Long Term Care Covid-19 Commission Mtg.

The Ontario Association of Speech-Language Pathologists & Audiologists OSLA
on Friday, December 4, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 4th day of December, 2020, 11:00 a.m. to 12:00 p.m.

BEFORE:

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

1 PRESENTERS:
2 Ashwini Namasivayam-MacDonald, Assistant Professor
3 McMaster University
4 Patty Matsuo, OSLA Past-President, Speech-Language
5 Pathologist and Clinical Informatician, Trillium
6 Health Partners
7 Natalie Beechey, Speech-Language Pathologist,
8 Clinical Resource Support CBI Home Health
9 Olivia Petric, Speech-Language Pathologist Veterans
10 Centre, Sunnybrook Health Sciences Centre
11 Teresa Valenzano, Research Manager and
12 Speech-Language Pathologist Unity Health Toronto
13 Kelly Murray, CEO, The Ontario Association of
14 Speech-Language Pathologists and Audiologists
15 (OSLA)
16 Rex Banks, Director, Hearing Health/Audiologist,
17 Canadian Hearing Services (CHS)
18 Jennifer Wong, Professional Leader and
19 Speech-Language Pathologist, Sunnybrook Health
20 Sciences Centre and Sunnybrook Veterans Centre
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1 PARTICIPANTS:
2
3 Alison Drummond, Assistant Deputy Minister,
4 Long-Term Care Commission Secretariat
5 Ida Bianchi, Counsel, Long-Term Care Commission
6 Secretariat
7 Dawn PalinRokosh, Director, Operations, Long-Term
8 Care Commission Secretariat
9 Sanjay Bahal, Team Lead for Operations, LTCC
10 Derek Lett, Policy Director, Long-Term Care
11 Commission Secretariat
12 Kate McGrann, Counsel, Long-Term Care Commission
13 Secretariat
14 John Callaghan, Counsel, Long-Term Care Commission
15 Secretariat
16 Lynn Mahoney, Counsel, Long-Term Care Commission
17 Secretariat
18 Adriana Diaz, Senior Policy, Long-Term Care
19 Commission Secretariat
20
21 ALSO PRESENT:
22
23 Janet Belma, Stenographer/Transcriptionist
24
25

1 I N D E X
2
3 **The following list of undertakings, advisements
4 and refusals is meant as a guide only for the
5 assistance of counsel and no other purpose**
6
7 INDEX OF UNDERTAKINGS
8 The questions/requests undertaken are noted by U/T
9 and appear on the following pages: 53
10
11 INDEX OF ADVISEMENTS
12 The questions/requests taken under advisement are
13 noted by U/A and appear on the following pages:
14 None
15
16 INDEX OF REFUSALS
17 The questions/requests refused are noted by R/F and
18 appear on the following pages: None
19
20
21
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1 -- Upon commencing at 11:00 a.m.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Well, the Commissioners are here. I'm
4 Frank Marrocco. There's Commissioner Angela Coke,
5 and Commissioner Dr. Jack Kitts.
6 COMMISSIONER JACK KITTS: Good morning.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 So -- and we have a court reporter here, Janet, who
9 will create a transcript which we will eventually
10 post on our website so that people who are
11 interested can follow along with what we're doing.
12 We tend to ask questions as we go
13 along, if that's okay, so that -- rather than
14 trying to go back. So please don't think it's rude
15 if we, sort of, stop you in mid-sentence and ask a
16 question.
17 Unless you're waiting for someone, then
18 we are ready to go, so...
19 KELLY MURRAY: Is Rex here? I'm trying
20 to --
21 COMMISSIONER FRANK MARROCCO (CHAIR): I
22 think so.
23 PATTY MATSUO: Yes, Rex is there.
24 KELLY MURRAY: Yeah, I can see Rex is
25 here.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Mr. Banks?
3 REX BANKS: I'm here, yes.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 How do you do?
6 PATTY MATSUO: Okay.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Well, then, go ahead.
9 PATTY MATSUO: Okay. That's great.
10 Thanks very much to the Commission for having us
11 today. My name is Patty Matsuo. I am a
12 speech-language pathologist and past president of
13 OSLA, and I'll be doing a bulk of this presentation
14 today, but, certainly, will be referring to my
15 colleagues to chime in with examples and to answer
16 the questions that we're anticipating today.
17 So just so that you are aware, we're
18 represented by clinicians who work in long-term
19 care, and they work as service providers through
20 the LHIN, clinicians who work in complex continuing
21 care, and clinicians who are service providers as
22 private practice clinicians and researchers in
23 long-term care.
24 I'm going to share my screen.
25 COMMISSIONER FRANK MARROCCO (CHAIR): I

1 can see -- I can see it.
2 PATTY MATSUO: So I'll just bring that
3 up for you --
4 COMMISSIONER FRANK MARROCCO (CHAIR): I
5 think -- can the other Commissioners see it? Yeah,
6 I think -- I think we all can.
7 COMMISSIONER JACK KITTS: Yes. Yeah.
8 PATTY MATSUO: Okay. Wonderful. Okay.
9 So today, we're here to let you know that we
10 support the work of the Commission, and in our
11 presentation, we will give a bit of background on
12 The Ontario Association of Speech-Language
13 Pathologists and Audiologists and the role of
14 speech-language pathologists and audiologists in
15 long-term care in particular.
16 We wanted to share with you the
17 recommendation we put forth in response to the
18 Canadian Armed Services -- Canadian Armed Forces
19 report. We wanted to let you know we are aware of
20 the Commission's recommendations and actions taken
21 in response to the long-term care crisis by
22 government and where we see that there is an
23 opportunity for OSLA to help.
24 And we wanted to couch the discussion
25 against the backdrop of how professional services

1 are currently being offered in long-term care, and,
2 finally, wanted to share with you our thoughts on
3 how we could potentially help.
4 So who is OSLA? We are speech-language
5 pathologists and audiologists who are regulated,
6 and we play an important role in working with aging
7 populations. We work in the prevention,
8 identification, evaluation, treatment, and
9 management of communication, swallowing, hearing
10 and balance disorders.
11 With respect to communication, this
12 means the ability to speak, not only to articulate
13 words, but to be able to come up with the right
14 words and string them together including the
15 ability to logically formulate thoughts to engage
16 in conversation and information exchange.
17 It also includes understanding and
18 reading and writing. The most recent stats
19 identify that 1 in 6 of the general population have
20 a communication impairment. In long-term care,
21 there's -- it's far more prevalent.
22 With swallowing, 59% of the long-term
23 care residents have some degree of swallowing
24 difficulty that can lead to dehydration,
25 malnutrition, and serious health complications

