Long Term Care Covid-19 Commission Mtg.

Ontario Health Coalition (Dr. Amit Arya and Natalie Mehra, Executive Director
on Monday, November 23, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 23rd day of November, 2020, 1:00 p.m. to 2:51 p.m.

BEFORE:

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

PRESENTERS:

Natalie Mehra, Executive Director, Ontario Health Coalition
Dr. Amit Arya, MD, CCFP (PC), FCFP, Lecturer, Division of Palliative Care, Department of Family and Community Medicine, University of Toronto
Assistant Clinical Professor, Division of Palliative Care, Faculty of Health Sciences, McMaster University

OBSERVERS:
Riley Sanders, Communications and Campaigns Coordinator, Ontario Health Coalition
Megan Lee, Campaign and Project Coordinator, Ontario Health Coalition
Salah Shadir, Administration and Operations Manager, Ontario Health Coalition

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead of the Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
Michael Finley, Counsel, Gowling WLG

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, let me introduce ourselves. I'm Frank Marrocco, Dr. Jack Kitts, Commissioner Angela Coke, and we're the Commission. Olivia Arnaud is our court reporter or our reporter.

So we're at this stage. We issued a first interim report. We may well issue a second one, and we're proceeding towards our deadline of April 30th, although that poses some difficulties for us.

So we understand what you've done. Well, at least we have a briefing note of what you've done, and it sounds very interesting from our perspective. And so we very much appreciate your sharing it with us.

We tend to ask questions as we go along, if that's all right?

NATALIE MEHRA: That's great.

DR. AMIT ARYA: Yeah, perfect.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Fine. So we will do that. I don't -- there are other people on the screen who are associated

with the Commission, but it's just us asking the questions, the three of us. So with that, we're ready when you are.

NATALIE MEHRA: Okay. Thank you. So maybe while we introduce ourselves, is it all right with you -- Riley is going to share his screen. Can he do that? And --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, sure. That's fine.

NATALIE MEHRA: Okay. And we have a PowerPoint presentation. I apologize for not sending it before. We've been sort of working to the very deadline here to finish.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine.

NATALIE MEHRA: And...

COMMISSIONER FRANK MARROCCO (CHAIR): That's not the first time that's happened. Now we don't worry about it. We can read as we go along. We'll be just fine.

NATALIE MEHRA: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Now we can see Riley's screen.

NATALIE MEHRA: Okay. And maybe, Riley, can you e-mail this over as well?

All of the links in the PowerPoint -- sorry, in the submission are live links, and they link to the various pieces of data that are relevant to that section, and the submission title here links to the submission as well.

They're up on our website, but they're not in a public part of the website. They're just available for you to access at this point.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that would be very, very helpful.

And, Riley, if you e-mail it to Alison Drummond, our executive director, I'm sure she'll make sure that it gets to where it's supposed to go.

NATALIE MEHRA: Thank you --

RILEY SANDERS: Yeah, I can deal with that.

NATALIE MEHRA: -- very much. Okay.

So this, for us, will be kind of an interim submission to you, looking at particularly because -- because the most urgent issues are that the second wave is not under control in long-term care.

And so we specifically wanted to look at conditions in the second wave, whether they have

improved or not, and what factors we think are contributing to the spread of COVID-19 now, a few elements of sort of ongoing or longer-term issues, but mainly, that's what we've focused on.

We would like to provide you with a submission that looks more broadly at the issues in long-term care as it relates to COVID-19, but we felt at this point that it was most important to kind of get the most up-to-date information and our analysis of what's happening. So that's where we're at.

Can we go to the next slide, Riley, and then if you can click on "Who We Are"?

So the Ontario Health Coalition is -- we have 400-plus member organizations. They include -- we represent more than half a million Ontarians. Our mandate is to protect public healthcare under the principles of the Canada Health Act, and the sort of foundational principles of equity and compassion that underlie the act.

And so we work to empower members of our constituent organizations in the community to engage in debate and discussion about public policy to improve public policy and improve public healthcare, and we represent the whole range of

organizations and individuals concerned about protecting public healthcare, including physician organizations, nurses, unions, seniors' organizations, Family Councils, residents, patient advocacy organizations, a whole range of ethnocultural organizations, and so on. And so we sort of have a broad coalition.

And we can go back, Riley.

We've been working for -- we've been in existence since the 1970s, and we've been working for 25 years on improving long-term care. And so we have a kind of long history of working for improvements to care levels and quality of care and quality of life in long-term care.

Amit, did you want to introduce yourself?

DR. AMIT ARYA: Yeah. So I'm Amit Arya. I'm a palliative care physician who has a special interest and practice focus in long-term care, although I also work in the hospital system, and I work in home care as well.

I have faculty appointments at the University of Toronto and McMaster University. I give workshops regularly, provincially and nationally, on systems issues in long-term care

with a specific focus on my area of expertise, which is palliative care.

I've led Rapid Response Teams on behalf of my hospitals into long-term care facilities in the first wave, and I am a board member of the Ontario Health Coalition. I'm also a member of the Ontario Health Coalition Long-Term Care Committee.

NATALIE MEHRA: Thank you. And I'm Natalie Mehra, and I'm the executive director of the Ontario Health Coalition. And our Long-Term Care Committee, which has been meeting weekly through the pandemic, includes physicians, the Advocacy Centre for the Elderly, other advocacy groups, family and residents and seniors' organizations and unions and health professionals.

Okay. So that's -- can we move on, Riley?

So I'm guessing you'll just stop us and ask if you have questions or want clarification or things like that; is that right?

COMMISSIONER FRANK MARROCCO (CHAIR): That's right.

NATALIE MEHRA: Okay. So looking -- and can you click, Riley, on the -- so looking first at the second wave versus the first wave:

What has changed and what is the current situation and what is the comparison.

So at the time that we wrote this submission, which was November the 17th, there were 100 active outbreaks in long-term care homes up from 76 at October the 31st and up from 18 at the beginning of September.

There were outbreaks during the summer but none -- and we've tracked, I should say, the outbreaks and the cases from the very beginning of the pandemic since the second week of March before Public Health started reporting, and we've tracked all the way through.

And so what we've found was that there were outbreaks in the summertime. None, except for one, had more than 5 cases; at the end of October, there were 3 active cases among residents and 18 active cases among staff in long-term care.

That has subsequently changed very dramatically, and so according to the epidemiologic data on November the 18th, there were 700 currently active cases among residents and 524 among staff.

Of those 100 outbreaks, 34 were what we would consider large outbreaks. That's an arbitrary designation, really, that we were just

counting those that had more than 10 residents and staff infected. 13 of those had more than 50, 12 had more than 99, and 4 had more than 150.

COMMISSIONER FRANK MARROCCO (CHAIR): Wow.

NATALIE MEHRA: So if we go down to the next page?

So, you know, what we can conclude from that experience at this point is that the measures that were taken in the first wave were inadequate or have been inadequate so far to stem the tide of infections in the second wave.

Once school started in particular and the case positivity rate went up in younger people to between 2 and 4 percent in September, then we saw, as the epidemiologists have predicted with a lag of a couple of weeks, the outbreaks starting among the four -- or the transmission starting to the 40-year-old-plus age group, and thus, the 70-year-old-plus age group.

And, of course, it found its way into the homes which it had done all along, but in a number of homes, they have not been able to control the spread. And so if we look at changes from Wave 1 to Wave 2...

And can we keep scrolling down there, Riley? Can you go to the chart? There we are. Can you click on that? No, it's not working?

RILEY SANDERS: No, it's not letting me expand.

NATALIE MEHRA: Can you look for the printable version and just pull it up?

RILEY SANDERS: Yeah.

NATALIE MEHRA: Okay. And then just scroll down to the chart. Okay.

So you can see the chart there.

Maybe if you can zoom in at all, Riley, that would be great.

But the first wave you can see -- now, there were problems with the Public Health data all the way along, and in our final submission, we'll give more details about the problems with the data that we found because we also were tracking every case in every home through the whole pandemic.

But the top two lines show our data and Public Health Ontario's data. There's also the Ministry of Long-Term Care database, and that data also differs from both ours and Public Health Ontario's, at times by several hundred. But they track the same sort of wave. So at least you can

see with some -- it gives a sense, anyway, of what the first wave looked like.

The red line shows the second wave, and so if you look at the second wave, what you'll see is that the growth -- I mean, it's hard to sort of figure out accurately when to say that each wave started. I think we can accurately say that the second wave started August 30th with the outbreak at Extendicare's West End Villa.

And within a couple of weeks, 11 long-term care homes in Ottawa were in outbreak. A number of those, then, were out of control, and the outbreaks started to spread in Toronto and then geographically across the region.

At this point now, by mid-November, November 17th, outbreaks are happening from border to border across the South, and they've spread into Northern Ontario as well with the first outbreak starting in Northern Ontario. And if you look at the sort of rate of increase in the second wave, you'll see that in the last three weeks, there's been an increase of approximately 1,500. 1,500 residents and staff infected.

So when we look at the first wave, that mirrors the escalation in the two and a half weeks

from March 31st to about halfway through the third week of April. And then in the two weeks from April 21st to May 5th, then the very fastest escalation we saw in the whole pandemic so far in long-term care happened from May 5th to May 19th, that two-week period where there was 2,000 positive cases in two weeks. And then it slowed down a bit to 1,500 over the four-week period from May 19th to June 16th.

So in the sort of foothills or the very beginning of the very sharpest escalation, we saw the spread mirror what we're looking at now, approximately.

