

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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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held Virtually via Zoom, with all participants
15	attending remotely, on the 23rd day of November,
16	2020, 1:00 p.m. to 2:51 p.m.
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

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9 Natalie Mehra, Executive Director, Ontario Health
10 Coalition

11 Dr. Amit Arya, MD, CCFP (PC), FCFP, Lecturer,
12 Division of Palliative Care, Department of Family
13 and Community Medicine, University of Toronto
14 Assistant Clinical Professor, Division of
15 Palliative Care, Faculty of Health Sciences,
16 McMaster University

17

18 OBSERVERS:

19 Riley Sanders, Communications and Campaigns
20 Coordinator, Ontario Health Coalition

21 Megan Lee, Campaign and Project Coordinator,
22 Ontario Health Coalition

23 Salah Shadir, Administration and Operations
24 Manager, Ontario Health Coalition

25

1 PARTICIPANTS:

2

3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5 John Callaghan, Counsel, Long-Term Care Commission

6 Secretariat

7 Derek Lett, Policy Director, Long-Term Care

8 Commission Secretariat

9 Dawn Palin Rokosh, Director, Operations, Long-Term

10 Care Commission Secretariat

11 Jessica Franklin, Policy Lead of the Long-Term Care

12 Commission Secretariat

13 Lynn Mahoney, Counsel, Long-Term Care Commission

14 Secretariat

15 Kate McGrann, Counsel, Long-Term Care Commission

16 Secretariat

17 Michael Finley, Counsel, Gowling WLG

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19

20 ALSO PRESENT:

21

22 Olivia Arnaud, Stenographer/Transcriptionist

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

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, let me introduce ourselves. I'm

5 Frank Marrocco, Dr. Jack Kitts, Commissioner

6 Angela Coke, and we're the Commission.

7 Olivia Arnaud is our court reporter or our

8 reporter.

9 So we're at this stage. We issued a

10 first interim report. We may well issue a second

11 one, and we're proceeding towards our deadline of

12 April 30th, although that poses some difficulties

13 for us.

14 So we understand what you've done.

15 Well, at least we have a briefing note of what

16 you've done, and it sounds very interesting from

17 our perspective. And so we very much appreciate

18 your sharing it with us.

19 We tend to ask questions as we go

20 along, if that's all right?

21 NATALIE MEHRA: That's great.

22 DR. AMIT ARYA: Yeah, perfect.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 Okay. Fine. So we will do that. I don't -- there

25 are other people on the screen who are associated

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

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

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

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

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

16 NATALIE MEHRA: And...

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

21 NATALIE MEHRA: Okay.

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

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

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

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

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

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

15 NATALIE MEHRA: Thank you --

16 RILEY SANDERS: Yeah, I can deal with
17 that.

18 NATALIE MEHRA: -- very much. Okay.

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

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

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

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

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

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

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

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

8 And we can go back, Riley.

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

15 Amit, did you want to introduce
16 yourself?

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

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

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

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

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

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

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

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

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

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

3 So at the time that we wrote this
4 submission, which was November the 17th, there were
5 100 active outbreaks in long-term care homes up
6 from 76 at October the 31st and up from 18 at the
7 beginning of September.

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

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

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

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

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

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Wow.

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

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

13 Once school started in particular and
14 the case positivity rate went up in younger people
15 to between 2 and 4 percent in September, then we
16 saw, as the epidemiologists have predicted with a
17 lag of a couple of weeks, the outbreaks starting
18 among the four -- or the transmission starting to
19 the 40-year-old-plus age group, and thus, the
20 70-year-old-plus age group.

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

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

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

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

8 RILEY SANDERS: Yeah.

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

11 So you can see the chart there.

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

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

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

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

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

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

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

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

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

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

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Are people dying at the same rate?

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

1 at all glib, but they follow by several weeks.

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

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 Okay.

11 NATALIE MEHRA: Sadly. I mean,
12 horribly.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Yeah, no. It is -- but, anyway, thank you for the
15 answer.