1 including death if not appropriately managed.
2 With respect to hearing, almost 100%
3 have hearing impairment, and what's really
4 interesting about hearing impairment specifically
5 is that reported hearing impairment is
6 substantially less than actual. One study showed
7 that 93% of the population aged 70 to 79 have
8 hearing loss, but only 19% indicated that they had
9 hearing impairment.
10 And speaking of hearing, most people
11 are unaware that hearing and balance are linked.
12 Our balance centre is located in our ears;
13 therefore, even a mild degree of hearing loss
14 triples the risk of accidental falls, and this risk
15 is increased by 140% by each 10 decibel increase in
16 hearing loss.
17 So with all that's happening in
18 long-term care, we felt that there was a role for
19 our professions to improve not only care for the
20 residents but also to make a positive difference
21 for those who are providing the care.
22 This is work that embodies the --
23 embodied the vision of OSLA when Ontarians in
24 long-term care are so challenged at this time.
25 So in response to the Canadian Armed

1 Forces report, these were our recommendations, and
2 it was clear that the -- that COVID didn't cause
3 the problems in long-term care, but COVID did
4 reveal them. And I think we've heard that several
5 times.
6 Our report was sent to you previously
7 that expanded upon these five recommendations, but
8 I'm happy to go through each of the recommendations
9 at this time if that will be helpful, or I can just
10 provide examples in the context of COVID that
11 amplify the need for these recommendations.
12 So with --
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 We're probably all familiar with your report, if
15 that helps.
16 PATTY MATSUO: Okay. So maybe what
17 I'll do is try and just lay some contextual
18 scenarios or examples associated with the
19 recommendations. Would that be okay? All right.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Certainly, and I didn't mean to interfere with the
22 way you wanted to present it. I was just letting
23 you know that.
24 PATTY MATSUO: Yeah. Yeah. No,
25 that's --

1 COMMISSIONER JACK KITTS: What might --
2 yeah, what might be helpful for us is what is the
3 current practice in long-term care homes with this
4 Association, and what would the future look like if
5 you were to make recommendations for us?
6 KELLY MURRAY: I can take that one if
7 you want.
8 PATTY MATSUO: Sure, Kelly.
9 KELLY MURRAY: Or did you want to take
10 it?
11 PATTY MATSUO: No. Go ahead, Kelly.
12 KELLY MURRAY: Okay. I think at the
13 end of the day, you know, we agree with your
14 recommendation to swiftly implement the staffing
15 study. But that current backdrop of long-term care
16 is that, while speech-language pathology is
17 enshrined in the Act, it's not actually accessible
18 very much through long-term care. We have -- it's,
19 like, .2% of speech-language pathology is delivered
20 in long-term care against the backdrop of those
21 extremely prevalent numbers that Patty went
22 through.
23 So given that it's, you know, important
24 and it's prevalent and it's not being delivered, we
25 would really be looking for your support in real

1 access to these services in long-term care.
2 So I think your support with the
3 Ministry of Long-Term Care would be -- would be
4 helpful, and that access probably could be more
5 realized if there was screening in homes as a
6 requirement, and then also if audiology was also
7 enshrined in the Act as a required service.
8 PATTY MATSUO: So --
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 What's the barrier to participation now from your
11 perspective? How does it express itself?
12 PATTY MATSUO: I'll take that question.
13 So building on what Kelly had said around that
14 .2 stat, so in 2018, 2019, .2 of long-term care
15 residents actually receive speech-language
16 pathology services. Yet we said, you know, 100% of
17 them have some degree of communication impairment,
18 and 59% have swallowing issues, but yet .2 receive
19 services.
20 And that's largely because the way
21 services are accessed for SLP is that it's an
22 individual referral for service, and so an
23 individual is referred to a speech-language
24 pathologist through, probably, a private contracted
25 agency through the LHIN, then comes in, gets 1, 2,

1 maybe 3; it's probably closer to 1 or 2 visits, and
2 that's it.
3 What we're seeing as a gap is in the
4 training of staff who are there 24/7 to identify
5 issues and to manage these chronic problems safely,
6 the feeding problems, engage the residents
7 optimally in activities and day-to-day
8 communications that support their care.
9 The opportunity to pull these
10 individuals, these regulated, knowledgeable
11 practitioners -- and it's not just speech-language
12 pathologists; it's all -- it's -- there are other
13 allied health professionals -- to come in and
14 advise on programming, advise on environmental
15 layout, advise on quality assurance programs,
16 standards of care, and really help to establish
17 practices within the homes to meet the needs of
18 those residents. And that piece, that access piece
19 in that regard and that more consultative model, we
20 don't see that happening.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Can I -- I'm just trying to understand what -- you
23 could go into the home if somebody asked you to
24 come in. And would that be the medical director or
25 the quality -- who -- who typically -- who do you

1 think that would -- or who does that when it does
2 happen?
3 PATTY MATSUO: So when somebody is
4 identified as having an issue, an acute issue, then
5 it's probably a member of the care team not really
6 sure who would flag it to the physician, and the
7 physician would, then, request a speech pathologist
8 from the community to come into the home.
9 We are capped at, often, like I said,
10 one or two visits, and we may make special requests
11 if the situation is more complex for that
12 particular individual, not to advise on, sort of,
13 standard practices within the home to manage
14 problems that are pervasive.
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 So if the medical director doesn't ask you to come
17 in, you don't come in at all. If they do ask you
18 to come in, you're capped at one or two visits per
19 patient in the home?
20 PATTY MATSUO: To address the specific
21 issue for that specific patient. I don't --
22 Natalie has worked in long-term care as a
23 speech-language pathologist in that regard.
24 I don't know, Natalie, if you have more
25 to add?