So that's our assessment of where we're at at this point in the second wave.

And the main point of this is not to be alarmist at all, but the numbers are escalating every week. The number of outbreaks and the size of the outbreaks has escalated week over week, and now we're seeing the second-fastest kind of escalation that we've seen in the pandemic so far.

COMMISSIONER FRANK MARROCCO (CHAIR): Are people dying at the same rate?

NATALIE MEHRA: We haven't measured that, and the issue is that the deaths, not to be

at all glib, but they follow by several weeks.

So as you can see in the second wave, the escalation in the number of cases has happened more slowly than in the first wave. It's now, just now in the last three weeks really ramping up, and we won't be able to really see how the death rates compare to, you know, that big escalation in the first wave probably for a few weeks at this point.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: Sadly. I mean, horribly.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, no. It is -- but, anyway, thank you for the answer.

NATALIE MEHRA: Okay.

So, Riley, we can go back to the main PowerPoint, if that's okay.

So we wanted to give you a few case studies that we've done about large outbreaks in the second wave because we think that they're illustrative of what is happening in the second wave to contribute to the spread of COVID-19 now; so after the directives and guidance and policy was put in place in the first wave and through the

summer, what's happening now and what factors are contributing to the spread.

So we wanted to look more closely --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just --

NATALIE MEHRA: Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): -- interrupt you for a second?

NATALIE MEHRA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): One of the things we are interested in is if there is something that should be happening now --

NATALIE MEHRA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- that can happen now, you know, as opposed to some long-term solution? We are very interested in that.

NATALIE MEHRA: Yes, okay. Well, I hope that this will help sort of illustrate some of the things that we think can happen now.

So this section is the case studies, and the next section is the factors -- sort of systematic look at the factors that we think are contributing to the spread.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right.

NATALIE MEHRA: So if you can click, Riley, on the case studies link there? Okay.

So the one that we have the most information on is West End Villa in Ottawa, and that certainly -- that is the one that really kicked off the second wave, and if we look at -- we sort of track the outbreak in West End Villa.

So it started August the 30th, and it's not clear why the spread happened across Ottawa, in particular, so quickly. But what we have learned is that -- and so we theorized that there were a number of agency staff that work in multiple homes at the same time across Ottawa.

And we don't have anything beyond kind of anecdotal information on this, but what we do know, the chair of our board, for example, his mother is in home care in Ottawa, and she has a number of PSWs that they've hired in to provide home care for her. And a number of those PSWs work not only in home care but also in long-term care homes at the same time. They work in -- some of them work in Extendicare West End Villa and a range of other long-term care homes in Ottawa.

So in terms of concrete factors, the

loophole in the requirement that staff choose one home to work in that allows agency staff to continue to move between homes and between home care and long-term care homes, we think, is a contributing factor here. And a little further down, we'll see that in the data that's available publicly, at least one of the 45 staff by sort of mid-September that tested positive was an agency staff person.

It's not clear what other homes -- I'm going to say she; I'm assuming it's a she -- worked in and whether or not that staff person travelling between multiple homes was a contributing factor to the spread.

But what we do know is that by mid-September 11 of -- the long-term care homes in Ottawa were in outbreak, and then, of course, in West End Villa in particular but also in Starwood and Laurier Manor, the outbreaks really spread very dramatically.

And so if you scroll up a little, just charting that outbreak, started August the 30th. By September 16th, 31 residents were infected, 5 had died, and 5 staff were infected.

By September 18th, 46 residents were

infected, 6 had died, and 17 staff.

By October 18th, 84 residents, including 20 who had died, and 43 staff were infected.

By November 9th, 87 residents, including 20 who had died, and 45 staff were infected.

So we've been able to piece together what happened to some extent in that home, and I just, if it's okay, wanted to kind of walk you through what we saw, what we found.

So that first paragraph after the tracking, Riley -- sorry, you've gone down a little too quickly -- well, actually, you're right. We'll just go to the delays in testing.

So the failure over the summer by the Provincial Government to make a coherent plan for testing, ramping up testing capacity, ramping up laboratory capacity in the public hospitals and other labs across the province but particularly the public hospitals -- not all of which are even testing now to their capacity -- and in contact tracing really has been a fatal error.

And we don't think it's an exaggeration to say that it is a fatal error.

The lack of capacity once businesses and particularly once the schools reopened in September resulted in a very severe backlog of testing, of processing of the tests, and contact tracing. By the middle of October, 45 percent of the cases in Ottawa were not being contact traced, as an example; 67 percent in Toronto; about 17 percent in Peel.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you for a minute?

NATALIE MEHRA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): I understand the logic of what you're saying.

Is there any reason that's emerged why there wouldn't have been more of an effort at contact tracing and more of an effort to expand the capacity to turn around sample results quickly? In your work, did any reason emerge for this?

NATALIE MEHRA: No. We haven't -- we have not -- no is the simple answer. Um...

COMMISSIONER FRANK MARROCCO (CHAIR): Simple answer's okay, you know.

NATALIE MEHRA: Yeah, there just has not been any explanation for not kind of using the summer months to do it. We did see in the summer

that there was some ramp-up of hospital laboratory testing.

So not all public hospitals that can run COVID-19 tests are running COVID-19 tests, and those that can have additional capacity that could have been built and should continue to be built that has not yet been built. So that's on the laboratory side. We are --

COMMISSIONER FRANK MARROCCO (CHAIR): Can private labs do this testing?

NATALIE MEHRA: They are doing the testing, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

NATALIE MEHRA: So, like, Dynacare --

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

NATALIE MEHRA: Yeah, they're doing the testing.

COMMISSIONER FRANK MARROCCO (CHAIR): So the province is making use of those resources?

NATALIE MEHRA: Yeah. And, in fact, they ramped up right at the very beginning back in March, April.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

NATALIE MEHRA: But not all of the public hospitals did. So in the first wave, the ramp-up of the public hospitals was sort of ad hoc. It was organized among the hospitals and Public Health themselves. The Ministry didn't sort of convene a planning table or group and make it happen.

There were a number of hospitals -- so they had a limited number of hospitals that ramped up to testing. They have to be validated. It takes a few weeks to be validated, and so on.

And then through the first wave, those hospitals and the private clinics and obviously the Public Health lab, the big Public Health lab, were ramping up their testing, but not all hospitals came online. Then, some more came online in the summer, but there was no coherent plan to sort of ramp up the laboratory capacity or the assessment centres, the testing capacity and the assessment centres, to meet what was predictably a big increase in population demand once the schools reopened and as businesses reopened as, you know, Phase 2 and Phase 3 came in. Okay.

So that impacted West End Villa, in

part, but the other thing that impacted West End Villa is that within the home itself, from the accounts of the families, testing was slow to happen. So residents who were showing symptoms didn't get tested for several days, according to the accounts from the families, and they weren't cohorted.

So even residents that were showing symptoms were not separated from residents -- even when they were sharing rooms were not separated from residents who were not showing symptoms. And we see this through the homes where there is large spread until, you know, several days later, sometimes until the family was, you know, screaming at the home, wondering why their loved one was still in a bed beside someone who was COVID-positive or had symptoms of COVID-19.

So within the home, one slow -- you know, slow testing. And throughout September, there were public reports about how many tests were pending. So once they did test, then slow test results, and then a failure of the home to cohort immediately. As soon as symptoms were present, they should be required to and inspected on cohorting, and that is not happening.

So there were several accounts from families who described this. One is Lea Maurice.

Oops. Don't go too fast, Riley.

So Lea Maurice, their grandmother was left in a room for more than 24 hours after her roommate began showing signs of COVID-19. Even after the roommate tested positive -- so the roommate wasn't actually tested for a few days. Even after she tested positive, she wasn't moved. The family had to advocate for her to move. They had to advocate for the room to be cleaned.

Finally, she was moved, and there were two other people also sharing the same bathroom with that COVID-positive patient, then, for a number of days from the time that they started showing symptoms.

COMMISSIONER FRANK MARROCCO (CHAIR): I'll ask the same question I asked before: Does a reason emerge why in September, having gone through Wave 1 and having had all those experiences, this kind of thing happens?

NATALIE MEHRA: No. In fact, throughout, the home has denied that there were problems. I mean, the only explanation that the home has made, in fairness, is that they said that

the lag in getting test results contributed to the spread in the home.

Other than that, there has not been any kind of response to the very specific cases that the families have raised in which they hadn't moved their loved ones out or sequestered the COVID-positive and the COVID-negative residents in the --

COMMISSIONER FRANK MARROCCO (CHAIR): I can understand the frustration in waiting for a result, but you have to test the person right away.

NATALIE MEHRA: Absolutely. And if they're showing symptoms, they should be separated --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

NATALIE MEHRA: -- immediately, regardless, while they wait for the test results.

And that didn't happen here, and it didn't happen in a number of the other homes where we've seen the big outbreaks.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: And so under the sort of array of directives and guidelines and so on,

there is kind of a network of requirements for the homes that suggests that they should cohort right away. But there's no real concrete enforcement or consequences if they don't, and they're not in a number of the homes.

So then we move on.

So poorer care, poor infection control practices were demonstrated in the home. And Public Health and government surveillance and interventions were too slow to improve them.

So on multiple occasions, actually, Public Health Ontario, Ottawa Public Health, and the Ministry of Long-Term Care Homes said that the home had sufficient PPE, that they had sufficient staff, and that they were following infection control protocols.

