Long-Term Care COVID-19 Commission Meeting

University Health Network (UHN)
on Wednesday, January 27, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 27th day of January, 2021, 9:00 a.m. 10:04 a.m.

REPORTED BY: Helen Martineau, CSR

C O M M I S S I O N E R S:

Frank N. Marrocco Lead Commissioner

Dr. Jack Kitts Commissioner

Angela Coke Commissioner

P R E S E N T E R S:

Joy Richards VP, Patient Experience & Chief Health Professions, University Health Network

Susy Hota Medical Director, Infection Prevention & Control (IPAC), University Health Network

Rebecca Repa Executive Vice President, Clinical Support & Performance, University Health Network

Joanne Bridle Senior Director, Environmental Services & Nutrition, University Health Network

A T T E N D E E S:

Alison Drummond	Assistant Deputy Minister Long-Term Care Commission Secretariat
Derek Lett	Policy Director Long-Term Care Commission Secretariat
Jessica Franklin	Policy Lead Long-Term Care Commission Secretariat
Angeline Hawthorn	Senior Policy Analyst Long-Term Care Commission Secretariat
Rose Bianchini	Senior Policy Analyst Long-Term Care Commission Secretariat
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Peter Gross	Commission Counsel Gowling WLGN
Kavi Savisothy	Commission Counsel Gowling WLGN

--- Upon commencing at 9:01 a.m.

LEAD COMMISSIONER FRANK MARROCCO:

Before you start, the UHN's been here before, so I'll skip the formal introductions. There is a transcript, which we post on our website, so that people can see what we're up to and we will do that in this case.

Mr. Gross, go ahead.

MR. GROSS: Okay. First of all, thank you everybody from UHN for coming to speak to us this morning and giving us your time.

And I understand that there isn't a PowerPoint, so we'll have a dialogue back and forth, and if anything I ask you is not clear, please feel free to stop me, jump in, interrupt me. I'm used to it.

Who would like to start?

MS. HOTA: It's Susy Hota here. We were thinking maybe what we could start with is I understand that the interest and the focus here is on hearing a little more about the experience with St. George Community Care and some of the contributors and some of our thoughts around there.

So I was thinking maybe I'd start with what

is -- how we synthesized the outbreak and contributors to the outbreak.

And then Joanne has some comments, I'll pass it on to her, about the environmental aspects that I think are interesting and relevant. So if that's okay, I'll get started with that.

MR. GROSS: That's fine.

MS. HOTA: Thank you.

So one of the things -- I think there are a few themes that I'd like to highlight that played a big role in how this outbreak transpired. One of them had to do with leadership and I'll start with some of the comments about the leadership, locally at St. George, that I think is important.

First of all, I think I mentioned this the last time that we met, but the leadership there is quite a young and inexperienced team. And some of that became apparent in terms of the way that they interacted with their staff.

There was a lot of, I think, work that was happening in their offices in the back rooms and less interaction with the frontline staff and so that engagement was a bit of a challenge when it came to trying to hold people accountable. And I do want to be just sensitive, but honest about some of these

experiences.

And one of the examples of this that I think may have led to some of the transmission that we saw in the outbreak had to do with their, sort of, challenges in implementing staff cohorting, which is really important. That means keeping the staff members to their floors and not having them work elsewhere.

We checked in repeatedly through the outbreaks on whether this was occurring and how well it was occurring, and were always reassured that it was. But unfortunately, it was -- the middle of January where we discovered that there was still many instances where people were working on multiple floors. So that was just one example of some of the challenges around there.

We had encountered, throughout this outbreak and even prior to the outbreak, some resistance from the local leadership to implement some of the recommendations that we've made. And even just, for example, have us bring a third party in to do HVAC assessments, which has become a standard, routine part of our, sort of, infection control assessments, the passage of assessments that we do for all of our homes.

And so that, I think, resulted in delays in actually implementing some important control measures

and revealing some of the issues that I'll speak to you around the HVAC.

There were also some challenges with leadership on the Sienna end. We did engage with one of the VPs when we, early on, recognized there was a problem with leadership and implementation of some of the measures that we thought were critical to managing the outbreak back in November, but there was really no follow-up and we didn't really get good evidence of change. And it wasn't until things really exploded with the outbreak that we saw more presence of the corporate leadership on site and also present on all of our meetings.

And then they really did kick in and I think we got some excellent resources and supports that were put into place. The corporate IPAC support that was brought in has been very helpful in managing the outbreak, as well as the CMO, Dr. Moser, from Sienna, who's really been instrumental in kind of turning the corner and providing a lot of the medical, hands-on even, support when needed at the home.

We encountered some issues around communications that I think are actually quite critical because, you know, that's one, of course, the backbones of outbreak management is having good outbreak

management team meetings and effective communication amongst the team.

They had, at Sienna, actually implemented IMT meetings or I believe it's intimate management team meetings on a regular basis. They do that daily. That's part of their usual operations through this.

We were trying to get dedicated outbreak management team meetings to occur so we could not just focus on what the data was, case counts and things like that, but also talk about control measures and, again, have an eye to the implementation and any barriers that were coming -- they were coming across and implementing the control measures so we could troubleshoot together. And it took a lot of convincing to have that happen.

And part of the problem was they felt there was too much overlap between these meetings. But what they weren't really seeing is that the IMT meetings were very focused on their KPIs and very metrics-focused. And it was really going, kind of, going through a list of, you know, audits a hundred percent and people weren't questioning how is that all of your PPE audits and your hand hygiene audits are a hundred percent compliant, but we're still facing these problems?