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Commissioner Coke had a question maybe, Natalie,
3 before we hear from you.
4 COMMISSIONER ANGELA COKE: Yeah, I just
5 wanted to understand, are there any of the homes
6 that would have somebody like this on site all the
7 time? Like, if you had a larger home, and you're
8 saying so many people have these issues, are there
9 any that have a model that says we think we need
10 this person on site? Are there any like that?
11 PATTY MATSUO: Not your typical nursing
12 homes, but in more complex settings like chronic
13 care settings that you would have it, but in the
14 nursing homes, you typically would not.
15 They would have -- some of them would
16 have a dietician. Maybe most of them have a
17 dietician, but dieticians, it's not -- it's not
18 within their expertise around understanding the
19 swallowing disorders, for example, but somebody in
20 terms of advising on communication strategies, yes,
21 to me, those are foundational pieces that everybody
22 should have training on, but what is that training
23 and what is the understanding and knowledge and
24 ability to apply it optimally? I think there's
25 going to be a lot of variability, so -- but

1 speech-language pathologists, audiologists, we're
2 not in the home in that regard to advise on program
3 development and --
4 COMMISSIONER ANGELA COKE: Okay.
5 KELLY MURRAY: I don't know if our
6 friends here from Sunnybrook have a comment on
7 that? Are they on the line?
8 PATTY MATSUO: I saw Olivia on the
9 line.
10 JENNIFER WONG: Hi. Oh, sorry.
11 Olivia, do you want to go first? Or --
12 OLIVIA PETRIC: No.
13 JENNIFER WONG: Okay.
14 OLIVIA PETRIC: Jenn, you can go ahead.
15 JENNIFER WONG: Okay. Hi, sorry. We
16 have two of us here. So my name is Jenn Wong. I'm
17 the Professional Leader for Speech Pathology at
18 Sunnybrook as well as a clinician in their division
19 of long-term care, palliative care, which is the
20 Sunnybrook Veterans Centre.
21 So I'll start this by saying that our
22 facility is very different, and that's a function
23 of how we are funded. So our division of long-term
24 care is hospital-affiliated, and many of the beds
25 that we have are funded in a way similar to complex

1 continuing care rather than long-term care. And we
2 also receive funding through Veterans Affairs
3 Canada because it is a Veteran Centre, so the model
4 in our facility is exceptionally different in
5 comparison to the vast majority of long-term care
6 homes, but what that's resulted in is we have just
7 south of 500 beds, so amongst palliative care and
8 long-term care, so I think it's in the
9 neighbourhood of 450 at current.
10 And we do have a speech pathologists
11 and an audiologists who are employed as Sunnybrook
12 employees within this division, so we are staff
13 speech pathologists, staff audiologists, and so
14 this is -- this is a model where that is happening,
15 but, again, our funding sources are very different
16 than your typical long-term care facilities.
17 In terms of our ability to comment on
18 things like environment and training and things
19 like that, that certainly has profound impacts
20 on -- say, we do new staff orientations on a
21 routine basis, both speech pathology and audiology.
22 And then some of the, you know, ongoing and new
23 quality issues that come up, say, as an example,
24 the return of essential visits in the context of
25 COVID, our audiology and speech pathology teams

1 were really key in helping the larger institution
2 troubleshoot how to allow visitors to have a
3 meaningful visit with our residents with hearing
4 loss but still maintain a 6-foot distance and with
5 visitors wearing masks and things like that.
6 So it definitely does have an impact on
7 our ability to maximize quality and function for
8 our Veteran residents and things like that.
9 And then what I might do is just pass
10 it over to my colleague, Olivia, because she's
11 worked both in this kind of setting as well as in
12 your more typical long-term care setting just to
13 see if she has any other comments around, I guess,
14 the contrast in those kinds of models.
15 OLIVIA PETRIC: Thanks, Jenn.
16 Hi. So my name's Olivia Petric. I'm
17 also a speech pathologist working at the Sunnybrook
18 Veterans Centre. I do have previous experience
19 working as, sort of, a contracted clinician
20 indirectly through the LHIN, so I have had the
21 opportunity to go into long-term care homes and
22 provide, sort of, those one-off assessments that
23 Patty was speaking to earlier.
24 And as Jenn's mentioned, yes, there's a
25 very big difference in, sort of, the model both in

1 terms of accessibility and funding between, sort
2 of, the consultative model that the LHINs are using
3 versus what we have available to us at the Veterans
4 Centre.
5 And I think speaking to your question
6 about, sort of, who is able to make that call, when
7 are we able to go into a long-term care facility
8 and provide access, as Patty was mentioning, it
9 really is -- we're limited. We're only able to go
10 into the long-term care home for one specific
11 resident to -- for one specific concern whether it
12 be for communication or for swallowing, very, sort
13 of, quickly and briefly provide as much of a
14 service as we can within one or two visits, and
15 then we're removed.
16 That's much different than in the
17 Veterans Centre when we have the ability to, sort
18 of, work with a resident over time and be
19 available, sort of, as the needs of residents
20 change, but also, as Jenn was mentioning, sort of,
21 in the grander scheme of things, so when something
22 comes up unexpected such as COVID, we were able to
23 provide our expertise both in an SLP capacity and
24 for our audiology colleagues to provide, sort of,
25 best care recommendations or practices to really

1 help implement changes to best help -- best help
2 our quality of life for our -- for our residents.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Commissioner Kitts had a question, I think.
5 COMMISSIONER JACK KITTS: Yeah. I'm
6 just wondering is it -- is it the medical director,
7 is that the only person that can bring in one of
8 the specialists in speech-language pathology or
9 audiology? And if not, which members of the care
10 team can actually ask for someone to come in to
11 help with a patient that they feel needs your
12 expertise?
13 OLIVIA PETRIC: Natalie, I'm wondering
14 if you're able to comment on this a little bit
15 more.
16 In my experience, I would get, sort of,
17 consult requests from the physicians as well as the
18 dieticians to come into the homes.
19 NATALIE BEECHEY: Yeah, so currently
20 when I get a referral to go into a long-term care
21 home, it's from the physician, sometimes the nurse
22 on staff as well; and other times, the dietician is
23 the one making the request for me to come in
24 sometimes. If they're followed by a care
25 coordinator at the LHIN and they've had an update