But those accounts are directly contradicted from families and staff with immediate knowledge, and they've given immediate -- like, concrete examples of how those haven't happened. So the Ministry and Public Health in Ottawa made those claims both on September the 11th and then again on September the 29th, but in between, this is what we heard from staff and families.

So the last paragraph on that page, a

staff person who was a whistleblower went to the Ottawa Citizen and reported that the staff -- so this is on September the 19th -- that the staff working directly with residents who had COVID-19 did not have N95 masks.

They further reported that there were two PSWs left for 60 COVID-positive residents. So one for 30 -- one PSW for 30 COVID residents on one side; one for 30 on the other side.

Again, on September 29th, Ottawa Public Health said that they had been conducting daily onsite visits, and the Ministry of Health said that they were meeting daily with the licensees, so the homeowner/operator, local public health, and public officials. From that surveillance, they said there's enough PPE that concerns about staffing shortages were being taken of, and so on.

Yet, on September the 26th, Pierette died, and in the week leading up to her death -- and this is the last paragraph on this page -- her daughter describes the conditions in which she was living:

She was dirty. There was excrement on her hands. There was excrement dried on the wall. She had not been cleaned. Her tongue was bone dry.

There were drink cartons on the table, but all but one had been left unopened. She was severely dehydrated, and she had dementia and COVID-19 and was not able to open drink cartons herself.

She had been put into a private room for isolation; however, once she was pall- -- like, once she was immediately palliative, so she was going to die within a few days, her family was allowed into the home. And what they observed was there was no staff available, residents were wandering into and out of Pierette's room even though Pierette had COVID-19 symptoms, and there were not enough staff to stop them and protect them from being exposed.

There were not enough staff to provide hydration, nutrition, human company, or basic care.

On the day of her death, which was September the 26th, Pierette's daughter tried calling the home from first thing in the morning on. She finally got a call just shy of noon, she says, from a nurse. The nurse apologized. She said that she hadn't been able to get into her mother's room because the home was so short-staffed.

So remember, this is a resident who's

dying of COVID-19, who has dementia, who can't feed herself or drink, hadn't been into the room till just before noon, and her mother was dying. So the family raced down and was able to make it just at the time of her passing.

So the accounts from the families do not match at all the accounts from Public Health and government officials that they say are based on site visits and discussions with the administrators of the homes.

What we're saying is if Public Health relied on the administrator's accounts for that home, then they shouldn't have because there was plenty of evidence to show that that home already had a bad record in terms of inadequate care. And, in fact -- and you can just scroll down, Riley -- in 2018, there had been a lawsuit -- these are actually very rare in Ontario until COVID-19 -- for systemic neglect treatment, including that the grandmother's bandaged wounds were infested with maggots.

There were inspection reports and non-compliance reports and orders over a period of several years; nine critical incident reports; ten complaints. And they described conditions,

problems with housekeeping, medication errors, unsafe or rough treatment of residents, call bells not being heard, residents not being assisted to eat, offensive odours, blood glucose levels not being checked, falls resulting in injury, all kinds -- a kind of litany of conditions that describe poor or negligent care.

And so there was plenty of evidence not to support listening to just the administrators' contentions about what the staffing and care levels were in the home and what the level of infection control was.

And it's not clear -- there's no public reporting about what kind of inspections Public Health is doing when they go into the homes that are in outbreak, but clearly they're inadequate, and our fear is that they're only talking to the administrators. We have not found staff that they're interviewing, and we haven't found residents that they're interviewing or family members to ascertain the conditions on the ground in these homes.

That's Extendicare West End Villa.

Amit, did you want to just talk about Kennedy Lodge?

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have any --

NATALIE MEHRA: Oh, sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have any sense, when you describe the room in which they found -- I guess it's the mother?

NATALIE MEHRA: Pierette, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Were they not allowed in to visit before this; is that the idea? Because you would think as soon as you went in there and saw that that you would become very agitated, to say the least.

But were they not allowed in before? Is that what the situation is; do you know?

NATALIE MEHRA: Yeah, they weren't allowed in because the home was in outbreak until Pierette was considered palliative, so immediately at risk of dying, and then they were allowed in, and it was just a few days before her death.

And as you can see, they had problems contacting the home. It was hard to get through because once there's not enough staff, there's no one to answer phones and so on as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Is that all staffing? I mean, is that the reason

that's given why this is allowed to occur? Does the home or does anybody tell you that they're just short-staffed?

NATALIE MEHRA: Well --

COMMISSIONER FRANK MARROCCO (CHAIR): That the reason for this is short-staffed?

NATALIE MEHRA: Yeah. The home is desperately short-staffed, for sure. I mean, the staff describe a level of staffing that I -- you know, I mean, I've been doing this for 25 years. We have witnessed short-staffing in long-term care homes for a long time but particularly after 2017 when, really, there emerged a crisis.

But, you know, to the level where there's one PSW for 30 COVID-positive residents, two PSWs for 60 residents, that is a -- you know, even in our long experience, we have never heard of staffing levels like that. And we're now hearing them, actually, in a number of the homes, that kind of one-for-30 situation.

That is beyond any kind of level of -- obviously, you can't really provide any care. There's no -- what kind of infection control could a PSW engage in if they have 30 residents? They're not changing PPE between people. There's no way.

There's no time. They're not -- who would be there to stop residents from wandering? There's no way to do that. You know, just all infection control that should be happening cannot happen when you're at that kind of critical shortage of staffing.

And the home itself, from what I've seen -- and I haven't seen every single statement that they've made -- they have not -- I mean, they've said all the way through that staffing is adequate, and, in fact, a later report that I saw, they said that they were overstaffed.

So, you know, the accounts from the home compared to the accounts of the families and the workers couldn't be more different.

COMMISSIONER FRANK MARROCCO (CHAIR): Where did they say that they had adequate staffing? Where was that recorded?

NATALIE MEHRA: In newspapers.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. So their public statements were to the effect that they were adequately staffed, and while there's probably no satisfactory explanation for what's been described, the idea that it's staffing appears not to have been the case because they say they were adequately staffed.

So either they're lying or they're negligent or they're incompetent at managing.

NATALIE MEHRA: Or both, yes.

DR. AMIT ARYA: Yeah. I just wanted to add to kind of, you know, validate what Natalie is saying, and it's really from my own clinical experience working in long-term care homes.

And it maybe sounds obvious, but I just wanted to put it on the record that when people are sicker, they don't need less care. They need more care, and they need more monitoring.

And especially with a disease like COVID-19 where, you know, people with dementia who live in long-term care facilities or this is a pre-existing population of people that are already quite sick and ill with other illnesses, they need very close monitoring, and they can rapidly become short of breath, their oxygen levels can drop, they can become delirious, dehydrated.

And, I mean, I would actually say you can't -- obviously, you cannot function with less staff, but I would even argue that you cannot function with the same amount of staff, which was barely adequate even before the pandemic.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

NATALIE MEHRA: So there's no real explanation as to why the Ministry, Public Health officials, the home -- reportedly -- and the staff and the families have such totally different accounts of what's happening.

But that pattern runs through the case examples that we've looked at and also through the staffing surveys and so on that we've done as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: And so, you know, one of the things we're concerned about is -- and this has been a case for many years -- that we've advocated that Ministry officials not rely on accounts from home administrators to ascertain the level of care in the homes.

And so for many years, we advocated that the inspections regime include interviews with residents and their families or their substitute decision-makers and staff to actually ascertain what the conditions of care are in the homes. And that was adopted in the RQI inspections that were stopped by the government in 2018.

So moving on to Kennedy Lodge, is that

okay? Go ahead, Amit.

DR. AMIT ARYA: Yeah. So just the story from Kennedy Lodge, which is somewhat consistent and indicates these issues around staffing and transparency around staffing.

I mean, November 16th, they had 31 residents who had died at Kennedy Lodge in Scarborough, which is a Revera home, and 128 residents and staff were infected. And the spokesperson for Revera claimed that staffing levels were stable and they were cohorting properly and there was enough PPE.

The Honourable Minister of Long-Term Care, Minister Fullerton, in the legislature on October 28th, also kind of echoed these comments and said there are actually no homes with critical staffing levels because help is being provided, including PPE.

And there was a journalist who then sort of was preparing an investigative report looking into that specific home, Kentucky Lodge in Scarborough, and they confirmed with the Ministry staff -- at least, the Ministry's perspective -- that homes had enough PPE and they're overstaffed, but when they interviewed the staff themselves, the

story was quite different.

So the November 17th report, sort of by PSWs, stated that because of shortages, proper infection control practices could not be followed. What that means is that they were supposed to have seven to eight frontline staff working on one floor, but unfortunately, only four were showing up to work and were not replaced.

Staff were supposed to remain on one floor but instead had to go in between floors, including units that had COVID-positive residents and COVID-negative floors. And N95 masks were there, but they weren't fit-tested, and there were shortages of sort of things that we would consider very obvious for PPE, like gloves.

And the union actually sort of confirmed this situation and said that this home already had a problem with short-staffing before the pandemic, and really, what was going on during the outbreak was far worse and that the home was described as "horribly short-staffed."

NATALIE MEHRA: So in a third case study that we just are compiling the information on, Starwood in Ottawa, another Extendicare home, the weekend before last, they're testing weekly on

Thursdays, and this is another home with an outbreak that now includes more than a hundred residents and staff.