So there wasn't enough dialogue in those

meetings, so it took a while to overcome that, but I think that the focus on the numbers and not so much on the issues was part of what we struggled with earlier on in the outbreak.

LEAD COMMISSIONER FRANK MARROCCO: Did you form a view about why you were having -- why you were having that difficulty?

MS. HOTA: I think one of the problems was it might speak a little bit to the tension between the local leadership and the corporate leadership. And they're really -- my impression and I'm speaking about my impression, was really that the local leadership felt the Sienna leadership wanted to hear about the numbers. They wanted to hear about the metrics and how well they were doing with the metrics. And they didn't necessarily want to delve into the nitty gritty and the details of, you know, the issues around garbage cans and things like this that really are actually important in facilitating the human factor side of infection control, but they didn't feel it would interest the corporate leadership.

And so that was one of the challenges of the IMTs with having such high level representation there and so many individuals. You can't get into those little details that end up making a difference with

outbreak management.

COMMISSIONER JACK KITTS: Just a quick question, and I apologize if I missed it at the beginning, St. George had a number of outbreaks, one in the first wave, I think, in April and then a few in September and November, December, whatever.

Which -- was UHN involved in each of the outbreaks or which -- are you speaking to one particular outbreak?

MS. HOTA: I'm speaking to the most recent outbreak which was quite large and I think got some real attention because of the size of the outbreak. The attack rate in that outbreak was quite high in that the number of residents and staff members compared to the denominator was more than you would expect to see.

We did get -- we were involved in previous outbreaks there, but they were all very limited. And despite that, we did see some of these issues in earlier outbreaks and tried to resolve and overcome some of them with them. But there were these -- the issue of having resistance to change is something I would say has woven through this entire experience.

Many of these other observations only came out when we were able to get in there and provide the kind of support that we're giving now, because if you

looked at everything on the surface, if you attended meetings to discuss these problems, you would not see them.

COMMISSIONER JACK KITTS: Okay. A lot of the questions now and, the Commission has the same questions is, what did we learn from Wave 1 and did we implement it to try and mitigate Wave 2? So if you can keep that in mind, we're interested in your thoughts about things that should have been done between Wave 1 and Wave 2.

MS. HOTA: Yes. And as, I guess, a general commentary, many of the things that we speak -- I'll speak about here, we did see some the issues. We tried to address them. Quite often, your assessment only goes as deep as you're allowed to go when you're interacting with individuals at the homes.

And we were often reassured that, for example, and you'll hear from Joanne about environmental management in the home, that everything was fine. And even on our site visits, you can't see what the actual practices are unless you spend a lot of time there.

So I think that's what this experience has allowed us to see is a much deeper dig into what was actually happening on the ground.

MR. GROSS: Dr. Hota, I wonder if you might be able to just step back to the beginning a little bit and just give us, sort of, an overview of what type of homes this is, physical constraints it might have. What makes it unique as far as the demographics, if anything?

MS. HOTA: Sure. So St. George is a long-term care home. It has about 200 beds, plus or minus. And it mostly has individuals who are a little bit younger than your typical long-term care home resident, but has more mental health and addictions issues as well as people with a lot of other underlying health problems. So it's a bit of a medically complex population, but mental health and the addictions issues are quite prevalent there.

I don't know, Joy, if you wanted to say anything else about the population? I can talk about the physical plant because that was something I was going to get into next anyways.

MS. RICHARDS: No, I think you've covered it. There's 268 beds in the home of which -- under the directives of limiting the number of folks in beds is 158. So I think you've covered it.

It's a younger population. A lot of males. And addiction and mental health issues are the primary

concern that cause a lot of the noncompliance on the resident side as a result.

LEAD COMMISSIONER FRANK MARROCCO:

Before you go, and then I'll let you carry on with what you were doing, do you have a view about whether there's an optimum size? Whether there's a point where these homes are too big based on your experience?

MS. HOTA: Yeah, I guess I'll just make my comments and then I'm sure -- I'd be interested in hearing Joy and Rebecca's thoughts on this as well.

I think it depends on the population really and what the building's like. It really is dependent on those two factors.

For St. George, 268, is that correct, Joy, as the physical capacity? That would be, I think, far too much for what they can accommodate.

Joy, do you have thoughts on that?

MS. RICHARDS: Yeah, I would agree. I mean, I've worked in really large long-term care homes that have had a thousand beds and the care has been exceptional.

I think it really comes back to how the leadership and the design of each of the units are.

So in this particular case, this building

doesn't really accommodate for folks who have behavioural issues related to addiction and mental health. And a large population of smokers, for example, in this population who want to go outside and smoke.

So I'm not sure. It's a really interesting question. I'm not so sure it's about the size. It's about the leadership and the structure.

Rebecca may have some thoughts on that.

MS. REPA: Just some past life work on optimum size in redesign has said that patients prefer smaller so, you know, 40 to 80 is preferential. And when you look at how patients make their decisions around ranking their selection, they like the smaller homes. They think they'll be a bit more intimate.

The efficiency of the funding formula suggests that less than 80 doesn't really make sense in terms of an efficiency point of view.

And in order to get the best outcomes with respect to shared resources like physio, and speech pathology and rec therapy, all of which you can't afford for a 40-bed home, 200 is sort of the number that seems to maximize the allied health across in a way that gives residents access to other disciplines other than nursing care.

LEAD COMMISSIONER FRANK MARROCCO: I guess my issue was, intuitively you would think the larger the home the more institutionalized it would be. And the smaller, the more homelike it would be. And that's what was prompting my question.

MS. REPA: So we're going to talk a little bit about the regs, actually, in our conversation today.