1 meeting or a case conference, and sometimes it
2 comes directly from family bringing up the issue
3 with the care coordinator and then the care
4 coordinator putting my service in, but it has to be
5 raised by someone that's -- the issue has to be
6 brought forward, so -- and the challenge is
7 sometimes not recognizing those issues.
8 And there's sometimes large gaps where
9 I'm not in long-term care homes for months or all
10 on end if the referral doesn't get put through.
11 COMMISSIONER JACK KITTS: So if a
12 number of members of the care team can ask for your
13 assistance, what's the rate-limiting step that
14 only -- I think you said .2% or 2%?
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Point 2.
17 COMMISSIONER JACK KITTS: It was 1 --
18 2% or .2% of residents actually get evaluated?
19 What is the rate-limiting step there?
20 NATALIE BEECHEY: I would say there's a
21 few factors: Education, and just in terms of what
22 our role can be and how to -- and to bring our
23 services in. Often times, too, there tends to be a
24 higher priority for swallowing referrals over
25 communication. I don't have stats off-hand, but I

1 see far more referrals for swallowing, and very
2 rarely do I get communication referrals in the --
3 in long-term care homes, and that's some of the
4 mandates from the LHINs. So I -- those would be
5 parts of it.
6 And then also the funding in terms of
7 being able to access the number of sessions that
8 we're able to provide to be able to continue to
9 follow them versus that snapshot of, you know, two
10 visits versus ongoing care to be able to monitor as
11 clients' status changes. And sometimes, you know,
12 if you're able to follow them for a longer period
13 of time, you can see either improvements or decline
14 to be able to adjust recommendations, whereas we're
15 only seeing them for those couple of visits, and
16 then we have to wait for someone on the care team
17 to recognize to refer back in.
18 COMMISSIONER JACK KITTS: So I'm
19 hearing that there's a -- that one of the issues is
20 staff in the long-term care homes are not educated
21 or trained to recognize the issues that you could
22 help with. And once they do, you're limited in how
23 much help you can give; is that correct?
24 NATALIE BEECHEY: Yeah, I would agree
25 with that. That's kind of a summary of two of the

1 components that we're facing when trying to provide
2 our care.
3 KELLY MURRAY: And then I think we also
4 want to discuss the audiology side because, as I
5 mentioned, they -- long-term care homes, because of
6 the Act, have to provide speech-language pathology
7 services if they're required.
8 The same is not true for audiology, so
9 we find, in many cases, the audiological community
10 that I've spoken to, a lot of times, it's the
11 families asking to bring an audiologist in or
12 taking their parent out to go to an audiology
13 clinic to get those services.
14 But, Rex, maybe I -- once again, with
15 both -- the delivery of both of these services,
16 it's so variable. It's variable between the type
17 of institution, the LHIN itself, and the
18 profession.
19 So, Rex, if you want to talk a little
20 bit more about that audiological perspective.
21 REX BANKS: Sure. And thanks for
22 letting us talk with you guys today. I'm Rex
23 Banks. I'm an audiologist, and I've worked with
24 several long-term care homes in my area here with
25 Canadian Hearing Services.

1 As Kelly has indicated, though,
2 audiology is actually not in the Act, so there
3 really is no real coordinated plan for people that
4 have hearing loss that are the LTCs, and some of us
5 guarantee that a hundred percent of these most
6 vulnerable people are spending their last days,
7 many of them suffering from a lot of hearing loss.
8 And this has been very much exacerbated during the
9 time of COVID due to social distancing and
10 providers wearing masks. Communication issues have
11 really spiked even for people that have typical
12 hearing who are all having trouble hearing each
13 other right now.
14 So the LTCs really, in my view, we need
15 to have a continued conversation about how to
16 develop a road map to ensure that people are
17 screened for hearing loss, that LTCs have an
18 audiology contact that they would bring into the
19 home to do more of a bedside hearing test, to
20 understand the funding that's available to get
21 people hearing aids if that's possible so, you
22 know, they're not necessarily just given out.
23 But, you know, could there be some kind
24 of special funding envelope to provide this
25 population with hearing aids where needed? Cerumen

1 management, or ear wax, is another huge issue. So
2 not only will they have hearing loss, many of them
3 have -- their ears are plugged with wax. Some of
4 the homes do have physicians on board and nurses
5 who are able to clean ear (sic) out of ear canals.
6 Some of them do not.
7 So -- and also, in the environment,
8 many of their recreational rooms need to have
9 devices attached so people could enjoy listening to
10 the television, amplified telephones. There's so
11 much to do around hearing that's so connected to
12 quality of life, and it -- you know, it really
13 kills me when I went in and saw some residents who
14 just don't have access to basic communication
15 because they have undiagnosed hearing loss, ears
16 full of wax, no hearing aids, no amplification
17 devices in common recreational areas.
18 My feeling in working with the staff,
19 though, in LTCs is they were really receptive,
20 wanting to help, which is great, but there's no
21 real plan as to what they should be trying to do in
22 terms of seeking out help from regulated
23 audiologists, and that's sort of my comment on that
24 today.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Commissioner Coke.
2 COMMISSIONER ANGELA COKE: Yeah, so I'm
3 just trying to understand. So there's no, sort of,
4 standard assessment of these needs that is part of
5 the care plan for the residents?
6 NATALIE BEECHEY: Not to our knowledge,
7 no. And I --
8 COMMISSIONER ANGELA COKE: And the care
9 plan would not include an assessment of these types
10 of requirements?
11 ASHWINI NAMASIVAYAM-MACDONALD: Can I
12 step in, Patty, and discuss this a little bit? I'm
13 Ashwini MacDonald. I'm a professor at McMaster
14 University and a speech-language pathologist, and
15 I've done a lot of research in long-term care
16 specifically in the area of dysphagia, so
17 swallowing disorders.
18 And one of our biggest studies was 32
19 long-term care homes across Canada included eight
20 in Ontario, and what we found is that a lot of
21 these homes are relying on these quarterly
22 assessments that really simply ask the question if
23 the resident is on a modified diet, and that's the
24 only type of screening for swallowing disorders.
25 There's very -- there's really no questions about

1 communication on that quarterly assessment. And I
2 would argue that a question about modified diet
3 isn't sufficient to screen for swallowing
4 disorders.
5 What we've also found -- we have
6 current research going on looking at the education
7 of those staff, and from our preliminary analyses
8 and results, what we're finding is that, you know,
9 staff are overburdened. Even if they make a
10 referral, it can take a long time to bring someone
11 in, so they find it easier when they see -- I'll
12 speak to swallowing disorders because that's my
13 specialty -- when they see someone with a
14 swallowing disorder, they make decisions about what
15 texture should -- so what happens is when someone
16 has a swallowing disorder, we often modify the
17 diet, so they might be eating purees or thickened
18 liquids in order to help them swallow more easily.
19 So what a lot of staff are doing is,
20 without training, they are making those decisions
21 on texture and modified diets, and they are putting
22 off a referral. So education is really needed and
23 to help, you know, understand standardized ways to
24 flag for referrals.
25 And also, I think there's a huge --