And so Roseanne Riley (ph) told her story of her mother, who's 104 years old -- her name is Rose -- and her roommate was tested on the Thursday two weeks ago. Test result came back positive for COVID-19 on the Friday. By Sunday, Rose still had not been moved out of the room or, you know, neither Rose or the other resident -- Rose was not COVID-positive at that point, had not been moved out of the room and separated from the COVID-positive resident. By Thursday, then, of last week, Rose tested positive for COVID-19.

And so we undertook to do a staffing survey of the staff who are currently working in homes with large outbreaks specifically, to ask them what they thought was contributing to the spread of COVID-19 in the homes.

And their reports, there's a kind of wide range of conditions, and a number of them confirm these types of examples of inadequate PPE, inadequate cohorting, residents wandering, and so on, and we'll get kind of more into detail on that in a minute, if that's okay.

COMMISSIONER FRANK MARROCCO (CHAIR): Mm-hm.

NATALIE MEHRA: Okay. So that's that section.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you just -- you said you did a study of staff, like --

NATALIE MEHRA: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- a survey of staff. Very briefly, but what was the methodology? How'd you do it?

NATALIE MEHRA: Well, we just worked with the unions who are in the homes where there are large outbreaks now. So "large" being defined as more than ten people.

We asked them -- so as not to kind of weight it towards one home or the other, we asked them if they could get, you know, around three staff at max in each of the homes in large outbreaks from their staff group to answer a very quick survey about, you know, are there enough staff, do you have enough PPE, are residents cohorted, are residents wandering, you know, et cetera, a list of questions which we've provided to you, and they provided answers to the questions.

We're still midway in that. So we have about, I think, 32 or so responses. We're still waiting for more to come in, today and tomorrow, and we'll write up the final study, but we can provide you with the interim results that we have at this point.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure, that would be fine. So you went to the unions; the unions went to their members in the homes where there were significant outbreaks. And you provided the questions, and one assumes the union asked the staff to answer it or ask three staff members to answer the survey, and they did?

NATALIE MEHRA: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: That's right. Okay.

So, Riley, we can go back to the main --

COMMISSIONER JACK KITTS: Natalie, before you go on, can I just ask a question? You said a couple of times that you don't really ask or don't believe the leadership in the homes.

Is that widespread, or is that -- I'm just kind of curious because, you know, the quality

control in the home is the responsibility of the executive director, director of care, and the medical director.

And are you seeing that all three are not monitoring or managing the care?

NATALIE MEHRA: Amit, maybe you want to add in on this a little bit.

Like, our experience now for decades is that there have been very serious quality problems in a number of the homes. There are, of course, homes with fantastic management, with competent management, but there are homes with really terrible, negligent management.

And it's not a small number of homes. It's a significant number of homes.

And so for all of these years, sort of tracking the inspection reports and so on, you know, we really were concerned because in the -- you know, up until about 2007 in the years in which there were inspections -- and, of course, the homes have lobbied routinely to get rid of annual, unannounced inspections, but in the years in which there were regular, unannounced inspections, the accounts of administrators about what was going on in the homes did not match what our members and

what other people were saying was happening in the homes.

So we pushed very hard for the Ministry to ensure that the inspections regime actually interviewed residents and staff. In the end, the RQI regime does require interviews of residents and substitute decision-makers and -- oh, sorry, we also advocated for Family Councils.

And I think that's a recognition from the minister at the time that there really are significant problems about how the homes report on conditions in their own homes.

COMMISSIONER JACK KITTS: So who do you think would be the most accountable body to deal with that, with the homes that a lot of people recognized doesn't have good management? Where would you pick that up?

NATALIE MEHRA: One of the things we've talked about is that -- I mean, there isn't an infection control lead in many of the homes, so in terms of infection control, you know, there actually isn't sort of a clear lead who is responsible for infection control and accountable for infection control in many of the homes.

But in terms of the general care

standards and so on, I mean, the administration has to be accountable, but in terms of actually ascertaining what's happening in the homes, the people that can tell you are the residents, the families, and the staff.

And so one just cannot -- I mean, our position is that you can't just trust the administration to tell the truth about what's happening in the homes. They don't do it.

COMMISSIONER JACK KITTS: Okay. Thank you.

NATALIE MEHRA: I don't know if you want to add anything, Amit? That's fairly blunt, I guess.

DR. AMIT ARYA: Yeah. I mean, I can just sort of say [indecipherable] management [indecipherable] that there's a lot of variability in terms of what happens in these homes at baseline.

From the physician perspective, I mean, there's many physicians -- I can share who went above and beyond during the COVID-19 pandemic and were so proactive, and I'm happy to share details about that at another point.

And then there were other situations

where, unfortunately, the physicians, you know, couldn't -- like, didn't have that skill set, you know, possibly before the pandemic. And it was very hard for them to kind of provide the higher level of acuity -- or, like, manage the higher level of acuity and complexity that was required during an outbreak.

But I'm not targeting physicians. I mean, that can apply across, you know, all areas, all disciplines working in the homes.

COMMISSIONER JACK KITTS: Okay. Thank you.

NATALIE MEHRA: We also asked -- sorry, I should just mention this. We asked -- because when the military report came out, you know, one of my questions was, well, where was the management? When these things were happening, where were the managers? Where was the director of care? Where was the administration?

And I asked the unions, where were the managements? And they said, you know, the administrative staff in many of the homes that they were in were not working onsite. They were not going into the homes during the outbreaks. They were working from home.

So I also wondered, you know, if you have so few staff on the floor, why is management not helping out? Why are they not -- why isn't it all-hands-on-deck? You know, people are dying of dehydration here. People are dying of starvation. Surely, every body that you can get in there would be in there trying to provide care, and that just wasn't the case. They left it to the one PSW, left for 30 people or 16 people or 26 people, you know, et cetera, in the homes.

And there really -- the answer was that, you know, they have their own offices. Often, they're air conditioned even when the homes are not. The administrators are not onsite.

Okay. So the factors contributing --

COMMISSIONER FRANK MARROCCO (CHAIR): So the infection control lead should be onsite?

NATALIE MEHRA: Well, on --

COMMISSIONER FRANK MARROCCO (CHAIR): Wouldn't it be satisfactory to -- and I'm not trying to put words in your mouth. Tell me if you think that's right or not, but it would seem from what you're saying that the infection control lead person should be onsite?

NATALIE MEHRA: Yes, and the

responsibilities for the infection control lead person and the accountability for them need to be clarified. So who is --

DR. AMIT ARYA: Absolutely.

NATALIE MEHRA: -- responsible and what is their accountability for that needs to be clarified because it is not clear, actually.

Sorry, Amit, did you want to say? Like, in --

DR. AMIT ARYA: Nope, nope. I was just seconding what you were saying that, yeah, absolutely, you need an infection control person onsite to monitor everything very closely, make sure the proper PPE is being used and all the staff are trained in how to use it, and residents are being cohorted.

I wanted to highlight one example from early on in the pandemic where I can give you an example the differences in support for infection control that were available in the hospital setting versus long-term care because I worked on the COVID-19 ward in the hospital.

So when I worked on the COVID-19 ward, there were two nurses who were kind of there to help me at all times before I went in to see a

patient, with donning and doffing PPE, make sure I followed all the, you know, the protocols properly, and that training was readily available.

But yet I haven't heard of any situation where, you know, say, for example, a new PSW was sent out and was working in the middle of the night with an unreasonable number of patients, as Natalie has outlined, that was offered that level of support.

NATALIE MEHRA: So, for example, like what Amit describes, in hospitals, they work in teams, and the team scrutinizes each other as they don and doff their PPE to make sure that they don't get contaminated. That does not exist in long-term care homes, not in any way, shape, or form. It just doesn't.

So, I mean, that would be an extraordinary leap forward from what we have. What we have at the moment is that they're not even donning and doffing between residents.

Okay. And --

COMMISSIONER ANGELA COKE: Can I just ask one question?

NATALIE MEHRA: Yeah.

COMMISSIONER ANGELA COKE: Just in

terms of all your observations so far, what sort of key differences you've seen between profit and not-for-profit and municipal homes in terms of their management of COVID?

NATALIE MEHRA: Well, I mean, there are very significant differences in the amount of staffing available, and particularly -- I mean, that's always been the case. And again, not every home is terrible that's for-profit; not every public or not-for-profit home is fantastic.

But generalizing across the sector, you can say without any shadow of a doubt that the staffing shortages, prior to COVID-19, were much worse in the for-profit homes than they were in the not-for-profit and the public homes.

And we can say that because we studied it, and we've provided you that study. And that echoes, you know, all of the academic research as well that has been done, the big body of academic research around powers of care.

But in addition, once COVID-19 hit, those homes that paid less -- and the for-profits pay less -- lost their workers more quickly, and once the April 22nd requirement that staff had to choose one home to work in, if they worked in

multiple homes -- staff chose where they could get more hours and where they could get higher pay, as a general rule, or where the working conditions were better. And those were the municipal and not-for-profit homes.

So in a number of the for-profit homes, in particular, we've seen staffing levels truly crumble through the first wave of the pandemic, and now in the second wave with no resilience going into the second wave because there was no capacity enhancement over the summer and no plan that was put in motion to get staff into the homes, we're seeing the very, very serious emergency, critical, critical staffing shortages in these homes with outbreaks and particularly in the for-profit homes.

And that is also echoed through our staffing surveys that we've done.

COMMISSIONER ANGELA COKE: Thank you.

NATALIE MEHRA: Okay. So looking at the factors that we think are contributing to the spread of COVID-19 in the homes.