16 NATALIE MEHRA: Okay.

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

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

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

3 So we wanted to look more closely --

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Can I just --

6 NATALIE MEHRA: Sorry.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 -- interrupt you for a second?

9 NATALIE MEHRA: Yeah.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 One of the things we are interested in is if there
12 is something that should be happening now --

13 NATALIE MEHRA: Yeah.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 -- that can happen now, you know, as opposed to
16 some long-term solution? We are very interested in
17 that.

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 All right.

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

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

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

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

25 So in terms of concrete factors, the

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

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

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

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

25 By September 18th, 46 residents were

1 infected, 6 had died, and 17 staff.

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

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

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

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

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

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

1 The lack of capacity once
2 businesses and particularly once the schools
3 reopened in September resulted in a very severe
4 backlog of testing, of processing of the tests, and
5 contact tracing. By the middle of October,
6 45 percent of the cases in Ottawa were not being
7 contact traced, as an example; 67 percent in
8 Toronto; about 17 percent in Peel.

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

11 NATALIE MEHRA: Yeah.

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

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

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

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

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

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

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

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

11 NATALIE MEHRA: They are doing the
12 testing, yeah.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 All right.

15 NATALIE MEHRA: So, like, Dynacare --

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Yes.

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

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.

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

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

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

25 So that impacted West End Villa, in

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

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

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

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

3 Oops. Don't go too fast, Riley.

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

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

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 I'll ask the same question I asked before: Does a
19 reason emerge why in September, having gone through
20 Wave 1 and having had all those experiences, this
21 kind of thing happens?

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

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

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

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

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

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Yeah.

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Okay.

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

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

6 So then we move on.

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

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

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

25 So the last paragraph on that page, a

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

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

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

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

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

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

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

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

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

25 So remember, this is a resident who's

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

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

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

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

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

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

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

23 That's Extendicare West End Villa.

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Do you have any --

3 NATALIE MEHRA: Oh, sorry.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Do you have any sense, when you describe the room
6 in which they found -- I guess it's the mother?

7 NATALIE MEHRA: Pierette, yes.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Were they not allowed in to visit before this; is
10 that the idea? Because you would think as soon as
11 you went in there and saw that that you would
12 become very agitated, to say the least.

13 But were they not allowed in before?

14 Is that what the situation is; do you know?

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

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

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Is that all staffing? I mean, is that the reason

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

4 NATALIE MEHRA: Well --

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

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

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

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

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

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

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

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

18 NATALIE MEHRA: In newspapers.

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

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

3 NATALIE MEHRA: Or both, yes.

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

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

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.

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

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

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Okay.

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

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

25 So moving on to Kennedy Lodge, is that

1 okay? Go ahead, Amit.

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

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

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

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

1 story was quite different.

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

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

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

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

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

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

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

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Mm-hm.

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

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

8 NATALIE MEHRA: Yes.

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

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

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

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

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

14 NATALIE MEHRA: That's right.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay.

17 NATALIE MEHRA: That's right. Okay.
18 So, Riley, we can go back to
19 the main --

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

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

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

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

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

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

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

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

1 what other people were saying was happening in the
2 homes.

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

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

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

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

25 But in terms of the general care

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

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

10 COMMISSIONER JACK KITTS: Okay. Thank
11 you.

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

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

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

25 And then there were other situations

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

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

11 COMMISSIONER JACK KITTS: Okay. Thank
12 you.

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

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

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

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

15 Okay. So the factors contributing --
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 So the infection control lead should be onsite?

18 NATALIE MEHRA: Well, on --

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

25 NATALIE MEHRA: Yes, and the

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

4 DR. AMIT ARYA: Absolutely.

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

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

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

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

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

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

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

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

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

21 Okay. And --

22 COMMISSIONER ANGELA COKE: Can I just
23 ask one question?

24 NATALIE MEHRA: Yeah.

25 COMMISSIONER ANGELA COKE: Just in

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

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

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

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

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

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

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

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

18 COMMISSIONER ANGELA COKE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

18 NATALIE MEHRA: From the homes
19 themselves?

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

24 NATALIE MEHRA: Yeah.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Okay.

25 NATALIE MEHRA: But there may be some

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

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

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

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay.