1 bigger funding issue to have more availability of
2 speech-language pathologists and audiologists so
3 that, you know, once a referral is flagged, they
4 can be in within 24, 48 hours.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 And so as I understand it, then, these needs are
7 not captured in any kind of inspections that are
8 going on now.
9 ASHWINI NAMASIVAYAM-MACDONALD: No.
10 There's no formalized process.
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Yeah, no sense of this would go to the quality of
13 care that they're -- that's being provided. I
14 mean, it does seem odd to me that you'd be in a
15 room with a television and nobody's asked the
16 question of whether you can hear -- whether you can
17 hear what's going on on the TV.
18 KELLY MURRAY: Yes, well, I think,
19 again, I did speak with one -- it was also a
20 Veterans Affair. It wasn't Sunnybrook. It's
21 another one in London. I spoke with someone there
22 who said, when they're admitted to that long-term
23 care facility, again, because it's funded
24 differently or whatever, they do a complete
25 head-to-toe screening.

1 So here, again, I think it's a lack of
2 standardization in protocol. It's just
3 variability, so I'm not sure we can say very much
4 with -- you know, as a full stop and other than,
5 you know, lack of access, lack of referral,
6 generally, lack of screening, that sort of thing.
7 I know it does happen in some places is the point,
8 though.
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Right.
11 KELLY MURRAY: Just not nearly enough.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Commissioner Coke.
14 COMMISSIONER ANGELA COKE: So in
15 addition to the funding issues, is there an
16 adequate supply of people in your profession? If
17 you should have an increased demand and people are
18 using your services more regularly, more
19 systematically, is there enough of a supply of
20 people in this profession?
21 KELLY MURRAY: No. So it -- yeah,
22 we -- I don't think -- there's only 4,000, 4,500 if
23 you add up speech-language pathologists and
24 audiologists in the province, so I don't think we
25 can be the solution to the problem, but this is

1 why, you know, Patty was talking about the capacity
2 building that would be required and the train the
3 trainer type of -- so, yes, you need those direct
4 referrals, and sometimes you need that very
5 specialized expertise at bringing the professional
6 into the home.
7 But otherwise, the professionals can go
8 into the home and build that capacity within it
9 through that -- through supporting training
10 development programs.
11 COMMISSIONER ANGELA COKE: Okay.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 So it's two parts, then. It's training, and it's
14 inspections or monitoring after the training is --
15 has taken place, right? Does that -- you seem to
16 be nodding. Okay. Thank you.
17 KELLY MURRAY: Well, you need training,
18 but you need direct service as well. I mean, there
19 are certain things that, you know, you can train
20 someone how to feed somebody else, but, you know,
21 if there's a swallowing assessment required, the
22 speech-language pathologist should do that.
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Right.
25 PATTY MATSUO: And it's also advising

1 on standards and really working at a quality
2 assurance and oversight perspective in order to
3 ensure that we're meeting the right standards and
4 there are standards from residents to residents.
5 And one example is the implementation of standard
6 food textures. When we say puree, that is actually
7 going to be the same from home to home. When we're
8 saying it needs to be moderately thick fluids, that
9 it's the same from residents to residents.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Commissioner Kitts.
12 COMMISSIONER JACK KITTS: Yeah, I
13 just -- I just want to go back because I'm --
14 there's a lot of moving parts in this, and I'm just
15 trying to put them in sequence.
16 So when you talk about standards, are
17 you saying that when a resident is admitted to
18 the -- to the home or brought into the -- that
19 they're not checked for hearing, swallowing, or
20 speech difficulties? That's not part of the
21 standard assessment of their well-being and health?
22 PATTY MATSUO: Not by a speech-language
23 pathologist. Whether they have somebody assigned
24 to do a head-to-toe screening and what that looks
25 like, I can't speak to that, and I don't know if

1 any of the clinicians who have worked in long-term
2 care can speak to that.
3 But I feel that it's one of those
4 where, when we say, like, 100% of the residents
5 have some degree of communication impairment, is
6 that something that they just accept that that's
7 what it is, but they don't really identify the
8 special needs and how to manage their challenges.
9 It's not -- they're not apples to apples, and so
10 there needs to be specialized care plans. Is that
11 being addressed? I think there's -- that's
12 definitely an opportunity.
13 I had a very personal experience during
14 the first COVID [indecipherable] where there were
15 great challenges with managing mealtimes, and I --
16 actually, I work in hospital, and I volunteered
17 after hours going to local long-term care
18 facilities and helping at mealtime. And that was
19 an incredibly eye-opening experience where I saw a
20 lack of communication, lack of knowledge and
21 understanding.
22 My very first experience was I walked
23 into a home, and they said, you're feeding Margaret
24 today; she's 101. That's all I was told. And I
25 said, well, can you tell me something about

1 Margaret? Well, what do you want to know? She's
2 101; she's probably not going to eat very much.
3 That's about it.
4 And so I was privileged with being a
5 speech pathologist and knowing how to actually feed
6 a patient. I was not supported around positioning
7 her properly. I knew how to do that, but what if I
8 didn't? I could have been a volunteer coming
9 without clinical experience, and there was no --
10 that individual would not have been set up for
11 success, and I would have been very concerned how
12 Margaret would have been fed.
13 Interestingly, when they said, she's
14 not going to eat anything, it took me an hour, and
15 it was a lot of hard work. I was sweating under my
16 PPE. She ate 90% of her meal, and so I'm just
17 wondering how many preceding meals she had where
18 she wasn't eating very much.
19 So what were the skills of those
20 individuals -- and I'm not going to assume that
21 they were all volunteers because staff were also
22 part of the feeding team at mealtime, but do they
23 have the skills to feed from day to day, from meal
24 to meal so that the residents are optimally fed?
25 Are they positioned appropriately? Are they given