So there have been -- in terms of directives, Directive No. 5, there has been improvement in PPE. And we have written this up, and we will send it to you once we've got it

complete and up to date. So Directive No. 5 has been amended multiple times. The most recent amendment says that:

> "Any staff person who comes within 2 metres of a person who is infected with COVID-19 should have access to an N95 mask upon their request."

The problem is that they have to request it and that it's not a requirement. It's inexplicable to us why this wouldn't be a requirement at this point and why the homes would not be inspected to that requirement.

Because what we're hearing from the staff is that either -- as in some cases, there are N95 masks available but not in their sizes or that they're being dissuaded from management from wearing N95 masks even now in the fall of 2020 after everything that we've seen.

In some homes, the training videos that are shown to staff say that N95 masks are only required when there are aerosol-generating procedures. In other homes, the management simply tells the staff that they are required. In some homes, staff have to sign out the N95 masks.

There are a whole array of ways in which the homes are rationing access to N95 masks.

And people under droplet and contact protection, they're not using N95 masks as a rule for those people, so those are people awaiting test results and so on. They're using surgical masks, or surgical masks and shields.

So although there have been improvements in access to PPE, that is a partial improvement. It's inadequate. It's at the staff's request rather than by requirement for the licensee, and it's not enforced.

In terms of the bar on -- sorry. Oh, you're on mute. There you go.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there a shortage of N95 masks in terms of the information you're getting?

NATALIE MEHRA: From the homes themselves?

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, actual physical shortage? I mean that really, though, more globally. You know how at the beginning --

NATALIE MEHRA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

-- everyone was concerned they didn't have enough.

So now we move from March to, let's say, September or August, and I'm wondering from the perspective, the sources that you're accessing, is there a shortage?

NATALIE MEHRA: So, Amit, maybe you can help me here, but I remember that on our Long-Term Care Committee, the Family Councils in Sudbury were mentioning that at least one or more of their homes was having a problem getting access to N95 masks in particular, but I don't know -- and then the rest of the Family Councils were not reporting that. The staff don't know.

So that's the only one that I'm aware of. So there may be some, and I actually had asked the non-profits whether there was -- oh, yeah. I did ask some of the non-profits, and they did say that there was some stockpiling of masks that was happening. There was some problem, but it had improved, and I don't think globally, like, across the board there is a problem for the homes accessing supply.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: But there may be some

homes that for whatever -- I don't really know the reasons, have some problems accessing supply. That's particularly --

COMMISSIONER FRANK MARROCCO (CHAIR): So there's no problem -- if there's no problem accessing supplies, then if you have a shortage, it's because you haven't purchased sufficient supplies?

NATALIE MEHRA: Well, it's a cost issue. I mean, if you look at Extendicare's report to shareholders from the summer, they report the cost, the extraordinary cost of PPE is eating into their net revenue. It's a cost issue. I mean, if they ration supply, they have less expenditure.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: Okay. So bar and transfers of residents. So this is Directive No. 3, I believe.

And so in the spring, they barred the transfer of residents from hospitals, so patients from hospitals into long-term care homes that were in outbreak and people from the community into long-term care homes that were in outbreak. That was a significant improvement.

Also barred COVID-positive patients from being transferred from hospitals into long-term care homes. That was definitely an issue in the first wave and contributed to the spread in the first wave. That bar on transfers has, we think, generally worked, but there is a loophole that says that local public health officials, in agreement with the home and the hospital, can still transfer patients into homes with outbreaks.

Again, we don't know why there would be such a loophole. It's obviously very dangerous to do that, and in the directive, consent is not required for that person to be transferred. And the Advocacy Centre for the Elderly has had one case in the spring in which there was an issue of a resident being forced into a transfer, coerced into a transfer without appropriate consent into a home with outbreak.

But we're not aware of whether -- you know, we haven't heard whether that's happening anywhere else. I have not heard of it as an issue. It does, though, remain as a loophole in Directive 3.

The bar on the four-bed shared rooms, that's a definite improvement. It's in process, as

you know, through attrition and as they are cohorting.

Crisis interventions: So these are the Rapid Response Teams; military; management orders. So these are kind of the last-ditch efforts for homes that are in total crisis.

In our experience, as evidenced in, you know, Extendicare West End Villa -- sorry, I just drew a blank on it -- but also a number of the other homes in large outbreak, the orders are coming too late. Once you have, you know, more than 50 people infected, as was the case in Extendicare's West End Villa, you know, there's no reason why there shouldn't be intervention at a much lower threshold.

And they are ad hoc. At this point, it's local public health unit officials, and they have varying approaches across the province that are now making these orders, and they're late. They're ad hoc. The agreements are not the same.

In a number of cases, they've, you know, gone for sort of partnership agreements between the long-term care homes and the hospitals -- and, Amit, I don't know if you want to add in on this -- but what we're seeing is they

don't actually go in until the spread is devastating, in many cases, and then, even after that, it's not clear entirely what measures are being taken in each home and whether they're sufficient.

Because in a number of homes, they have managed to stop the outbreak. In other homes, the outbreaks continue to spread, as in Extendicare's West End Villa, for example, for a number of weeks. And, in fact, in Extendicare's West End Villa, the number of people infected doubled after the management was taken over by the Ottawa Hospital.

Did you want to add anything, Amit?

DR. AMIT ARYA: Yeah. I mean, I can just briefly add: Like, once again, a consistent theme is emerging, I feel, from my perspective and my expertise is that, you know, long-term care homes were always reliant on hospitals even before the pandemic, and then once it's [indecipherable], I commonly present and [indecipherable] to do is that, well, 65 percent of residents have transferred to hospital in their last year of life, and it's 7 percent in the last week.

There's national data from the Canadian Institute of Health Information that shows

that 21 percent of people from long-term care are transferred to hospital for palliative care, and as we talked about, some of this is a skill set and training sort of deficiency, and some of this is a sheer deficiency in staffing and the numbers of staff that are...

NATALIE MEHRA: Amit, you've cut out. Oops. He may have to dial back.

COMMISSIONER FRANK MARROCCO (CHAIR): That's right.

NATALIE MEHRA: Okay. So if that's okay, I'll just carry on, and then we'll just go back, if that's -- when he comes back in?

COMMISSIONER FRANK MARROCCO (CHAIR): Sure. That's fine.

NATALIE MEHRA: Okay. So we talked about assessment in testing capacity. I don't think I need to go through that again.

So while there were gains in the first wave, we saw lost ground, very significant lost ground once businesses and schools reopened, and there was no coherent plan to ramp-up capacity for that.

And then we saw the very, very severe backlogs in the fall. By the sort of height of the

backlogs, mid-October, there were 90,000 tests backlogged in the system, and that meant -- and the testing centres closed down for two days, and that meant a very severe backlog in tests, and obviously that affected the wait for results in long-term care homes.

Okay. So the allowance that COVID-19-positive asymptomatic staff can be required to work by their employers, you know, this one we still find quite shocking that it would be allowed in any way whatsoever. I mean, obviously from February on, information around COVID-19 being spread by asymptomatic carriers was well known around the world. Certainly, by March and April, it was well known.

But still, the allowance that employers can require COVID-positive staff to work supposedly on isolation, there is no such thing as work isolation for a PSW in a long-term care home or for an RN or an RPN. This was definitely a factor in the first wave.

We thought that it had actually been discontinued as a practice, although it is allowed in the second wave. But from our recent staffing survey and a few individual accounts from staff

that have called us, it is actually still happening in a number of homes where staff who are asymptomatic, positive but asymptomatic, are being required to go in to work. And they are not on work isolation, despite the recommendation and the protocol. So that should just be stopped. Period.

Staffing and care levels, we'll get into more detail in the next section, but I think we covered it, are worse now than they were in the first wave and certainly worse than they were prior to the pandemic.

Have we found -- did Amit come back in yet? No? I don't see him.

DR. AMIT ARYA: Yeah, sorry about that.

NATALIE MEHRA: He's here. Sorry. Thank you. Sorry, did you want to finish what you were trying to say? We lost you there.

DR. AMIT ARYA: Yeah. I don't know what happened to my hotspot. I have a hotspot right next to me, so I don't know why I got -- like, there was an issue with the connection.

But basically, I was just alluding to how long-term care facilities already had a reliance on acute care hospitals, and once again, I mean, this sort of issue around preventing

residents from going into hospital during a COVID-19 outbreak is actually quite harmful and, you know, can be deadly in certain circumstances.

I mean, of course, we have to obtain residents' consent, and there needs to be a goals of care discussion around what are the best options in that moment to make sure that resident is well looked after and are getting the best treatment for their condition, whether it's, honestly, COVID-19 or not, and that did not happen, actually.

And I hope we get some time to talk about how -- you know, hospitals are one option, but you may be aware that in Windsor, they kind of, you know, developed a third setting, a field hospital which was specifically designed for the care of residents in long-term care. And they had, for example, palliative care specialists working in the field hospital.

NATALIE MEHRA: So this is Crisis Interventions II: So everything else having failed or if staffing has crumbled to the point that basic care cannot be provided for residents and certainly not for residents who are sick with COVID-19, as well as the other conditions that they have, you know, it's our position that either the care needs

to be got into the home or the residents need to be gotten out of the home somewhere where they can be safe, be it a field hospital or a field centre, and that those need to be set up and ready to go.

The example of Windsor in the first wave, we believe -- you know, the evidence is pretty clear that it saved lives, and it meant that both the people in the field hospital and the people left in the home finally were able to get enough care, and it should be considered a model that could be used as we're in the second wave. But it's not happening.

