario

did in limiting workers from being in one workplace, but they also took an added step of making sure that any worker -- they actually stabilized, brought all the wages up, but they actually made it so that those employers actually had to give workers full-time work if they were restricting them from more than one facility if they wanted it.

Now, I mean, I have to tell you that sometimes there are people that work a full-time job and a part-time job, so that doesn't cover all of that. But again, it would be -- it would be a step. If they're restricting them from working at a second facility, that they should at least guarantee those workers full-time hours. And, you know, like, that's just -- that's just very basic. And B.C. acted very, very early. In fact, B.C. was able to prevent a real tragedy with some of the steps that they took.

Oh, Nancy?

NANCY MCMURPHY: If I could just add as well, I think what was very troubling for some of the staff was the fact that there was no consistency. So we absolutely understood that you shouldn't have staff going from home to home to

home. These are very, very fragile individuals that they're dealing with on a regular basis, but when you looked at some of the directives and orders that were coming down, there was directives that would say, we're going to redeploy from the hospital. Those individuals can continue to work in the hospital, but they can also work in long-term care.

And so our members are feeling very frustrated saying, I had to give up my secondary job for the best interests of the residents, and yet we have these others, such as Andy suggested, the agency workers or those that were being redeployed that were continuing to work at more than one workplace.

KATHA FORTIER: Okay. I think we'll move to Tullio now. Tullio's going talk about -- he represents the workers at the hospital, Windsor Regional Hospital and also the -- represents one of the homes, the code red, that had a code red outbreak in the province, so over to Tullio.

TULLIO DIPONTI: Okay. Thanks, Katha, and thank you to the Commission here for giving us this opportunity to speak to you. Obviously, it's very important to us that we make sure that this

gets out there, and changes have to be made. And going last makes my speech a little bit -- because the three of -- Nancy, Katha, and Andy really highlighted the issues going on in the long-term care facilities and the retirement sector.

So like Katha said, I want to talk about what happened here in Windsor. We had a specific home that was in code red, and that was Heron Terrace. And at that point in time, it was just overwhelming. They couldn't handle what was going on in their home. And the CEO of Windsor Regional Hospital, David Musyj, wanted help. He saw the stories. He knew what was going on, and he saw the deaths that were happening. And what he did, he came up with the idea about creating this field hospital.

And the field hospital was an old gym of one of our colleges, St. Clair College here in Windsor, and he was able to get that thing up and running. And I think he was able to, if needed, that he could bring in about a hundred COVID patients where they would be taken care of, hospital staff.

Now, that goes to what Nancy's point was or Katha or Andy in regards to -- oh, sorry, go

ahead.

COMMISSIONER JACK KITTS: Mr. Diponti, could I just ask, was this home licensed by the -- was it the hospital?

TULLIO DIPONTI: No. No. This was a privately owned home.

COMMISSIONER JACK KITTS: Okay. And the hospital stepped in?

TULLIO DIPONTI: Well, the hospital stepped in for the whole community, not just for that home. But because of that home was in that code red and they had so many COVID patients in there, and the staffing, because of the pandemic, we had a big shortage of staffing in that home that they pretty well took 25 of the residents out of that home. I believe there was close to 40 residents that tested positive in that home and quite a few of our staff and was one of the reasons why they were working short.

But how that worked out, it worked out great. It was a blessing for that home and for our community that we were able to do that because now, by taking those 25 residents or COVID patients into the hospital, it give the opportunity for the remaining staff at Heron Terrace the opportunity to

be able to really take care of these residents, the rest of the residents that were in there, whether they were -- whoever was left over as a COVID or just regular residents of long-term care.

And I can tell you, our staff was overwhelmed to the point --

(DISCUSSION OFF THE RECORD)

TULLIO DIPONTI: Okay. So I just want to tell you a little bit of what was happening in that home. Obviously, there was a working shortage because like Nancy says, everybody was afraid of catching the disease, bringing it home, and infecting their family. And they didn't want to get themselves infected.

Obviously, they got into this field to take care of residents, and that's what they wanted to do. But because they really at the beginning didn't have the proper equipment to be -- do the job, it was going rampant into that home.

So we had actual staff that felt comfortable enough to work for 45 days straight so in order for them to be able to take care of whatever residents was left over with COVID and the rest of those residents. They brought in trailers where they didn't even go home. They actually

spent the rest of their time, until they had enough relief, in these trailers. One particular member of ours pretty well was -- was reporting to us, here I go again. And she was in regards to what's it like to live in a trailer and try to do your job as a PSW, a healthcare worker, to take care and making sure that these residents are in there -- got the proper care.

And if we didn't have this field hospital, I believe a lot of those residents -- and I think out of the 25, only 1 died in the field hospital. But you got to remember, the field hospital is a lot more staffed. It's almost like 1 to 1 to those residents compared to these long-term care facilities.