So the regulations really do, in design of even in size of building, force you to create those homelike pods. And they're pretty consistent in terms of it isn't, sort of, a hospital-like design where you have rows of beds. Even in a 200-bed facility in past ones that I've been part of designing, they are grouped in pods and smaller groupings, so I think it's possible to do that. I don't think larger necessarily means institutional. Larger sometimes means greater access to resources.

So from my perspective, I don't know that size in this case is the issue. I think the regs probably help to make sure that that environment's maintained.

LEAD COMMISSIONER FRANK MARROCCO:

Okay, thanks.

MR. GROSS: Can I ask one follow-up question

and then I promise I will not interrupt? You mentioned that a lot of the residents tend to be younger than the average cross-section for a long-term care home and that many suffer from addictions and mental health issues.

And I'm just wondering if you have any knowledge, are the staff at that home, do they have any specialized training so that rather than just putting these people away, they can help with their addiction and their mental health problems? Such as, I know wandering is a problem. Or behavioural problems that would prevent cohorting might be exacerbated in a cross-section of residents of that nature. Is there any specialized training or do you know?

MS. RICHARDS: I can respond to that. There is not. I think that's one of the challenges. I think they have strong relationships, so they've gotten to know these residents over the years and are very committed to their care. But they do not have specialized training. The leadership doesn't have specialized training.

And there are unique needs there, for example, monitoring psychotropic medications and making sure that their medications on the psychiatric end and the addictions end are adjusted to meet their needs.

Not good assessments for that either.

So I would argue, the physicians are probably not -- they're GPs, they're not specialized.

And this home, if I had to recategorize it, I would not actually make it a long-term care home. I would actually have a mental health overlay and a different structure for this particular home.

It is very unique from other long-term care homes that we've been involved in.

LEAD COMMISSIONER FRANK MARROCCO:

Thank you. Dr. Hota, would you like to continue?

MS. HOTA: Yes. I will just make one mention of environmental services and the management of the environment, but Joanne will go on to comment on some of these really important points.

But what we did uncover relatively late into the outbreak, unfortunately, is that the quality of the environmental cleaning and disinfection in the home was not what we had been told it was or what we were -- our impression was.

And in the end, I do think a major contributor to transmission in this outbreak was that we were trying to cohort positive residents, which is the right thing to do, but in doing so, there were a

lot of bed moves, and unfortunately not appropriate terminal cleans of those spaces, so the individuals who then occupied the space were exposed. So I do think this played a big role in transmission and is unfortunate that it occurred.

We did talk a little bit about -- you asked about the design of the environment and this is another important factor. It's a very old building. It has a lot of multi-bedded rooms and the attack rate within these multi-bedded rooms was virtually 100 percent. I mean, if you shared a room with somebody who had COVID in this organization, you were likely -- you were going to get it.

It was very cluttered and it still is. We've been doing a ton of work to improve on this and I think it's in a better place now, but very cluttered environment, lots of wheelchairs and other items, even just chairs and old furniture that was in the environment that made it very difficult to clean and also to manage flow of individuals within that area. And so that was also, I think, a significant factor.

The building itself is overall in disrepair. There are some major problems that I think Joanne will speak to perhaps with the physical infrastructure.

But also the ventilation. And we did have

some difficulty getting in to have an HVAC assessment done, but it was done this month and unfortunately revealed that there was no fresh air coming into the facility.

There were some issues in terms of the dampers for the air handling units on the rooftop, the intake, and there was also some mold issues that are being explored and remediated right now. So significant concerns about the quality of the air that was in the facility.

I just have a couple of other comments in terms of staffing. You did ask about the appropriateness of the training of the staffing. I think because they had such a large outbreak, it became apparent they also just did not have the number of staff at the time or they had such acutely infected individuals within the home, it was insufficient. And that has been improved upon, but that was a concern for sure in terms of being on top of who is becoming symptomatic and the kind of surveillance needed.

And then the resident population we just talked about, but it certainly did make it difficult for us to implement some of our IPAC measures and we had to be creative around how we managed it.

And the issue of the smokers wanting to go

out for smoke breaks is actually a contributor as well because that took a lot of work to try and design to do in a safe way, given their physical set up.

So I think if it's okay with you, I'll pass it on to Joanne Bridle to say something.

LEAD COMMISSIONER FRANK MARROCCO: Can I ask one question, Dr. Hota, about the staff? Was there a designated IPAC specialist who ensured that the training and education on using the PPE was up to the speed it should be for -- particularly in the midst of an outbreak?

MS. HOTA: So they had an ADOC, an assistant director of care, who was given the title of being the IPAC lead, but unfortunately did not have any IPAC training and was asked to get training repeatedly, but it didn't happen over the course of this outbreak.

Beyond that, there was nobody else in the home that had any kind of IPAC responsibility in particular. As I mentioned, they did pull in somebody from Sienna Corporate with IPAC experience and that's been help.

LEAD COMMISSIONER FRANK MARROCCO:

Thank you.

MR. GROSS: Did you have any comments about the medical director that was in place at the time when

you arrived?

MS. HOTA: I do.

The medical director was present at the outbreak meetings, which is a good step, however, quite often disagreed with what public health and what I would recommend. And sometimes was quite adamant about certain measures being in place, certain testing criteria, sometimes questioned whether a positive result was truly a positive result.

You know, I'm open to discussions in these meetings, it's the purpose of the meeting so that everyone understands what is happening and why, however at times it was a bit disruptive and that was really the extent of my interaction with the medical director during the outbreak.

LEAD COMMISSIONER FRANK MARROCCO: If I can just -- before we move on.

I'm having some difficulty understanding why UHN would be -- having difficulty implementing its view concerning what's necessary to get the outbreak under control.