In West End Villa, for example, by the end of September, only four residents had been moved to hospital. And as you can see from the family accounts, there was never even any question. You know, the families were never given any kind of choice, any kind of informed consent to move their loved ones out to somewhere where they could get enough care.

Obviously, this is a problem in the second wave because hospitals are open, and in Ottawa, for example, they're running at more than 100 percent capacity. And so every day that's lost is a risk to life. We need to build the capacity.

We needed to have done it through the summer. We needed to have done it prior to that.

But it needs to happen now to have either teams that are adequate to go in or a place where residents can be taken out where they can get enough care to live.

DR. AMIT ARYA: Yeah. I wanted to just add to that, that it's definitely a risk to life when basic care needs such as hydration or nutrition are not being met or residents aren't being bathed.

But it's also an equal risk to suffering of the residents, whether they're COVID-19-positive or not. We definitely know with COVID-19, once again, residents need close monitoring for symptoms such as breathlessness and agitation, for example, and they may need oxygen. They need their oxygen levels to be monitored.

They would need medication to make sure that they're not gasping for air and they're not short of breath, but they're comfortable and peaceful. Then, we need health workers that are trained in having conversations with family members and maintaining regular communication around what the treatment options really are.

So absolutely, that has to happen in the long-term care facility, but then if it can't happen, then we need to make sure that we transfer people to another place where it can and offer them that option.

NATALIE MEHRA: And then just the last two, so, you know, in terms of -- so some of the factors, we've seen some improvement. In others, like testing and contact tracing and lab capacity, we saw some improvement followed by lost ground.

But the abject failures, from our perspective, have been that there has been no coordinated systemic or systematic approach by the Ministry of Long-Term Care to dealing with outbreaks in the homes. That, in each case, at a low threshold, you know, one or two people infected because we know how quickly this virus can move, you know, these measures need to be in place.

Someone needs to be in the home, whether it's local public health or inspectors from the Ministry, or what have you. I mean, either could do it. They need to make an assessment on the ground. They need to be back in making regular assessments. They cannot just rely on the accounts by the telephone or in person by the

administrators.

They need to go and look at the condition of care, condition of life for the residents, and they need to interview them and the staff to ascertain what's happening. They need to ensure that there are strong-enough directives and guidelines and consequences for not actually providing PPE, as should be required -- should have been required months ago, but absolutely at this point, there's no excuse for not having it.

You know, they need to assess the staffing levels as the outbreak progresses and ascertain whether the residents are safe in the home or not safe in the home and have an array of options for either getting people in or getting the residents out that are available and in place to do that.

We cannot believe that we're in mid-November at this point, and that still is not in place. The measures are ad hoc. They're now being locally done. There still is no plan to actually recruit enough staff to get them into the homes. You know, that is, for us, a total kind of system failure in terms of providing a coordinated systematic response.

And following that, and Amit may want to take this one, but there really has been no accountability and no enforcement at every stage for the home operators. And so there's no real consequence for them not doing what they should be doing.

DR. AMIT ARYA: Yeah. I mean, I just wanted to add that one can't help but feel that there is an issue around divided loyalties here, and from the home's perspective, I mean, if they call in the hospital sort of based Rapid Response Team, or if it ends up that the military is in the home and so on, it could be very possible that that would open up a channel for them to be sued, right, and for them to be part of litigation. And perhaps it would affect their business image or corporate image.

But we know that we can't have conflicting loyalties at this time, and our sole loyalty should be to making sure that the residents who live in these homes are receiving, really, the best care and are receiving enough skilled care.

NATALIE MEHRA: Okay. So moving on to the next slide? Sorry, this the one that takes the longest.

So we've done a series of reports, and I won't -- I'll just take a few sentences on each between the two of us, but just to describe: We looked at staffing pre-pandemic, and there was a crisis in staffing prior to the pandemic.

We did roundtables in partnership with a union, UNIFOR. Across the province, we invited administrators, the people that run the PSW programs at the colleges, PSWs themselves, Family Councils, and we had more than 350 come to eight sets of roundtables from Thunder Bay right down to Windsor to Ottawa across -- sorry, Ottawa was not included -- but across Southern Ontario.

And what we found was that every home, without exception -- sorry, every region without exception reported that there were critical staffing shortages, PSW staffing shortages in the homes. And what that looked like was that there were not enough PSWs to start to fill all shifts. When PSWs called in, they were not replaced, and it led to critical staffing shortages across the board.

Then the pandemic hit, and after the first wave, we did a second survey, this time of direct frontline staff.

And, Amit, you're going to give the sort of quick summary of that?

DR. AMIT ARYA: Yeah. In the interest of time, I'll make it definitely quick. So basically --

NATALIE MEHRA: And [indecipherable] click on that link? Sorry. The July survey?

DR. AMIT ARYA: Yeah. So basically, the survey was done for more than 150 long-term care staff, and we asked if staffing was worse, better, or the same compared to prior to COVID-19.

And 95 percent of the staff reported that their long-term care homes were short, and 53 percent actually said that there was staffing shortages every day. 63 percent of the staff actually said that the staffing levels were worse than before COVID-19.

So what this led to, as one can sort of imagine, is that this led to neglect of the residents. It kind of led to rushed care in certain circumstances when it came to essential duties like bathing or feeding someone, and sometimes there was actually no care because they would just have to skip over bathing altogether, or there would be specifically no time for emotional

support or easing residents' depression or loneliness. Staff also reported there were more frequent falls. There was less time to reposition residents in order to prevent bed sores, for example.

And I just wanted to share one example from my own experience, which echoes the experience of people working in long-term care homes is that before the pandemic, because there was already a shortage, as Natalie talked about, we would see PSWs sort of feed three or four residents sitting together at a table, you know, at the same time, right? And sometimes, of course, family caregivers would often be present and helping as well and performing that frontline duty.

So what that meant is that depended on congregate dining, and when you can't have congregate dining because the residents are all isolating, that obviously does not allow you to save that time, and then you have to kind of do it much quicker, right? And it definitely would be the case that you would be leaving people hungry.

And the clinical experience -- and what we're hearing, actually, from family caregivers more than clinical experience is that people, you

know, have lost a lot of weight through this whole process.

NATALIE MEHRA: So in that survey, we asked what kinds of care couldn't be done, and then we've -- in the survey results which you have in the link, the most common thing when staff are short, the first thing to go is bathing and emotional support.

And then after that, it's the activities of daily living like, you know, brushing their teeth, shaving, cleaning, nail care, that kind of thing. Rushing room cleaning, and then feeding, repositioning, you know, and the other types of care that Amit said.

So in a very significant number of these surveys, we see that those very elemental pieces of care the staff were reporting could not be done. That's as of July of this year, and that's the majority of the respondents saying that these things could not be done in the homes in which they worked.

Again, in this survey, we limited it to three survey responses per home, so it wasn't weighted towards any one particular home. Okay.

So we'll go back to the next.

So then we did a repeat survey, but this one was specifically -- so we can go back to the, sorry, the main slideshow. And can you click on the bottom one?

So this is the current survey that we're doing on homes with large outbreaks now. So really, this was a bit about staffing levels, but also just about what are the conditions in the home that the staff think are contributing to the spread of COVID-19.

So we asked, is there enough staffing? Out of the responses that we have so far, and obviously the homes are in crisis, so it's a bit hard to get the responses in, but 24 of them said no, 6 said yes, and 2 said sometimes.

We asked to describe which work could not be done. So interestingly, a number of the staff who said that there was enough staff also listed a number of these things as work that can't be done. So the staff, their -- you know, low staffing has been normalized in the homes, and so the staff might say that there is enough staff, but then when you ask them what work is not getting done, they list a bunch of things that are vital pieces of care that aren't happening, and that was

the case in this study.

And when we provide you with the final, which should be later this week, we'll give you the numbers so you can get a sense of, you know, how wide-spread this is. This is just among the 34 homes with large outbreaks.

So counselling and services to families; documentation; showers and baths; feeding and hydration; transporting residents to be able to cohort them; staff breaks -- so this is care that they cannot do because they don't have enough staff -- emotional support for residents; talking to family members on the phone; giving medication; documentation; supervision.

Okay. This is an equipment issue: Not enough oxygen equipment.

Housekeeping; not enough laundry staff; answering residents' call bells so they don't get up and fall.

So then we asked a series of questions about whether -- and I apologize. We just literally put this together this morning from the last set that we got in last night, so it's very quickly done.

But we asked, do you have adequate PPE?

And so the surveys were filled in over the last week in the homes. 21 said yes. 9 said no. Even, again, not having proper access to PPE is normalized among the staff, so we asked a bunch of special, like, specific questions. We asked a "yes" or "no" question but then also specific questions to gather whether, you know, they would be -- that access to PPE is adequate according to what should be an appropriate standard, which the staff might not know.

So even among those that answered yes, they described some of the following, and the ones that just said no described these things: So they've been asked to reuse face shields; had to advocate for more N95s; they don't have proper fit-tested N95s; not enough time to change PPE between residents; discouraged in a whole array of ways from using N95s.

These are homes in outbreak, large outbreaks: Using surgical masks with COVID-19 residents; told to take their masks home and reuse them. In one case, the staff person who was a nurse couldn't get an N95 mask and had go back into her car to get a mask out of the backseat to use.

Locked up PPE. Not enough gowns; that

was fairly common. Not enough gloves.