1 the right food textures? Do they have the skills
2 to optimise their intake? I experienced a
3 situation where I absolutely questioned whether
4 that does exist.
5 COMMISSIONER JACK KITTS: So then in
6 the recommendations, Number 4 there, that's an
7 important recommendation, educate on feeding and
8 swallowing for both frontline staff,
9 administrators, et cetera. So that would be your
10 first recommendation is train the staff to look for
11 it, right?
12 PATTY MATSUO: That absolutely is a
13 priority recommendation.
14 COMMISSIONER JACK KITTS: And then the
15 Number 3, access the right professionals. So
16 there's a screening by the staff, and then the
17 right professionals do the evaluation?
18 PATTY MATSUO: As a speech-language --
19 all -- 59% of the residents have a degree of
20 swallowing difficulty; 59% don't need a
21 speech-language pathologist to come in to feed
22 them, but they will need trained support at
23 mealtime, 100%. We can do the training. We can do
24 the follow-up should there be changes in condition
25 to reassess and make new recommendations along the

1 road, but everyone who interacts with those
2 individuals should have training.
3 And we should have training around the
4 communication realm to manage the hearing and the
5 ability to verbally express and understand because
6 we know that 100% of them are challenged that way,
7 and to set up environments so that, as you said,
8 the TV isn't in the room on, but nobody can
9 actually understand and gain any benefit from and
10 enjoyment from that television being on. Like,
11 these are things that 100% of those working in
12 those residences should have awareness of and
13 understanding of.
14 But when there's a change in that
15 individual, then we are called in as a regulated
16 provider to do individual assessments. And right
17 now, we are just called in to do those individual
18 assessments on a far under-utilized basis, but we
19 are called in for those individual cases only, not
20 broadly building capacity within long-term care.
21 COMMISSIONER JACK KITTS: Okay. So you
22 suggested two -- I think, two things that need to
23 be improved, and one is the education of the staff
24 so they recognize it and can consult you. The
25 other, you spoke about funding.

1 Can you give me more information on how
2 funding prevents this from happening?
3 PATTY MATSUO: So I wouldn't say that I
4 am the expert on this, but my appreciation is as
5 complex because individual clinicians are hired
6 often -- like, one model would be hired through an
7 agency, and that agency is then contracted to the
8 LHIN to parcel out services to the community
9 including long-term care. And how these LHINs,
10 then, cap services, and we've seen considerable
11 variability from region to region.
12 Some areas will have more service and
13 offer more opportunity for speech-language
14 pathologists, for example, to go into the home, but
15 it also impacts occupational therapy,
16 physiotherapy, other services that are managed in
17 the same way where there are caps in service. And
18 I'm not sure how those rules are set and why
19 there's variability and how LHINs decide how to
20 parcel out their funding.
21 KELLY MURRAY: I can add a little bit
22 to that as well. I believe that the funding for
23 speech-language pathology comes from the personal
24 support services budget within the funding for
25 long-term care.

1 So when you look at a staffing report
2 and you see the allied health professionals that
3 are utilized, that they're utilizing with those
4 funds, you look down a list, speech-language
5 pathology and audiology aren't even mentioned.
6 So I think there's a bit of competition
7 for the utilization of those funds, I think, is
8 part of the problem.
9 TERESA VALENZANO: Sorry. I was just
10 going to jump in there as well. So in having
11 worked -- I'm Teresa Valenzano. I'm a
12 speech-language pathologist as well, and I had a
13 fortunate opportunity to work both in acute care,
14 so I'm often working with individuals who are
15 transitioning to long-term care.
16 And in regards to the funding that we
17 are getting for services in long-term care, we're
18 often finding out at -- even at the acute-care
19 level that our requests for services -- so we're
20 putting in the referral that this individual needs
21 to be followed up on in long-term care -- those
22 requests are actually potentially being declined.
23 So those individuals who we might have
24 made an initial snapshot -- or we've gone in to
25 see, we've made an initial clinical judgment based

1 on when we are able to see them when they're in
2 their most acute stage of the disease, we've made
3 these recommendations, and now we've asked for
4 follow-up in the community when they are a bit more
5 stable and for the long-term, potentially, as their
6 disease progresses or potentially improves, those
7 are potentially being declined, meaning, as Ashwini
8 had mentioned earlier, an individual who might be
9 on a modified diet texture but might not need it
10 anymore even, so can go back to something a bit
11 more regular, so not having to eat everything
12 pureed up, unfortunately, isn't actually getting
13 that service.
14 And as has been mentioned and talked
15 about quite a bit, in regards to the education and
16 the training, if the individual doesn't have the
17 appropriate training in order to know that they can
18 be upgraded, and that is something that does fall
19 under the speech-pathology domain at this point, if
20 they don't have that training, that individual is
21 going to be left on that modified diet texture and
22 negatively be affecting their quality of life at
23 this stage.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Well, I think we've taken you all around your

1 presentation, but you can carry on from -- carry
2 on.
3 PATTY MATSUO: Thank you, Commissioner.
4 So moving on, so you, obviously, are aware of the
5 recommendations --
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Well, we better be.
8 PATTY MATSUO: But we're saying we
9 agree with your recommendations and certainly, the
10 increase in staffing and the strengthening of
11 relationships, those two really speak to us more
12 directly with our professions.
13 Fundamental issue, as we know, is --
14 has been the ability to attract and retain staff.
15 There's the staff workload. There's a staff mix,
16 the training, and the leadership. I did read the
17 personal care support workers' transcript, and so
18 it really did bring to light the impacts for them
19 with regards to workload and training and
20 leadership.
21 Currently, the way many Allied Health
22 Providers, as we said, are called into the team are
23 through those resident-specific referrals where
24 services are really on one-to-one and capped, and
25 so we really want to see there be an opportunity

1 and a way to make it easier.
2 I don't even know that these residents
3 would even know how to access services from a
4 consultative program development or training or
5 quality assurance and how that -- those funds would
6 be exchanged so that the long-term care -- yeah, so
7 how that remuneration for those services happens,
8 not really sure.
9 So when one speaks about strengthening
10 relationships across the healthcare sector, again,
11 in other sectors, we may have more expertise that
12 can advise in long-term care. But again, how are
13 we accessing those? It just seems like there's a
14 lot of silos and barriers to move expertise and
15 services from one sector of healthcare to another.
16 KELLY MURRAY: Can I jump in there a
17 little bit, Patty, too?
18 Back on that point about the silos, so
19 another example would be, say, with, you know, DVA
20 is obviously Federally -- Federal funding, but then
21 there's ADP funding that is provincially funded
22 through the Ministry of Health for hearing aids or
23 other devices if somebody, you know, is still
24 getting hearing aids or whatever through WSIB. So
25 there is some knowledge that's required also on