Was the local Medical Officer of Health engaged? Because they can, of course, make orders and was the Ministry's inspectors engaged? Because I think they also have authority.

MS. HOTA: Absolutely.

LEAD COMMISSIONER FRANK MARROCCO: I'm having a little difficulty understanding why you have to engage in a debate or persuasion with people who have got a real problem on their hands. Can you talk to that?

MS. HOTA: I'm happy to try and explain that.

So the local AMOH from Toronto Public Health was absolutely involved and continues to be and we've got an excellent relationship and we see things very similarly.

And the way that these IPAC hubs have been set up with long-term care homes, they lead Toronto -- Toronto Public Head leads outbreaks. We are there to provide recommendations and additional support, so UHN. But we work very collaboratively together in essentially leading outbreak management and infection control advice. Giving infection control advice.

It is up to the home to implement all of that. And the homes gave us the impression, when we would check in with them, even with site visits, that these things were underway or had been done. But until you spend the time to actually truly follow up with every detail on that, unfortunately the deficiencies were not apparent immediately.

So we found out about some of these things quite late into the outbreak. And it came right down to even doubting the numbers at one point.

In early January, they had brought in an interim executive director to help with the situation. And it became apparent as he was going through the numbers, and as things were being reconciled, that the data was not adding up completely in terms of case counts and resolved cases and how we categorized the cases within the home, which was a big eye opener to me because everything depends upon that.

We make our decisions depending upon what those numbers are. And it helps to us to understand progress through an outbreak. So we have no way of knowing that the numbers we are being told are incorrect until you really dig deep.

MR. GROSS: Were the numbers low balled in your opinion?

MS. HOTA: They were actually not off by much. It was a minor reconciliation, but to me that introduced some concern and doubt as to what all of the numbers would mean or the feedback that you get.

And it's been a real learning curve for us in terms of the importance of how much on-site presence you need to have in supporting the homes.

LEAD COMMISSIONER FRANK MARROCCO:

Commissioner Coke?

COMMISSIONER ANGELA COKE: Just following up on the question before, what was the involvement of the Ministry inspection folks? So I understand you're saying they have to do the implementation, but who else is checking that the implementation is in fact happening and what consequences if it's not?

MS. HOTA: They were present -- the Ministry of Long-term Care inspectors were present at outbreak meetings, so they would hear the updates and they would hear what's happening with the outbreak on those meetings.

Beyond that, I'm not sure, Joy, if you have any more information about their involvement.

MS. RICHARDS: They do come on site, but I actually think they're not asking the right questions. So I would have thought that they would have had a much better handle on some of the deficiencies in the environment. That they would have a much better handle on issues like falls and pressure ulcers and skin injuries that they don't really report on.

So some of the basic care issues that I would expect that usually happens when inspectors come in wasn't happening. Right down to, you know, going in to

resident washrooms and rooms to see mold and mildew and reporting those things.

So I think -- and I've had conversations with Andrew Wisdom about this. I think how the inspectors, what they ask and what they look for, I think probably could use a review.

LEAD COMMISSIONER FRANK MARROCCO: Why wouldn't -- I'm still stuck on the idea that if the acting medical officer of health is engaged and you want to do something to try and get the outbreak under control, I'm having some difficulty with why they simply wouldn't order, under the legislation, order them to do it if there's any kind of resistance.

Is there a cultural thing there about making orders? Well, maybe you can't answer. I don't want to ask you an unfair question, so but is there?

MS. HOTA: I'm not sure I can answer. I think maybe what I haven't been able to convey well enough is many of the deficiencies and the drivers in this -- what I believe are the drivers in this outbreak were fairly subtle to uncover and they occurred over time.

And my impression, maybe it's incorrect, is an order would be issued by public health if something egregious was happening that needed immediate

addressing.

But, you know, when you're dealing with a series of things that you flag and you're being told are, yes, we understand, we'll take care of that, it's -- you feel like you have to give them a chance to deal with it, perhaps. Maybe that's what it was.

And what is the threshold? That's a good question. What is the threshold for escalating it beyond that? Maybe that was -- maybe that's what the problem is, is that it's not always clear that there is a big problem in the implementation side until you see it physically yourself or you see that pattern emerge. And, you know, once we saw the pattern emerge, I think that's where things really escalated.

COMMISSIONER JACK KITTS: So can I just follow up on that? So the local public health officer does their job; they lead the outbreak. UHN does their role; they come in and they make recommendations and offer direction. The homes are tasked to execute the recommendations. And where it falls down is nobody checks to see that the recommendations or the actions have been taken.

So my question would be, and I think that's where Commissioner Marrocco is going, should someone be appointed to ensure that the recommendations are

implemented and would that be UHN?

LEAD COMMISSIONER FRANK MARROCCO:

You're nodding. You're nodding, yes. But --

MS. HOTA: I think, you know, it's been a bit of a perplexing experience, I have to say, through all this. And I've never quite been in an outbreak that's kind of progressed this way.

So I'm open to thinking about all the different ways that this could be managed differently.

And I don't know if Joy or Rebecca or anyone else has other thoughts about this.

Ultimately I'm a big believer of the folks in the home have to be accountable for implementing things in the end. Some of that accountability has to be ingrained there or else the frontline staff there are not going to feel the ownership to do things.

So that was really the model that we were trying to operate under for as long as we could.

MR. GROSS: So I just have a follow-up question and I apologize if you've answered this.

I'm trying to figure out if -- so the local medical officer knows what's going on and is involved. You have calls with the investigations unit or folks from that unit, I guess, on a daily basis.