This one was surprisingly common: No disinfectant wipes. In one home, they're using hand gel and paper towels to clean. In another home, they described the disinfectant wipes as old and dry, so they existed, but they weren't useable.

So these are current conditions, and so our question is why, you know, why are the homes not inspected to this? Why is there no accountability for the homes not providing these supplies?

We asked our COVID-19-positive residents, separated. In most of the homes, they said yes. In a few of the homes, they said no, so two. In three, they said they were at first during this outbreak, but now there are too many infected residents to be able to cohort them. And in ten, they said, yes, they're cohorted, but there's not enough staff to keep the residents from wandering into and out of each other's rooms in COVID hot zones and non-COVID hot zones.

And then we asked about, are there physical barriers to stop residents from wandering? In a few of the homes, they reported that they've removed the wheelchairs from residents' rooms so

that they can't move. I mean, that's -- that's a human rights issue. There should be enough staff to provide care for the residents. Just removing their wheelchairs so that they can't get up out of bed and go anywhere is not a solution to a COVID-19 outbreak.

Carrying on: Are there staff who are COVID-positive but asymptomatic being required to work? In seven, 7 of the staff said yes, and 22 said no. 3 didn't know.

And then we asked what other issues they thought would be contributing to the spread of COVID-19 in the homes. In a number of homes, actually, we've heard this, that they were not testing, and they were resistant to or delaying testing. So they said they had to fight for additional testing.

In one home, they described all different types of service in the building going in and out, so Rogers cable; maintenance; hairdressing services; staffing bringing it in from the community; equipment being shared between residents and not cleared properly; improper cleaning; short of qualified staff; using helpers that are not PSWs; discouragement from sending residents to the

hospital; and then problems with inadequate equipment.

Riley, can you scroll down a little bit?

And then agency staff moving in and out from coming in from various COVID hotspots, improper hygiene, and residents using shared spaces.

So those are the conditions that we're finding right now in the homes with the large outbreaks.

Okay. If we can go back to the main again? Sorry. Okay. And on to the next slide.

Amit?

DR. AMIT ARYA: Sorry, I think I'm on mute, right? So --

NATALIE MEHRA: You're on.

DR. AMIT ARYA: Yeah, I'm off mute now.

So, yeah, basically it's just kind of, you know, a slide that we need to enforce some standards of care in these homes, and some of it is around the number of staff, but some of it is around the skill and training that is not really enforced very closely in long-term care.

And basically, the same approaches to

medicine that might work in a middle-aged person with general medical training, you know, would not work in people that are seniors and especially people who have life-[indecipherable] illnesses such as dementia or heart failure and frailty, as are found in these nursing homes.

So we know that for COVID-19, specifically talking about treatment and testing, I mean, that requires that skill and knowledge where the presenting symptoms might not just be shortness of breath. It might not just be fever or cough, but it might also be falls or delirium or dehydration, right?

And we know that what we've seen is that -- I mean, perhaps this is much more of a long-term recommendation, but there is a short-term recommendation tied to this, is that we know that many of the physicians who work in long-term care tend to be older. It's a bit of an older workforce, so we need to make sure that if they cannot go in and actually see patients that need to be seen, there needs to be, you know, replacements available that can assist them and work together.

Virtual care has obviously risen up during the pandemic, and hopefully it's here to

stay, but virtual care cannot be a substitute for situations where you need an in-person assessment.

And really, it should not be about -- you know, for example, when I'm doing a virtual care assessment, it shouldn't be about my convenience, but it should be about what's in the best interest of the resident always because, as physicians, we have a fiduciary relationship with our patients.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there any reason why the combination of a registered nurse practitioner and virtual care couldn't substitute for an absentee or sometimes there/sometimes not there medical director?

DR. AMIT ARYA: It's hard for me to say. I mean, I can tell you in general that there are some excellent nurse practitioners that, for example, I work with very closely in my region who are trained in geriatrics, once again, and trained in palliative care.

And, you know, we know that there is overlap in the scope of practice of physicians and nurse practitioners; they're not exactly the same.

But absolutely, I mean, I would say in many circumstances, if you had a nurse practitioner

who had the training and the skill and the time who was there onsite, they could work collaboratively with, you know, a physician who perhaps could not be there.

But the bottom line is that I can share with you as a physician. Like, I cannot just -- or I should not be delegating in ideal circumstances, you know, all my work to another health professional, and these are -- I mean, these would still be my patients, right?

And once again, I appreciate that, you know, older physicians would be afraid or scared of maybe going in to these places due to the high risk of maybe contracting COVID-19 themselves, but then if this is really what's needed to assess the residents and make sure that they get care, then it still needs to happen.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: So, Amit, did you want to say anything about the other issues of the physicians? So there are the medical directors; there are other physicians working in the homes; there are issues around quality and practice.

Did you want to get into any of those

quickly?

DR. AMIT ARYA: Yeah. I mean, it kind of speaks to -- I mean, this slide is kind of focused on physicians, but I think it speaks to all skilled disciplines in long-term care where, you know, we know that the acuity and the medical complexity in the patient population is rising where, for example, I think 50 percent of residents now admitted to these homes have dementia. You know, the average age is rising, and the median prognosis in Ontario is 18 months.

Many of these residents would benefit from a palliative care approach, really, at the beginning, which doesn't mean end-of-life care, but it means integrating sort of a focus on symptom management and having early and frequent goals of care discussions with the resident, along with their substitute decision-maker, which is usually their family or family members.

But that, of course, takes skill and training, and we don't have that enforced standard of care in these homes. And I can share from a physician perspective: It doesn't exist. So what that leads to is variability.

I know many physicians that have

excellent skills in geriatrics and palliative care, and they are family physicians who have taken it upon themselves to learn more and expand their scope of practice or people with actual fellowship training beyond that.

But at the same time, there's also sort of some physicians who don't have the training and don't spend enough time with their residents and don't do, like -- you know, don't have these essential conversations. So that is a significant gap in the system that needs to be addressed, you know, as soon as possible.

NATALIE MEHRA: Okay.

DR. AMIT ARYA: Right? We wouldn't allow it in any other area of the healthcare system, right? We wouldn't allow somebody to work at the emergency department, for example, without knowing how to manage, you know, a trauma or, like, you know, being able to perform CPR, or we wouldn't allow a surgeon to be in the operating theatre without having these basic skills.

So we should really think about this in the same way in long-term care, and it's not just physicians, but nurses, nurse practitioners -- really, everyone in the intraprofessional team.

NATALIE MEHRA: Thanks. I don't know how -- I think we're running out of time. I wasn't quite sure what to do about managing the time.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we are at the 2:30 mark, but what's left for you to tell us?

NATALIE MEHRA: We just had sort of two sections.

Riley, can you flip forward one?

This really speaks to the issue of discrimination and not allowing access to hospital care for long-term care residents. That was just one piece.

And then the last piece was around the deregulation and the prioritizing of the lobby requests of the home industry over the public interests through the pandemic.

Should we go ahead? Should we -- I'm not sure what to do. Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, how long do you think it'll be?

NATALIE MEHRA: Ten minutes or so?

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, that's fine. Go ahead.

NATALIE MEHRA: Okay, okay. So I'll

just plough through quickly. Some of this you've heard, but in our written report, we'll give you more about this.

So leading in to the pandemic, obviously acuity in long-term care is a serious issue. The acuity of the residents -- that's the complexity and the heaviness of their care needs -- had increased very dramatically.

And if you can click on that link, Riley?

And so we've pulled together the most recent -- the orange link; there you go -- the most recent sort of data available up to 2019 looking at the increase in acuity of residents in the homes and then looking at the actual staffing. And what we see is a sharp, sharp increase in the acuity of the residents and an actual decline in the hands-on care levels in the homes.

It's okay. I just wanted you to see the reports so you know it's there, and you can access it.

So in this report, what we look at is the measures of acuity on admission to the homes, the MAPLe scores, which measure acuity on admission, and in Ontario, the residents are at the

highest tier of MAPLe scores on admission to the homes. The vast majority -- and this report, what we found was over 80 percent had dementia, half of those exhibit behaviours, and the level of violence is quite shocking in the homes. This is prior to the pandemic.

So there's a mix of residents now in the homes from younger people with chronic illness and disabilities, in some cases, to the frail elderly who require long-term care to people who, really, have psychogeriatric issues, which are different dementias and require different levels of training, specific training for which the home staff are not trained at all.

And so there's a resident population now that's significant with mental health issues, and then there's a resident population with dementias. There's a resident population who are frail and elderly, and there is a resident population who's young. And across the board, the acuity has increased very dramatically, but the staffing, without whom no care happens, has actually declined.

And the homes have become a dangerous place, even prior to COVID-19. And in the longer

term, there has to be a very serious look at this.

Like, Ontario has cut more hospital beds than any other province in the country, than any other developed nation. We have the fewest hospital beds per capita left of any province, by far, by a long shot, and we're at the very bottom of the OECD and the number of hospital beds per capita as well. So only -- I think it's Chile and Mexico now have few hospital beds per capita in the OECD, and we're miles behind our peer nations in Europe and so on.

And what that means is that long-term care homes have become a kind of privatized version of a chronic care hospital or, you know, a palliative care, and that whole kind of range of care as well as psychogeriatric care, and so on.

We believe that there has to be an upper limit, that you can't just continue to, forever, save costs in healthcare by off-loading ever-more complex patients into long-term care homes that are, you know, neither designed nor staffed nor have the training to provide for them; for example, a chronic care hospital bed in Ontario or a complex continuing care hospital bed in Ontario is funded at three times the rate of a

long-term care bed.