1 funding that's available for some of these services
2 that I think shows that this -- that those
3 relationships need to be strengthened and that
4 those silos aren't working to the advantage of the
5 resident.
6 PATTY MATSUO: Outside of my real
7 house -- I'm going off script here, but I just
8 wanted to make a comment on the IPAC practices.
9 Another personal experience during that
10 volunteer stint that I had, I had one patient
11 that -- where I needed somebody to help me
12 reposition the resident for -- prior to feeding,
13 and so I called in somebody who was working next
14 door. And next door was a patient who was
15 COVID-positive -- I should say resident -- and the
16 resident I was supporting was COVID negative. He
17 was going to come in, and he walked directly into
18 the room without even a thought of changing his
19 PPE.
20 I stopped him at the door, and I said,
21 you cannot come in here, and I said, you need to
22 change your PPE before coming in. You are
23 supporting somebody who is COVID-positive. My
24 resident is COVID-negative. You need to change and
25 do hand hygiene before you come in.

1 And so that was an interesting
2 conversation in that there was a supply issue, a
3 knowledge issue. And so to me, that was an example
4 of how it was -- COVID was spreading rampantly
5 through the long-term care facility when you didn't
6 have enough supply where you felt like you couldn't
7 change and then, but not even really understanding
8 the transmission of COVID through droplet contact.
9 And then on top of that, you've got
10 feeding that is rushed and residents who are
11 coughing and through the coughing are spreading
12 their droplets, and it was just this vicious circle
13 that was so apparent in just the short stint of
14 volunteer -- volunteerism. So I just wanted to
15 share that with the Commission that it was
16 something that was real, and I could see how it was
17 real in the moment.
18 So moving on to the Ministry
19 recommendations or some of the recommendations --
20 or their response -- I should say -- their actions,
21 they've launched the Ontario Matching Portal as we
22 know. And the last I saw, they successfully
23 recruited over 650 new staff into long-term care,
24 which is great, but our concern is the quality of
25 the training and are we going to optimally set

1 these folks up for success? Are we going to be
2 able to retain these individuals and create safe
3 working environments for them so that's translated
4 into safe care for residents?
5 So the four hours of direct care for
6 residents, great. Yeah, we're thrilled about that,
7 and then particularly the creation of the resident
8 support aide which looks at their task to
9 specifically support mealtimes and support social
10 interaction through virtual visits and providing
11 more social stimulation which directly speaks to
12 swallowing and communication and hearing.
13 And so we feel that this new role is
14 absolutely an opportunity to start on the right
15 footing and set these folks up for success, not
16 just success for them, success for the long-term
17 care sector from a capacity-building perspective,
18 from a consistency in human resources, but also
19 quality of care within long-term care.
20 So this was a framework that was
21 developed, as you may know, as part of the job
22 matching, and these are the learning competencies.
23 And I know and I apologize. This is very small,
24 but we see attendant across the top, meal
25 assistant, which really speaks to the -- that

1 resident support aide role, the personal support
2 worker, nurse, and then physician, and there's
3 practitioner. Along here, allied isn't even
4 mentioned in terms of how we're addressing all
5 these areas of care.
6 And -- and the -- so, you know, great.
7 We're talking about the competencies within these
8 roles, but the allied team needs to be part of that
9 care team beyond this group here. And even if
10 we're saying, okay, we're just looking specifically
11 at the day-to-day service providers, that's fine,
12 but within this, there's no mention of screening
13 and how to access those allied services should
14 there be a change in a patient's status or need for
15 support around programming and training.
16 We've talked a lot already about the
17 current state of professional service, allied
18 health professional services within long-term care.
19 I don't know that we need to speak any more around
20 this, but, yeah, access is limited. It's
21 under-accessed versus the prevalence within
22 long-term care, and we are not being accessed for
23 training and quality assurance. And even if they
24 want it to be, it is not clear how those services
25 would be accessed.

1 So how can we help? We did -- I did
2 already say once we want the situation better in
3 long-term care. We want -- we see an opportunity
4 to immediately set up that foundation for the
5 resident support aide role. We have expertise to
6 help, and we're offering our support.
7 We appreciate there needs to be
8 customisation to each home's needs and local
9 regions, and we should be investing locally in
10 developing the capacity locally within those homes
11 to meet that particular resident's care needs.
12 But more broadly across the long-term
13 care sector, we feel that there is a role for our
14 professions to inform on the standards of care for
15 feeding, swallowing, communication, hearing, and
16 balance; advise on specific curriculum training
17 programs to develop that skilled workforce; and
18 having that skilled workforce would be part of the
19 changing of the culture which we feel we can help
20 influence where staff feel safe and then have pride
21 in their work and are committed to the quality of
22 care. We are here to help.
23 COMMISSIONER JACK KITTS: Just a
24 quick -- a question about, so who have you
25 approached in the long-term care sector that would

1 be responsible for the team? Because you give a
2 very compelling presentation on the importance that
3 you can play. Who have you talked to, and who's
4 not -- who's not listening?
5 KELLY MURRAY: We started with that
6 submission. We have in response to the Armed
7 Forces Report and sent that submission that we sent
8 to you to both the Premier and the Minister and
9 then -- and then you.
10 I mean, we're, sort of, reasonably new
11 to advocacy in this area, I guess I would say. So
12 we -- I mean, my intention is, and one of the --
13 and one of my personal asks would be, you know,
14 support from the Commissioners in our continued
15 work with long-term care since that's sort of our
16 next step is to really try to have a voice within
17 the implementation of that staffing study.
18 COMMISSIONER JACK KITTS: Yeah, because
19 I think you need to engage the decision-makers in
20 the homes, and that would be probably the executive
21 director, the director of care, and the medical
22 director. That might be a reasonable place to
23 start and see what they -- what they would advise.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Well, and in terms of advocacy, obviously, you run