Did investigations ever come into the home to see whether an order by them to -- an order to comply was necessary? Did anybody show up on the ground to back you up and to go check for the mold in the bathrooms, to see if there was garbage cans where they needed to be, from the Ministry?

MS. HOTA: From the Ministry? I don't think so. I think they're there now. Is that correct, Joy?

MS. RICHARDS: That's correct. There's an advisor on site now for two weeks.

But we were having conversations. We met weekly with Ministry and public health and UHN to talk about all of the homes and we did raise this, but to my knowledge, there was no one on the ground during this timeframe actually following up.

MR. GROSS: And does that surprise you?

MS. RICHARDS: No.

MR. GROSS: Why not?

MS. RICHARDS: Well, I think to speak to the broader culture in long-term care, there is a sense, particularly in some of these smaller homes or homes that are under corporate management, that they don't want people poking around.

And so they say what you want -- what they think you want to hear and they don't want external

people coming in. They manage under a bit of a cone of silence and there's a lack of a sense of urgency.

I think the thing that always struck me with St. George is that we were really, really concerned and we couldn't somehow get the leadership on the ground or corporate leadership, because before the voluntary management order, we did escalate up through the senior team that there was sort of a lack of urgency across all of the leadership, both locally and at the corporate level, that this was a big problem.

So I think it's not unique to St. George. I think it's a culture in long-term care where it is a homelike environment, there isn't the same knowledge base, particularly on the clinical side, around some of these medical assessments and care assessments that need to be done. So I do think it's a broader cultural issue in long-term care.

LEAD COMMISSIONER FRANK MARROCCO:

It's a strange thing, though, because in your own home if you have -- if you think there's a mouse in the house, you turn the place upside down trying to get rid of it, let alone a virus that's capable of killing people.

I don't know what lengths you would go to in your own home if you thought that that was the case.

It's not just -- it's not just confusing or perplexing to UHN, it's perplexing to us.

But anyway, I'll let you carry on.

MS. RICHARDS: I'll just make one last comment.

LEAD COMMISSIONER FRANK MARROCCO: I don't understand it myself.

MS. RICHARDS: Yeah, I think part of it is what Susy talked about before is the inexperienced and young leadership team on the ground. I actually do believe they were, quite early on, overwhelmed and their way of coping was just to kind of pretend it wasn't there. So I do think leadership plays a key role, as we talked about at the beginning of our discussion.

COMMISSIONER JACK KITTS: And just to confirm, nobody from corporate came to the rescue until much later and even then needed to be coaxed when UHN was in there?

MS. RICHARDS: Correct.

MS. HOTA: Correct. And fairly early on, we did engage in ongoing discussions with a VP in corporate because we were concerned about some of the leadership issues, but I did not see more on-site presence or presence at outbreak meetings until much

later.

COMMISSIONER JACK KITTS: So that coincides with the culture of secrecy and lack of urgency?

MS. RICHARDS: Correct.

MR. GROSS: And I take it, you were -- it was well-known that they, as a home, were classified as high risk for an outbreak since May?

MS. HOTA: Yes.

MR. GROSS: And inspections never showed up, to your knowledge?

MS. HOTA: I was unaware of any.

MR. GROSS: So I wonder if -- there's a lot of probably interest in what Joanne has to say.

Is there anything else, Dr. Hota, that you'd like to say?

MS. HOTA: I'm all done.

MR. GROSS: Okay. Joanne, what can you tell us?

MS. BRIDLE: Thanks. I see there's an interest in environmental services.

MR. GROSS: There is. I think there's great interest.

MS. BRIDLE: Thank you.

To echo the themes that Susy and Joy both brought forward, I do believe that those themes of

resistance and this culture of keeping outsiders away and uninformed, and gaps in communication and junior leadership all are huge contributing factors, not only in this outbreak, but the foundation that set the ball in motion when we came on site in December during this large outbreak.

Prior to the outbreak in May, and again in October, my team and I did try to go on site and complete the environmental portion of the IPAC check list and faced an awful lot of resistance from the on-site leader at that time.

We were able -- some of my team were able to go on site for very brief visits that were very tightly controlled.

As I reflect, I believe had we had more opportunity and more willingness and collaboration, some of the underlying gaps in the environmental services program may have been resolved before the outbreak and perhaps may have helped eliminate some of the contributing factors.

Environmental services is a really crucial piece of the IPAC measures and operationalizing those IPAC measures. And on-site was a true gap between the IPAC directives and operationalizing those.

So when we came on site, realized that there

was some really apparent gaps that were contributing, and I'll go through a few of those.

The first -- from where I sit, my concern is that these are all quite simple things and also go back to some of the junior leadership and inexperience, unfortunately.

Before I go into them, though, I will say and I do need to say, that the team that are on site for environmental services, as well as senior director we're working with now on site for Sienna, have been very responsive. So as we've brought these concerns forward, as we've brought them forward, they have been very open to helping us get things done. It's unfortunate that we weren't in that position prior.

So one of the things is proper selection of a disinfectant for an outbreak. When we went on site, I was told that the disinfectant in use had a one-minute kill time; observed that the disinfectant was not being used and applied properly. And as soon as I saw the disinfectant, realized it's actually a product that has a five-minute kill time. Surfaces were wet, I observed, for about 30 seconds. And that was the product being generally used to disinfect all fomites in the organization.

So raised that concern immediately. They

switched to a product with a one-minute kill time. We trained all of the home staff and the agency staff on proper application of the disinfectant to ensure that any bacteria and viruses on the surface would be killed within one minute.

MR. GROSS: And just to be clear, they had the disinfectant in stock --

MS. BRIDLE: Absolutely.