And yet the acuity levels between, you know, a chronic or complex continuing care resident and a long-term care resident would be hard to differentiate. Even though their needs are different, the actual level of support that they need is the same or, in some cases, higher.

And psychogeriatric beds were funded at a much higher level than long-term care homes, even than, you know, complex continuing care beds.

And so this sort of drive to off-load patients and then also to deny them access to hospital care when they need it really is, we think, discriminatory, and it is dangerous. And it's resulted in the highest homicide rates of anywhere in our society in long-term care homes -- that's resident-on-resident homicides -- the highest staff injury rates of any sector in our economy, and, you know, really problematic outcomes for the residents in the homes. And so that was one -- so that's prior to the pandemic.

Once we got in to the pandemic, we were pretty horrified to see that even where COVID-19 was spreading without check in the homes, even where staffing had crumbled, there was no mechanism

to ensure that residents could have access to hospital care, even when families were asking for their family members to be moved. In some cases, they were denied access to hospital care. In some cases, they were told that residents could not be transferred to hospitals, and so on.

And that culture is a very problematic culture because, really, it needs to be about what the care needs are of the residents and what the reality is of the care that's available in the home.

I don't know if you wanted to add anything, Amit, to that?

DR. AMIT ARYA: Yeah. I mean, it's a complex conversation, and you captured some of the key elements of that for sure.

I mean, you know, generally, I'll share with you: I mean, many of these seniors with dementia, for example, or these residents who are already, as I mentioned, in the last months or years of their life, they don't like to be in the hospital as a first preference because in hospitals, we know that can increase the rate of delirium. People can -- you know, they can develop deconditioning, and they're surrounded by this sort

of staff that's constantly turning over that doesn't know them.

But then what that counts on is having the proper care and support where they are, and I think for most of the residents that I know, that's what they would prefer. But then if that care and support is not available, then this is where this complex and nuanced discussion comes in that they deserve to know or their substitute decision-maker deserves to know, and then there needs to be a conversation about what would be the best next step, which we call a goals of care conversation, right?

So it's not -- like, you know, I think what Natalie is describing is paternalism where somebody else is making a decision on behalf of the resident, and there's not what we call a shared decision-making and truthful decision-making.

NATALIE MEHRA: And it's driven by attempts to cut costs, by de-hospitalization of the health system, and then by not transferring people to hospitals even when care can't be provided in other venues for them. And this, I think, has been a very serious problem during the pandemic and continues to be a very serious problem.

Riley, do you mind going back in to the main slide? Sorry. Oh, sorry, can you go back to that slide? Sorry. I'm trying to rush.

So in the pandemic, what we've seen is this acuity and the complexity of the care needs of the residents is compounded by the reticence to hospitalize; the ignoring of the right to informed consent at that time; the use of advanced care directives that are being required by homes when people are admitted, which might be two years ago, but that is not informed consent. That is not informed consent based on the unique needs of that person in the situation as it changes and as their health status changes. And at the end, what it's meant is just the failure to act to provide care for people.

In the longer term, this issue of acuity and capacity in long-term care has to be addressed. There has to be an upper limit for acuity, and the resources that are provided to long-term care need to match the actual acuity of the residents, and they do not at this point.

There cannot be continued downloading of ever-more complex and a mix of residents that are unsafe, demonstrably unsafe in the home and

cannot be provided good care in those homes. And so that needs to be addressed.

The last bed study that was done in Ontario, there was a 1994 chronic care bed study. That's the last one that sort of assessed what level chronic care was supposed to be. Nothing has been done like that since, and there has been no capacity study across the hospital system into long-term care. It's a continuum of care, as you know, to ensure that there is care provided along the continuum and that it's appropriate for the care needs of people and can actually meet those care needs.

So in the longer term, those things need to be addressed, and then this issue of advanced care planning that Amit has brought up, which is not being done; consent, which is ignored often in long-term care; and access to hospital care when people need it, which is being denied often in long-term care, are significant issues.

Sorry, Amit.

DR. AMIT ARYA: Yeah. I just wanted to very quickly, in a couple of sentences, just outline what a real-world example of that looks like, you know, in terms of the staff and the

inequity between different places.

So we can imagine, of course, end-of-life care is an important aspect of care in long-term care facilities, given the patient population. And obviously, we have to do everything to prevent COVID-19 from getting in these homes, but if COVID-19 is in the home, we don't want people to die from negligence. If people are at end of life from the virus, we still have to provide them proper care.

And to give you an example, in the hospice setting where I also work, there is one nurse for five patients in the hospice setting, and there's one PSW for ten patients.

And there's nothing close to that happening in long-term care in spite of, as was already mentioned, you know, a much higher level of complexity and need for family support.

NATALIE MEHRA: Okay. And so the last slide. Okay.

So we've provided a link to the 1999 Red Tape Submission from the OLTCA. So essentially, it captures in the kind of euphemistic language that they use, what they've been lobbying for.

But having done this for 25 years now on the board and then as the executive director of the Ontario Health Coalition, really, the public interest groups that are concerned about conditions of care in long-term care and the for-profit industry in particular have really kind of fought a pitched battle for decades now to establish a better regime of care levels, of care standards, of accountability, and enforcement.

And so I didn't want to leave without at least mentioning this to you, and we can kind of give it to you in writing in more detail, but the bottom line is that what the homes have lobbied for is to get rid of the only existing staffing standards that we have. So there is a requirement -- that are not management.

So as you know, there's a director of care and there's the medical director, but aside from that, there's the requirement that homes have one RN 24/7. It's our view that that's inadequate. That's a 40-bed home or a 400-bed home, one RN 24/7.

The homes have lobbied in recent years to get rid of that minimum care requirement. That is in the act, and we pushed to have that in the

act in 2007 because the acuity of the residents was rising so significantly and because the workforce had been -- you know, care had been off-loaded first from RNs to RPNs and then from RPNs to PSWs to the point that now the majority of the workforce is PSW, even with a, you know, rising acuity among the residents.

Under the emergency orders in March, the homes won the deregulation of that RN care standard. We think that's dangerous. I mean, in a pandemic, you would need more trained care, not less. Similarly with PSW training, in the act, there is a requirement that personal support workers provide the personal support program, which is described in the act and in the regulations: There is a requirement that the PSWs have a diploma, that they are trained PSWs.

Under the emergency orders, again passed in March, homes were allowed to replace PSWs with untrained staff and with volunteers. Again, this is dangerous. In the pandemic, you need more, not less.

And while it might be understandable that a regulation might be waived for a period of time, it cannot be that the regulations are both

waived and there is no plan, and there has been and there continues to be no plan to recruit a staff force that is trained to get them into the homes to provide enough care. And that's what happened.

So at this point, we have the worst of both worlds. We have the regulation waived, PSWs being replaced by resident support aides -- and they come under an array of titles -- and even unpaid volunteers, so people who have no training whatsoever. And yet, still no recruitment strategy to actually get PSWs into the homes.

In comparison, Québec, on June 1st, announced that it would recruit 10,000 orderlies, their equivalent to PSWs, with the full weight of government behind the recruitment plan, and within a matter of weeks, they had 67,000 applicants for 10,000 positions. They paid $21 an hour for training. They did a three-month training for them, intensive training, and they have deployed those PSWs or their equivalents into the homes now to be in place for the second wave.

Nothing like that has happened in Ontario, and we are -- they have 400 homes; we have 626 homes. So the scale of the problem in Québec was similar, although I think it was worse in

Ontario. So we need the same kind of scale of response.

What we've had instead has been kind of an ad hoc, piecemeal approach with some funding, some programs, but no robust recruitment strategy with the full weight of the Provincial Government behind it with a paid training, sped-up, intensive program and a plan to actually get a small army of PSWs into the homes to make sure that there can be enough care provided.

That is a huge failing, and it is resulting in terrible inadequacies, horrific inadequacies in care for residents in the homes.

Couple that with, now, the deregulation of the care standards, something that the homes actually lobbied for for five years leading into the pandemic, approximately five years leading into the pandemic, which they won in the emergency orders. You know, very dangerous, unsafe, and the wrong direction as compared to where we should be going.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that -- I should tell you, we do have a hard stop at 3 o'clock.

NATALIE MEHRA: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): So if that's pretty much it, then that's it. If not, if there's something you need to conclude with, go right ahead, but we do have a hard stop at 3.

NATALIE MEHRA: Okay. Sorry. I went on too long there. So there are just a few other issues, then, that are in writing here and that we will be providing to you in writing as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you very much. Well, thank you for the presentation. We have been interested in getting this kind of a perspective, and this is extremely helpful. And thank you very much for taking the time to do this.

And we look forward to the balance of it in -- the balance of whatever it is you feel we need to know, but I can tell you some of this is very helpful.

NATALIE MEHRA: Oh, good. Okay. Thank you very much for your time, and we're sorry to have gone over.

COMMISSIONER FRANK MARROCCO (CHAIR): No, that's quite all right. Thank you very much. Bye-bye.

DR. AMIT ARYA: Thank you.

NATALIE MEHRA: Bye-bye.

DR. AMIT ARYA: Thank you very much.

COMMISSIONER ANGELA COKE: Thank you. Bye.

COMMISSIONER JACK KITTS: Thank you.

-- Adjourned at 2:51 p.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 23rd day of November, 2020.

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