1 down parallel streams. As Commissioner Kitts is
2 saying, you engage the decision-makers, but that
3 doesn't stop you from putting -- give -- bringing
4 the message forward to us and to others. It's --
5 and personally, it is rather compelling if a
6 hundred percent of the people in a home have a
7 hearing problem and this is their home, it doesn't
8 seem difficult to me that you would try to test for
9 that when a person is admitted and then monitor in
10 case there's deterioration.
11 I'm sure there's a cost to that. I
12 don't want to minimize that, but the alternative is
13 people listening to a -- staring at a television,
14 they can't hear it. I mean, they can't -- you
15 can't have a meaningful discourse at dinner with
16 anyone because you can't hear them. Even if the
17 other people are in a normal frame of mind and
18 capable of talking to you, you can't talk to them
19 because you can't hear what they're saying. It's
20 very isolating.
21 In any event, à propos advocacy and you
22 being new to it, I think it proceeds along parallel
23 tracks.
24 KELLY MURRAY: M-hm.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 And the written -- the written statement, it's not
2 necessarily a function of whether the person you're
3 giving it to is going to read it. It's a function
4 of this is the position, and we're bringing it to
5 the attention of as many people as we can.
6 Anyway --
7 KELLY MURRAY: Yeah.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 -- I'm not -- but I'm not holding myself out as a
10 lobbyist -- as a trainer of lobbyists, so...
11 COMMISSIONER JACK KITTS: But you have
12 a very compelling story, and I think, you know, you
13 need to spread the word because it is their home,
14 and there is a commitment in the fundamental
15 principle that you will make them as comfortable
16 and safe as possible, so I think -- I think that
17 this is, obviously, a very compelling presentation.
18 KELLY MURRAY: Yeah. Can I ask you a
19 question? Because you -- because you did support
20 the staffing study, and the staffing study does not
21 make recommendations for ratios, which I understand
22 because you want to have that flexibility for the
23 individual decision-maker to make the appropriate
24 decisions within the context of their facility.
25 Having said that, that appears to me to

1 be a bit of the problem that, you know, they're not
2 having -- not having to take care of something as
3 foundational to being human as communication, you
4 know, and they're spending this personal support
5 money on other things. So I just wondered what
6 your thoughts were on that.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Well, I don't know. I don't know what our thoughts
9 are on -- no. We understand the importance of
10 communication.
11 We were dealing with addressing a much
12 more direct problem, you know, which is we had been
13 informed that in some homes, 80% of the staff
14 hadn't shown up, and then -- and then we were told
15 there's a general staffing shortage and that this
16 is resulting in not sufficient attention being paid
17 to individuals. We were -- we were trying to
18 address that.
19 You raise a slightly different question
20 because this is an inadequacy. You're raising --
21 you're not raising a quantitative question. Yours
22 is going to the quality of care and a failure to
23 address a very important aspect of human existence
24 which is communication with other human beings.
25 And it's something that people probably

1 particularly understand today because so many
2 people are, in a sense, locked down trying to deal
3 with the virus and probably feel the need to just
4 want to communicate with other people and
5 person-to-person and talk to them.
6 But that's where we were going, and
7 you've raised -- you've raised an issue that I
8 think we hadn't appreciated until you raised it.
9 KELLY MURRAY: That's great. And I did
10 want to just let you know, we did distribute our
11 communications in this area, you know, more widely
12 throughout the Long-Term Care Ministry, so I
13 understated that earlier, so I just wanted to make
14 that correction.
15 And then the other thing I just want to
16 say, it's -- I just want to emphasize is the
17 self-reporting because I would believe that many of
18 those people that are making decisions in the home
19 or the caregivers themselves would think, well,
20 they don't complain about not being able to hear.
21 They don't complain about having difficulty
22 swallowing.
23 And in both of these situations,
24 self-reporting is an abysmal indicator of need, and
25 I think that's an important thing to know.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Thank you.
3 KELLY MURRAY: I think --
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 That is. I thank you for highlighting it. You
6 know, you can kind of get there if you think that a
7 number of people are having mental difficulties,
8 but still, it's just helpful to have somebody say
9 it other than -- other than -- as opposed to us
10 just think it.
11 KELLY MURRAY: M-hm.
12 ASHWINI NAMASIVAYAM-MACDONALD: And
13 just to build up what Kelly said. Sorry, I just
14 wanted to say that it --
15 PATTY MATSUO: Sure.
16 ASHWINI NAMASIVAYAM-MACDONALD: -- is
17 actually my study that looked at self-reporting.
18 And interestingly, we controlled for cognitive
19 status and had nothing to do with cognitive
20 impairment. They just are not able to recognize
21 difficulties, and, you know, if they say they have
22 them, they probably do. But if they say they don't
23 have a problem, it can go 50-50. They might have
24 it. They might not.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 So a person just gets used to swallowing in a
2 certain way or having -- and then they take it as
3 normal? Is that the idea?
4 ASHWINI NAMASIVAYAM-MACDONALD:
5 Exactly. Like, they compensate slowly. Like, they
6 will cut their food a little bit smaller. They'll
7 avoid certain items, and they make these small,
8 small changes, and they don't realize what a large
9 impact that has over a period of time.
10 And what our research has also showed
11 is that these residents of long-term care are at
12 high, high risk of malnutrition when they have
13 these swallowing impairments which I'm sure you
14 know causes a whole host of other problems.
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay. Well, thank you very much for meeting with
17 us and for your assistance with an aspect of it
18 that we will be -- we will consider going forward.
19 So thank you very much.
20 And two things: One, we may be back if
21 we have questions if you don't mind.
22 And secondly, if you have a website, we
23 wouldn't mind -- would you -- you know, you
24 might -- we'd ask you to consider providing a link
25 to our website so that any of your members who are

1 interested in what we are doing would have an easy
2 way of finding us.
3 U/T KELLY MURRAY: I will absolutely make
4 that commitment to you that we will do that. And
5 on behalf of OSLA and the team here, we really want
6 to appreciate -- thank you and appreciate the time
7 you're taking on this issue on behalf of the
8 Ontarians in long-term care and then specifically
9 with the nature of the work of our professionals.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Thank you.
12 COMMISSIONER JACK KITTS: Thank you.
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Bye-bye.
15 COMMISSIONER ANGELA COKE: Thank you.
16 COMMISSIONER JACK KITTS: Bye.
17 PATTY MATSUO: Thank you.
18 -- Adjourned at 11:58 a.m.
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24
25

1 REPORTER'S CERTIFICATE
2
3 I, JANET BELMA, CSR, Certified
4 Shorthand Reporter, certify:
5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;
9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;
13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.
16
17
18 Dated this 7th day of December, 2020.
19
20
21
22 ________________________________
23 NEESONS, A VERITEXT COMPANY
24 PER: JANET BELMA, CSR
25 CHARTERED SHORTHAND REPORTER

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