MR. GROSS: -- is that correct? They just weren't using it.

MS. BRIDLE: Correct. Storeroom full of all kinds of things.

So, you know, I don't want to speculate as to why they were not using the right product, but it's unfortunate. And when I explained why we needed to use it, how to use it, it was no problem, we made that transition in one day.

And then it was reinforcing it with the staff to ensure that the application was saturated properly so that the disinfectant would work.

One of the other immediate observations is that the staffing levels were quite low. On a routine basis prior to the outbreak in the home, and there's five floors in the home and there are 21 or 22 beds on each floor with 40 to 41 residents, and the prior

staffing levels was one housekeeper per day per floor, which is not sufficient to meet HYDAC best practices by any means to properly clean each room, as well as the common areas, the nursing station, dining areas, on that floor.

When we went on site, that one housekeeper was on per day as well as an agency person doing high touch cleaning on each floor, raised that concern. And the contractor, Marquis, did begin to bring in extra agency staff after they were swabbed. Within a few days, those staff were on site so we could train them and ensure that the rooms were being properly cleaned.

Through that process, it was also quite apparent that the staff that were on site also needed training. I was continually and unfortunately told that the staff were trained and knew what they were doing, but it was quite apparent by observation that that was not the case. So we've been able to work that forward and ensure proper training is in place. That's still a work in progress.

But to Susy's point, I think we both share the concern that the lack of proper terminal cleaning, with all of the bed moves, is a factor in the spread of this outbreak.

The level of cleanliness across the building

was very low. At the same time, as Susy alluded to, the daily IMT meetings, or Incident Management Meetings, reflected really strong environmental audit scores.

So they were doing glo germ audits, so fluorescent marker audits on surfaces, five to ten audits a day, and those scores, most days, tended to be in the 80s or 90s, which would indicate that touch surfaces were being wiped. However, there were no audits being done of the actual cleanliness and a full audit of the space.

Because of the high amount of clutter in the building, the staff were unable and uninterested to move all of this extra furniture, all of this extra clutter and boxes to properly clean areas, so that's been a huge focus of the team.

The housekeeping carts were dirty, the brooms were broken, their micro fibre was worn out, so they also didn't have the tools to be able to clean properly. So we've been able to get some of that changed as well.

As Susy mentioned, the leadership team as a whole are quite young and inexperienced and environmental services is no different. So certainly no disservice to the folks, but the supervisor on site,

and this is her first job out of college so it's great that she does have the two-year college program for environmental management, and she reports to the environmental service manager for the home who is Sienna. So you've got two different contract groups looking after environmental management in the home.

So there's a bit of a disconnect there and there's also some concerns about gaps in the scope between who does what between Marquis and Seinna.

There has been some mention of the regs. And one of the concerns that I have is the regs really, from an environmental are the other accommodation envelope manager, being environmental services, laundry and maintenance, that individual is to have completed two years of post-secondary education and have two years of supervision.

There's no requirement for that individual to have any training in environmental services management or maintenance management.

In 92 of the regs, I do see that as a gap, particularly in contrast to dietary, where the dietary manager is to be a registered dietician or have their CS&M.

Those frontline staff in dietary need to have completed their food handler. There's no requirement

for the frontline environmental services staff to have any training.

And so to have frontline staff that don't have proper training, to have managers who don't have any credentials in the field, I'm concerned that sets the provincially long-term care for failure.

MR. GROSS: Joanne, am I correct that when you arrived, the IPAC lead had no training whatsoever in IPAC? Is that correct or am I misstating that?

MS. BRIDLE: Yes, that is true. So there was a corporate resource from Sienna that was on site and that corporate resource does have IPAC training. And at the point that I arrived on site, our UHN IPAC lead for LTC had been on site as well.

LEAD COMMISSIONER FRANK MARROCCO: We've heard this before. Is there some reason why there would be a person in charge of IPAC who doesn't know anything about IPAC? Is there a shortage of these people? Why?

MS. HOTA: I think that's part of the problem. So there aren't people with IPAC training who are waiting in the wings for a job. It's -- there is a shortage of individuals who are already trained and have experience in the field to hire.

But I think the problem here was, you know,

the individual who's assigned this was asked to get specific IPAC training and did not carry through. And they're just -- I think it speaks to a lack of accountability because that was not managed. So that was part of the problem.

LEAD COMMISSIONER FRANK MARROCCO: So in addition to whatever inspection and follow up the Ministry is undertaking, the corporate ownership is not following up either. Otherwise they would have realized that the IPAC person who was supposed to get some training had not taken the initiative to actually get the training.

MS. RICHARDS: Well, the IPAC part of the role is added to an assistant director of care role. And so it's a bit of an off-the-side-of-the-desk.

So if you were to ask that person, she would have seen herself as the associate director of care, assistant director of care and, on the side, IPAC.

So we had been pushing in November for this person to get trained up. But I think the gap in the system is that there needs to be dedicated IPAC -- a role specific to IPAC in each of these homes, not an add on to other clinical or environmental roles.

MS. BRIDLE: And the other piece of that that I see as a disconnect because it really is a chain and

we need to break the chain of transmission with infection. Even if there was an on-site IPAC person, that person needs to be linked very closely with the environmental services management team to operationalize those directives. What we have seen, unfortunately, is a lot of time in the office by IPAC people trying to fix line lists.

So our UHN IPAC lead has been very instrumental in working with me and then I leading the on-site environmental team to be able to get proper operational practices in place under direction of IPAC. But if we sit back and look at it, it feels quite broken had we not been there.

One of the other things that feels concerning is the -- is really the staffing levels and being able to meet a level of cleanliness and standard.