Now, we know we'll never get to that point with long-term care, but it goes to the point about what -- how important it is to make sure that we don't have 12 or 16 people trying to be taken care of by one healthcare aid, one PSW.

And I could tell you, I can speak personally. I have a father-in-law that right now is going through dementia, and he should be in a home. And me dealing with all these homes and being involved in this industry, and I appreciate

everything our members do because they're phenomenal workers. Yeah, they're underpaid, but yet they go work and make sure they take care of those residents the way they're supposed to be taken care of. They give them dignity. They give them dignity to be able to live in those facilities and take care of them.

But when we're working this short, it doesn't happen. They can't do it. We've got four of us in our family, and it's so hard.

So now, not only do I know they're heros, they save our lives; they save our family [sic] lives. So whatever you guys do, I plead with you. You have to do everything possible to give them the tools and the ability to be able to perform their work and be able to save these lives.

And, you know, how do we get them back into the thing, and Nancy and Andy and Katha talked about it. What people tell us is, give us the proper tools; give us the PPE that we need. Give us the staff to be able for us to effectively do our job without cutting corners.

And also what they're looking for is that, we want to be valued. And how do we get value? We get appreciated. You know, it's easy to

say, well, these are our heroes. They're a -- we need them and we appreciate them. But show them how you appreciate them. Give them the staff; give them the PPEs; and give them the proper pay.

You want to get staff back in these facilities? That's what you got to promise. And it's got to be shown. It can't be just words because words don't cut it because we've been sounding the alarm way before all this started.

In fact, we met with the Minister of Long-Term Care in January, I believe, if I remember the date. And we brought this up to the Minister. And they told us, yeah, we understand. We know where the problems are, and we're doing something about it. Bang, COVID hit.

COMMISSIONER FRANK MARROCCO (CHAIR): When did -- when did you realize that COVID was going to pose a threat to the long-term care? Like, when did you sort of make the connection between what -- there's this virus out there, and long-term care homes in your backyard? Like, what -- around when?

TULLIO DIPONTI: I think it was right when -- in the beginning around March, maybe the end of February when the talks started getting more

and more in regards what this pandemic was about to do. We all knew that if it hit the home, we'd be in big trouble. Because, like, again, we've been sounding the alarm for years and years. You cannot operate in the way they were operating prior to COVID because they were just barely making it, barely making the -- barely enough staff to really take care of the residents.

And now, once that came up for us, we knew we were going to be in deep trouble. We were trying to figure out a way. And why didn't these homes have a pandemic plan? Because I believe that's part of their mandate is to make sure they get a pandemic plan in place. Why were they all caught off guard? Why didn't they have enough PPEs? Is it because they didn't want to spend the money, and they wanted to make -- keep the money for themselves? Because obviously, it didn't go to the frontline staff. And --

KATHA FORTIER: I would just add to what Tullio has said. You know, we wanted to talk about Heron Terrance very specifically because quite frankly, if that hospital had not moved those residents out of that home, several more of them would have died. It will save lives. It saved

lives of the residents that they took out of the home, but it also saved -- the residents were given a choice, and some stayed in the home, and it allowed them to actually provide the type of care that not only that a resident needs under normal circumstances, but when they're positive for COVID, it actually made -- you know, if the floor had half the residents on it, that actually gave you time to feed those residents, to make sure that they were hydrated, to make sure that they were turned, to make sure that they -- you know, all of the care that they needed. We found this wasn't our only code red outbreak home in the province.

We had Carlingview Manor in Ottawa which was a disaster. They've sent in two dozen staff from a hospital that all contracted COVID. You know, there was -- the cohorting were huge issues. But what this -- what this workplace did, and what -- well, what the hospital did was really -- was unique. It was the only community that we really saw the hospital taking that sort of action, and it saved lives.

And so we're moving into the second wave. We knew -- I think Heron Terrace was our first code red outbreak.

And it was over Easter weekend, I believe, Tullio, and we were talking, and you were talking about the crisis in the home, the immediate crisis. You have staff that are testing positive for COVID. You have staff that think, I don't -- I have a -- I'm immunocompromised, or my child is immunocompromised; I can't go to work. You have people that also say, you know, I'm not going to look after your children. I'm your babysitter, but I'm not looking after your children anymore if you work in that home.

You know, there was all sorts of the complexities to this. And as Andy has raised as well with the PPE, we had huge fights for PPE. We've had a significant win on Directive 5 which we think will better protect our members in long-term care.

But quite frankly, you know, we need to make sure that that translates to the ground because we already know for-profit employers in particular are saying, well, we can't provide that level of PPE. That's just not going to happen. So it's going to be a continual fight. But I can tell you that the solution of waiting weeks, of having the army go in, of having a hospital take over

administration, these are -- these are too slow. We -- if there's code red outbreaks in these homes, severe outbreaks, they need to take the residents and put them in hospitals.