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

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

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

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

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

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

1 you know, through attrition and as they are
2 cohorting.

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

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

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

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

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

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

13 Did you want to add anything, Amit?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 DR. AMIT ARYA: Yeah, sorry about that.

15 NATALIE MEHRA: He's here. Sorry.

16 Thank you. Sorry, did you want to finish what you
17 were trying to say? We lost you there.

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

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

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

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

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

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

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

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

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

21 Obviously, this is a problem in the
22 second wave because hospitals are open, and in
23 Ottawa, for example, they're running at more than
24 100 percent capacity. And so every day that's lost
25 is a risk to life. We need to build the capacity.

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

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

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

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

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

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

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

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

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

1 administrators.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 And 95 percent of the staff reported
13 that their long-term care homes were short, and
14 53 percent actually said that there was staffing
15 shortages every day. 63 percent of the staff
16 actually said that the staffing levels were worse
17 than before COVID-19.

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

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

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

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

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

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

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

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

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

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

25 So we'll go back to the next.

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

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

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

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

1 the case in this study.

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

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

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

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

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

25 But we asked, do you have adequate PPE?

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

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

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

25 Locked up PPE. Not enough gowns; that

1 was fairly common. Not enough gloves.

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

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

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

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

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

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

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

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

1 hospital; and then problems with inadequate
2 equipment.

3 Riley, can you scroll down a little
4 bit?

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

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

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

14 Amit?

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

17 NATALIE MEHRA: You're on.

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

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

25 And basically, the same approaches to

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

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

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

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

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

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

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Is there any reason why the combination of a
12 registered nurse practitioner and virtual care
13 couldn't substitute for an absentee or sometimes
14 there/sometimes not there medical director?

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

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

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

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

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

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

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Okay.

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

25 Did you want to get into any of those

1 quickly?

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

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

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

25 I know many physicians that have

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

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

13 NATALIE MEHRA: Okay.

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

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

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

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

7 NATALIE MEHRA: We just had sort of two
8 sections.

9 Riley, can you flip forward one?

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

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

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

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

22 NATALIE MEHRA: Ten minutes or so?

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

25 NATALIE MEHRA: Okay, okay. So I'll

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

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

9 And if you can click on that link,
10 Riley?

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

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

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

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

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

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

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

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

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

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

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

1 long-term care bed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 Sorry, Amit.

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

1 inequity between different places.

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

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

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

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

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

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

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

17 So as you know, there's a director of
18 care and there's the medical director, but aside
19 from that, there's the requirement that homes have
20 one RN 24/7. It's our view that that's inadequate.
21 That's a 40-bed home or a 400-bed home, one RN
22 24/7.

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

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

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

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

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

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

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

12 In comparison, Québec, on June 1st,
13 announced that it would recruit 10,000 orderlies,
14 their equivalent to PSWs, with the full weight of
15 government behind the recruitment plan, and within
16 a matter of weeks, they had 67,000 applicants for
17 10,000 positions. They paid \$21 an hour for
18 training. They did a three-month training for
19 them, intensive training, and they have deployed
20 those PSWs or their equivalents into the homes now
21 to be in place for the second wave.

22 Nothing like that has happened in
23 Ontario, and we are -- they have 400 homes; we have
24 626 homes. So the scale of the problem in Québec
25 was similar, although I think it was worse in

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

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

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

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

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

25 NATALIE MEHRA: Okay.

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

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

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

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

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

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

1 DR. AMIT ARYA: Thank you.

2 NATALIE MEHRA: Bye-bye.

3 DR. AMIT ARYA: Thank you very much.

4 COMMISSIONER ANGELA COKE: Thank you.

5 Bye.

6 COMMISSIONER JACK KITTS: Thank you.

7

8 -- Adjourned at 2:51 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, OLIVIA ARNAUD, CSR, Certified
4 Shorthand Reporter, certify:

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;

9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

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18 Dated this 23rd day of November, 2020.

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