As you know, the regs don't outline a standard for cleanliness in acute care. Our goal and our direction is to follow the PIDEP best practices. And we use those as our standard and requirement for cleaning. There is no such requirements in long-term care, so unfortunately it feels that there isn't as much of a focus on cleanliness and proper disinfection and infection control practices in long-term care. And consequently, the staffing levels, because they are

also not outlined in the regs, suffer. That other accommodation envelope tends to get broken up into many different ways.

If we were to contrast that to dietary, the dietary regs are very clear, and there's five or six pages if you're to print it off in the regs for dietary, that clearly outline the expectations around how you manage a food service operation. How you manage hydration in a long-term care home.

And so the dietician hours are a formula based on the number of residents in the home. Thirty minutes per resident per month. The dietary manager calculations are also very clear as well as the credentials that I've mentioned.

The frontline dietary staffing levels are also very clear. They are a formula. And what is in and out of that formula is quite clear. That time is only focused on resident food production service.

If you contrast that to a very small section in the regs around housekeeping, there are no standards around staffing levels. The home's expected to have practices and processes documented around cleaning and that's it. There's no standard for staffing levels. And there's no such standard for what those cleaning levels should be.

So I'm concerned that the regs set an underlying framework to the situation we've walked into.

MR. GROSS: I think Rebecca has been waiting patiently and I think she probably has some valuable information for us.

May I turn to you, Rebecca?

MS. REPA: Of course. And I think when we came before, I think we were -- we wanted to leave a message about long-term care as part of a bigger system. And I think in the conversation today, we really want, I think, to leave a message about thinking about the regs as a lever for change.

And I think one of the pieces that I think is also a contributing factor, and that's in the regs, and in fact UHN is building a new long-term care home, and we're at the state of which we are going to working drawings.

And the Ministry standards, as you all are aware, the funding model and how design and staffing is done is well embedded in a funding model.

And in the design model, the design specs for Ministry of Health, Long-term Care are shared rooms. And I think in all of our experiences, and we've had a few conversations offline to think this one through,

that it's the shared room, not necessarily the shared washroom, but the shared room that I think people feel contribute towards the -- this infection and IPAC standard and across the long-term care home.

And we're worried a little bit that -- and I don't think the Ministry -- we've been told that the Ministry doesn't have any plan at this point to change those building designs.

And so unless we have a way of -- there's probably two sides of this. Unless we have a way of either informing the design regs, we're going to continue to create facilities with shared double occupancy. And that will certainly be an improvement over those homes that are right now 3-bed or 4-bed rooms.

But the flip side is if we go into outbreak -- and as you also know there is a threshold for occupancy that is long-term care homes have to meet for their funding. And so the flip side is that if we do create semis in buildings going forward, then we have to be prepared to think about the fact that when we do get into outbreak and we use best practices, that those semis have to become private, and then therefore the threshold number of occupancy will drop during that time and homes can't be penalized for it because then

they won't do the right thing.

And so somehow the regs, the funding formula and human behaviour, I think, are all sort of interwoven.

And I think housekeeping presents a really interesting example because they aren't spoken to in detail in the regs and then you can see how it's become almost the primary contributing to what we're seeing.

So I think, you know, our key messages are that we think the regs can be a way forward. And we would -- we would like some consideration around how, if not in the regs, then in the application of how residents and outbreaks are treated in homes in the funding formula would be balanced off to deal with that.

I think it is going to be a hard decision around planning decisions around single bed, even single bed shared washroom designs, because I think clearly the private pay for semi-private and private is a key factor in how homes are funded.

And so I don't think we have the answers, but I think we have a sense of what those levers are.

And we did have a sort of a fulsome conversation. I think what has been really obvious for us, and we've done this in our acute care world for

quite some time, is that it's pretty natural for the people on the screen today to have come together to talk about this always.

When we jump into -- when we jump into an infection problem in the world that we had, it didn't take us long to get this group together, almost instantly, to look at how things could be resolved. I think that system, again, doesn't exist in long-term care. And so they don't have that depth to be able to pull quickly from and I think that's the message that we wanted to leave last time, but I still think is an important one to embed in this conversation.

And I would just ask my colleagues whether we missed anything that we wanted to make sure that we kind of thematically left with the group today? Maybe to Joy or Susy or Joanne?

MS. RICHARDS: Joanne, I was just wondering, is there anything else in some of our learnings in the environmental services around laundry and others that you may want to just flag for the Commissioners?

MS. BRIDLE: Absolutely, thank you, Joy.

So we did also recognize immediately there was some big concerns with laundry on site. Laundry was going upstairs wet and we were getting that reported from multiple floors. And upon investigation,

it was apparent that the laundry room was quite overwhelmed. So we made some changes to what was being washed and what was being used as disposable, isolation gowns being one example. And quickly went through and did some process change.

In terms of infection control, the biggest concern was throughout this outbreak, the home was continuing to use the laundry chute to get laundry from the fifth floor and each floor down to the laundry room. The chute door was left open and staff were working directly adjacent to that door. And, you know, I'm unable to attribute as to if that was part of the challenge, but staff in that work area were COVID positive. So had to make some very quick changes. Moved the laundry to soluble bags so that it would come down -- the laundry would come down the chute in a sealed bag that would then go directly into the washer to try to improve some of the infection control practices around laundry and linen.

And we are in the midst of getting the chute out of use and considering other options because there is also cross over clean and soiled in that area.

COMMISSIONER JACK KITTS: Can I just come back to Rebecca's comments on design?