COMMISSIONER FRANK MARROCCO (CHAIR): Go ahead, Commissioner.

COMMISSIONER JACK KITTS: Just, Tullio, were the patients from the -- or the residents from the long-term care home admitted as patients in the hospital, or were they admitted to the tent?

TULLIO DIPONTI: They were admitted as patients in that field hospital.

COMMISSIONER JACK KITTS: In the field hospital?

TULLIO DIPONTI: In the field hospital.

COMMISSIONER JACK KITTS: Is that field -- is that field hospital still standing today?

TULLIO DIPONTI: Yes, they did not dismantle it because, obviously, we all know that the possibility of a second wave is real, real. And so if it does happen in the City of Windsor, there's that opportunity to -- for them to help us out.

I just -- I want to add on, and not

only did the -- they also brought some of our PSWs, like Katha said, because they become some of these residents' families, and they're comfortable seeing that familiar face. They were able to bring some of those PSWs to that field hospital to help out.

And Katha is absolutely right. If we did not have that field hospital in Windsor specifically for that home, it wouldn't have been just one death. It would have been at least 25 deaths. And again, that saved a lot of -- a lot of those residents' lives. And we -- hopefully the rest of the communities do it.

Again, I've got to give kudos to that CEO of that hospital. He took it serious. He knew exactly how to try to help. And he said, he talked to me specifically, he says, Tullio, we can't just stand around and talk about it. We've got to do something about it. And I think that's why we're here today. We need to do something about it because we can't go back to that.

COMMISSIONER FRANK MARROCCO (CHAIR): How long did it take to turn that building into a field hospital? Do you have any idea?

TULLIO DIPONTI: I would say that it took them less than a month to get it up and

running. Obviously, they got a lot of help from the community and the government and all that. I'll tell you, though, that was a God save there, because -- and like Katha said, it was up to the residents and their family whether they wanted to go there or not. They gave them that option, but I'd say 75% of the residents that were infected went there.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. All right.

NANCY MCMURPHY: If I could just add one last comment from my perspective. I think one of the most troubling things for me that I see is that we've taken the home-like atmosphere out of these places. They've become a business more than a home.

TULLIO DIPONTI: Right.

NANCY MCMURPHY: And as I said earlier, I'm one of the lucky ones that can remember the day when I felt good about doing my job. But when we look at the aggressions that we're seeing or the violence that we're seeing, the residents that are having outbursts, so often those behaviours can be deterred by a little bit of human contact.

So if staff have the opportunity, they

could sit and have a conversation with someone that was having a rough day, that was struggling. If they could hold the hand of a resident that was passing away and didn't have a family member there with them, those are the types of personal things that make these homes, not business.

We are at the point now where we are nothing but an assembly line of care, and that's shameful. Just my last thoughts.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

TULLIO DIPONTI: Maybe I can just give you an example of what Nancy is talking about because my vice president, Shelley Smith, has been a PSW for 28 years. She works out of our local. And she always talks about a specific Mr. Jack. We'll call him Mr. Jack. Mr. Jack was a resident of her facility but didn't have no family. If he did have any family, nobody ever seen them.

Unfortunately, Mr. Jack, prior to this pandemic, this is, passed away, and Shelly, our vice president here working in that facility at that time, went out, bought Mr. Jack's suit to -- in order for him to have something to wear in that casket. And Shelley was the only one at that

funeral home that stayed with Mr. Jack.

Just think about what these people -- what these workers do for these residents. And for me, like, I talked about my father-in-law being like that. I struggle. I know there's a lot of Shelleys all over these facilities. But I know they're not -- they're always working short.

I struggle. Where do we put my father-in-law? We got great workers, but we can't -- they -- you can't -- we can't take care of these residents like we -- our members want to take care of them if we don't give them the tools. The biggest tool is the staffing and show them our appreciation by giving them the pay that they deserve, and obviously, because of the pandemic, we definitely need the PPEs.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, is -- I don't think we have any further questions. Is there -- is there anything further we need to hear?

KATHA FORTIER: I would like to just raise a couple of things, two things in particular: First of all, the -- what happened in Quebec. I talked a little bit about B.C., how they were far more proactive than Ontario was. In fact, I think

initially B.C. had far more cases than Ontario did, and did have some COVID outbreaks in long-term care homes but acted very quickly.

But I'd just like to talk a little bit about Quebec because I think we're going to draw a lot of parallels to what happened in Quebec to what happened in Ontario during the severe outbreak.

But the difference is what -- what the Quebec government did over the summer. They fast-tracked training for personal support workers, and they paid them for training, thousands of them -- I've heard as 10,000 personal support workers. They paid them $21 an hour for training. They upped the wages to $26 an hour, and everybody was guaranteed full-time work and a government pension and benefits.