I think -- so hospitals are -- new hospitals

are being built with single rooms and single washrooms. And I think we would all agree that is the ideal for long-term care. And if we're going to treat our elders like ourselves, that would be a bold change and a recommendation that would really do a lot to help them in times of outbreak.

We've also heard about the isolation and the human contact. So at most, I think you said, Rebecca, we could allow two bedrooms or semi-private, but they would have to be designed be able to cocoon them really in the midst of an outbreak, so you really have two smaller rooms within that larger two-bed room.

MS. REPA: So in one of our long-term care homes, we actually have something called a semi where it's two private rooms that share a bathroom. And in our conversations in preparing for today, we talked about -- we believe that's a better situation than two people sharing a room and a bathroom. And we believe that because of the number of touch points in the room.

We also know from a patient experience, patients and families perceive a single room with a shared bathroom differently than a shared room and a shared bathroom.

There seems to be -- and what we're worried for sure about is in order to make a design achievable

from the funding formula, you need to be able to follow the regs. We couldn't afford to make a single -- an entirely single room, single washroom.

And as you know, people wait on wait lists for rooms. And they're not waiting long for privates. They're waiting longer for ones that are semis and certainly ward is the longest wait list because people can't afford the premiums associated with it.

So when you design the home, you weight the privates to the semi-privates based on what the funding model will get you.

And so the preferred for sure would be to do a private room, private washroom, even a private room shared washroom. But there wouldn't be enough people waiting in the list that could afford that.

So much like in hospital, and I know you'll appreciate when things go to single room and single washrooms, we lose on preferred accommodation, but we also know that it's the right thing to do and we have a bit more buffer than the long-term care does to absorb that loss. That same situation plays out in the design of long-term care.

And I think the gold standard would be single room, single washroom. I'll let Susy weigh in on the single room shared washroom, double room shared

washroom debate. We have had that. It's certainly better than what exists in many of the C homes today.

So the question is, would you bring the C homes up to a standard that doesn't meet today, or would you bring them right up to a today's standard? And when the regs were rewritten in the early 2000s, that's basically what it was doing.

Susy, the comment about single room shared washroom, double room shared washroom.

MS. HOTA: Yeah, I think I agree with you in terms of the hierarchy of what we would prefer from an infection control perspective. The best, of course, would be single rooms with their own dedicated washrooms, that would be ideal. But if that's not available, separating people and being able to isolate in place is really critical, so having the two single rooms and having a shared washroom. You can always bring in bedside commodes or things like that if you need to separate out the toileting.

So I think it would make a big difference from the infection control perspective and from our experience at St. George that I described where roommate transmission was incredibly common.

COMMISSIONER JACK KITTS: So there are three levels of escalation or deescalation. The ideal to --

I'm trying to get the ceiling and I think I'm hearing that no more 3-bed or 4-bed rooms, regardless.

MS. HOTA: Right.

COMMISSIONER JACK KITTS: And the worst case would be two in a room, but the ability to isolate them in times of outbreak.

MS. REPA: I think it's two -- so the way our semis work in our current long-term care home that we have is two separate rooms with a washroom in between and that's called a semi.

In our new build, the semis actually going to be a washroom with two people in a room. And that's less desirable from a patient experience perspective and an IPAC perspective. But unless the regs were to change to help guide that, it's not affordable to do it the other way.

COMMISSIONER JACK KITTS: So you're. building the third most desirable model.

MS. REPA: That's correct.

COMMISSIONER JACK KITTS: And that's because of the regulations.

MS. REPA: That's because that's what the regulations will fund. So the funding, you get a premium to build as part of the capital submission, and that's basically what it will fund.

COMMISSIONER JACK KITTS: Okay, thank you.

LEAD COMMISSIONER FRANK MARROCCO:

Well, I think, Mr. Gross, is that it?

MR. GROSS: Mr. Commissioner, I believe it is, unless the Commissioners have any follow-up questions? I don't.

I certainly want to express my thanks on behalf of commission counsel for those of you that spent your time preparing for this and attending and for those that are simply watching, thank you for coming this morning.

LEAD COMMISSIONER FRANK MARROCCO:

Well, assuming the other Commissioners don't have any further questions, thank you for this. This is very helpful from our perspective.

I don't think we quite appreciated, for example, the extent to which the existing regulations will dictate the type of structure that's constructed, regardless.

And it does make sense that money will influence behaviour, so thank you for bringing that to our attention.

The other issues that you encounter in trying to resolve the outbreak we continue to wrestle with

because I think we're probably more the command and control model rather than endless negotiations.

I won't say much more than that because I can't presume to speak for the other Commissioners or to say we've reached a conclusion on that, but, as you may have gathered from the questions, some of us are more into issuing orders than debate.

But in any event, thank you very much for your time and thank you for what you're doing.

COMMISSIONER JACK KITTS: Yes, thank you very much.

COMMISSIONER ANGELA COKE: Thank you. Very helpful.

--- Meeting ended at 10:04 a.m.

REPORTER'S CERTIFICATE

I, HELEN MARTINEAU, CSR, Certified Shorthand Reporter, certify;

That the foregoing meeting was taken before me at the time and date therein set forth;

All discussions had by the participants were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and accurate transcript of my shorthand notes so taken. Dated this 27th day of January, 2021.

PER: HELEN MARTINEAU

CERTIFIED SHORTHAND REPORTER.

C L A R I F I C A T I O N S:

p. 35 line 2	"PIDAC" not "HYDAC". (Provincial Infectious Diseases Advisory Committee).
p. 37 line 23	"CSNM" not "CS&M". (Canadian Society of Nutrition Management)
p. 40 line 19	"PIDAC" not "PIDEP". (Provincial Infectious Diseases Advisory Committee)

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