So, you know, those nursing homes in Quebec are, I think, I believe we're going to see in a far better position than we are in Ontario right now. We had the great numbers in the summertime where COVID rates were low, yet we failed to act.

And I would add to that, when we met with Minister Fullerton in February, Minister Fullerton was very clear to us that she had a

staffing commission, that she knew that there was a crisis, and she knew that there was -- you know, things were -- that we needed to fix, and she had a staffing commission. Her -- their government's very own hand-picked staffing commission released their report on the Friday before the long weekend in August. I think it was July the 30th. And that report has sat on the shelf, and not one of those -- not one thing has been implemented from the government's own staffing report.

And they did talk about a minimum staffing standard. They did talk about better wages, all of the things. In fact, one of our for-profit employers was on the staffing commission, Jamie Schlegel from Schlegel, and Tullio and Nancy and Andy and I were before this panel, and Jamie Schlegel shook his head at one point and said, yeah, I guess you are right that they have to -- you know, he's got 32-bed wards or units with three personal support workers.

So it's 1 to 10, 1 to 11, 1 to 12; that's the norm. And then again, they're often working short.

So the government's ignored their own -- their own recommendations, and they've, you

know -- and I mean, I guess my other comments would be, you know, we really need to look -- and I know Nancy and Tullio said this: It's not just the personal support workers. It's the cleaners are so important that -- the activation workers, the rehabilitation workers, all of these workers, the dietary workers, everybody has to play a role in long-term care.

And, you know, I remember the outbreak at Carlingview Manor where we actually had to file complaints and go to a mediation to get PPE for those -- the workers in the home. It's a huge home, 300 beds, one of the worst outbreaks in the province. And they were down to a point where they had four cleaners going to work.

If you can imagine how four cleaners could go to work and clean a 300-bed facility in the midst of a COVID outbreak. You know, so everybody's critical. Everybody plays a role. You know, we need to make sure that this is a workforce that's sustainable, a workforce that feels respected, a workforce that, you know, feels like the system has -- cares for them because they don't feel that right now.

And, you know, this -- the solutions

are there. The solutions are the same whether they come from the Health Coalition, whether they come from unions, and even whether they come from the government's own staffing commission.

But, you know, somebody has got to take -- make the effort. I mean, we can't -- we've had a revolving door of personal support workers coming into these homes, but other people -- it's a difficult job. And you know, this is -- this is a challenge.

There's personal support workers out here that if the conditions were right, we could attract them back to working into this sector. And you know, as Nancy's raised, would you be able to implement four hours of staffing right away? No. But if you made the other changes and made a real sustained effort to get workers back, it's possible to do that. And, you know, we think -- we think the solutions are really, really important.

And again, thank you for listening. I had one more thought in my head, and I've now lost it. I don't know if Tullio or Nancy or Andy wanted to add anything?

COMMISSIONER FRANK MARROCCO (CHAIR): Well, you know, you can -- you can -- you can

certainly communicate with us after. It's not as if -- it's not as if somebody's going to reply and say, time's up. So, you know, if it occurs to you, you just pass it on and just send us a note.

KATHA FORTIER: Yeah, and we would really love to -- you know, we have workers from the homes, particularly the ones that have been in code red outbreak that would share their stories that we think that are so important, workers like Jenna (phonetic), who worked is Heron Terrace, who worked 45 days without a day off, and many of those days were 20 hours.

So, you know, there's important stories from the workers that we don't think, you know, that will allow you to do your job far better than just hearing us with -- and there's my phone again. They really want to clean my ducts today, so...

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Now, we understand that. We just have to deal with this other issue first in order to be able to receive this in the way in which the people want to give it to us. And that's what -- that's what we're trying to do, and we will do.

You were asking if there was anything from -- there's no questions on our side. If

there's nothing further from your side, then I guess we would close this for now. We might be back. We probably will be back. I want to thank you for this because it really does help us understand this problem from the perspective of people who are actually working there.

And I think it helps understand how personal a relationship there can be between the support worker and the person they're looking after which I think sometimes can get lost when you read about 60% of the people not showing up for work and so on, and it gives you a kind of -- that gives you a kind of superficial impression which your presentation and -- helps -- helps us understand a little better.

So, on behalf of our commission, thank you very much, and we'll be in touch. And then if there's anything further, I think you know how to contact us. Don't hesitate to do that.

KATHA FORTIER: Yes, thank you very much, and we appreciate your time. We'll send you some more documentation, the personal support worker report of course. And, yeah, if there's anything else we can do, we're happy to participate.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

NANCY MCMURPHY: Thank you very much.

COMMISSIONER ANGELA COKE: Thank you very much.

ANDY SAVELA: Thank you.

TULLIO DIPONTI: Thank you.

-- Adjourned at 2:30 p.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, 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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