

Long Term Covid-19 Care Commission Mtg.

Ontario Nurses' Association – Second Meeting
on Tuesday, October 20, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 20th day
of October, 2020, 1:00 p.m. to 2:33 p.m.

BEFORE:

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

PRESENTERS:

ONTARIO NURSES' ASSOCIATION:

Beverly Mathers, CEO
Vicki McKenna, President
Cathryn Hoy, First Vice President

1 PRESENTERS (cont'd):

2 Pat Carr, Team Lead, Labour Relations

3 Nicole Butt, Manager, Litigation

4 Marcia Barry, Senior Legal Counsel

5 Nikolas Baxter, Legal Counsel

6

7 PARTICIPANTS:

8

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

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12 John Callaghan, Counsel, Long-Term Care
13 Commission Secretariat

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15 Lynn Mahoney, Counsel, Long-Term Care
16 Commission Secretariat

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18 Derek Lett, Policy Director, Long-Term Care
19 Commission Secretariat

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21 Jessica Franklin, Long-Term Care Commission
22 Secretariat

23

24 Dawn Palin Rokosh, Director Of Operations,
25 Ontario Long-Term Care Commission Secretariat

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

2

3 COMMISSIONER MARROCCO: If everybody is
4 here, we're all here. We're not in such bad shape
5 that we don't remember that you were here before
6 and that you were coming back to talk to us about
7 matters of more long-term than what we talked about
8 last time. Quite frankly, anything else that you
9 want to talk about since we're here. So go ahead.

10 MS. BUTT: Great. Thank you very much
11 for allowing us to return. There are two areas we
12 wanted to cover during this session.

13 We do have more on IPAC but we do want
14 to speak to the difficulties, and I would say
15 almost the impossibility of enforcement, in terms
16 of enforcing the Directives and also enforcing
17 basic occupational health and safety legislation.

18 And I'm going to start with that,
19 because in looking through the transcripts, you
20 haven't had a whole lot of information on that, I
21 don't think, and I think that our experience may
22 help shed some light on some of the challenges.

23 I think if we've learned anything over
24 the last few months, is that there is really no
25 effective enforcement mechanism in terms of

1 enforcing the Directives. And we're not even
2 talking about challenging the Directives, you know,
3 challenging not putting the Precautionary Principle
4 in. We're talking about basically enforcing what
5 is in the Directives.

6 And we have been really wondering,
7 where do you turn? We don't want to do things
8 after the fact. We want to be able to respond as
9 these issues arise and get them dealt with as
10 quickly as possible, to make sure that the workers
11 are safe.

12 So ONA has tried a number of things,
13 including inspections under the Occupational Health
14 and Safety Act and Appeals at the Ontario Labour
15 Relations Board.

16 We also filed an injunction, and we've
17 also resorted to grievance arbitration, and some
18 implementation issues through grievance arbitration.

19 So I'm going to talk about all of
20 those, but before I do that, I wanted to turn back
21 to a question that you asked last week about
22 whether we ever contacted Local Public Health
23 Officials, and so we actually did.

24 So when we went back through our
25 records, we did once write a letter to the Medical

1 Officer of Health for Haldimand-Norfolk, and that
2 was on April the 9th. We raised concerns that we
3 had about Anson Place.

4 And Anson Place is one of those homes
5 where we called in the Ministry of Labour twice and
6 were not getting any orders issued there to protect
7 the workers.

8 So we then sent this letter to
9 Dr. Nesathurai and raised our concerns about Anson
10 Place, and said at that time 42 residents out of 61
11 had tested positive. 21 staff have also tested
12 positive. And we raised a concern that residents
13 and staff were not being cohorted in particular.

14 Residents were still in the
15 four-bedroom ward rooms, and some of them in the
16 rooms had COVID and others didn't. So we asked the
17 Local Public Health Office to take some action.
18 And we also noted that it was an offence under the
19 HPPA to not comply with directives.

20 We received a response that same day,
21 so they were very quick at responding, but the
22 response was not -- they thanked us for raising
23 concerns, and said they had been working closely
24 with Anson Place. And then they attached a letter
25 from Anson Place to us, in which Anson Place told

1 us exactly what they had been telling us for the
2 last few weeks.

3 They were compliant with Directives.
4 That they were protecting the residents with
5 privacy curtains in the ward rooms, and things look
6 that. So this didn't help us, and so we didn't go
7 down that route, again, we just didn't see it as
8 helpful. So the next step -- sorry, go ahead.

9 COMMISSIONER MARROCCO: I may be taking
10 you off your point a bit, if I am, just tell me.

11 Had Anson Place been through SARS? I
12 mean, you know, SARS was different, but SARS was
13 the same in a way. And I'm just curious if they
14 developed any kind of, they had a plan like, you
15 know, what to do in the event of a pandemic or
16 anything?

17 Were any of those issues addressed by
18 Anson Place or the local -- did it come up in the
19 correspondence?

20 MS. BUTT: No, I don't believe they had
21 a pandemic plan. Because Anson Place then, we went
22 on and filed the injunction. So I can double check
23 those materials, but I don't believe they had a
24 pandemic plan.

25 The chain might have had something, but

1 it certainly wasn't being communicated to the
2 people on the ground.

3 COMMISSIONER MARROCCO: Did the
4 Ministry of Labour respond to the injunction as
5 well, or was it just Anson Place?

6 MS. BUTT: No. The Attorney General
7 intervened.

8 COMMISSIONER MARROCCO: I see, yes.
9 Yes, okay.

10 MS. BUTT: Yeah, the injunction was
11 really our next step. Before I get there, I do
12 want to talk a bit about the Ministry of Labour
13 inspection system. Because that was what we
14 initially thought would be most responsive to the
15 concerns that were being raised.

16 And that's because that's the
17 Ministry's entire reason for being, in terms of
18 making sure that the workplace is safe under the
19 Occupational Health and Safety Act. Certainly that
20 workers aren't supposed to be getting sick in the
21 workplace and dying. If anything, it's set up to
22 go in and inspect and make sure the workplace would
23 be safe, would be the Ministry of Labour
24 inspectors.

25 Unfortunately, that isn't what we saw

1 happening. The first thing I wanted to point out
2 is that the Directives, Directives 1, 3 and 5, they
3 are subject to the Occupational Health and Safety
4 Act.

5 So at the very bottom of the Directive,
6 it actually says that long-term care homes,
7 retirement homes are also required to comply with
8 applicable provisions of the Occupational Health
9 and Safety Act and its regulations.

10 So we had expected that the Directives
11 are sort of a floor, they're not a ceiling. And
12 OSHA is sort of the legislation that governs and
13 that the directors are subject to OSHA as well.
14 But that's not what the Ministry of Labour's
15 position was.

16 And I did mention this a little last
17 day, initially, the inspectors were not doing any
18 on-site inspections. So when we would phone the
19 Ministry of Labour, or a worker would call with a
20 concern, they would just do a telephone inspection.

21 So they would speak with the employer,
22 they might speak to a worker rep on the Joint
23 Health and Safety Committee, assuming that the
24 Joint Health and Safety Committee was working and
25 that the members of it weren't off sick.

1 And they rarely spoke necessarily to
2 the worker who phoned with the complaint. So there
3 was not a lot of complete information being
4 provided to them.

5 And again, Anson Place -- and I'm using
6 it just as an example -- but the Ministry of Labour
7 was called in on March 30th and on April 8th, and
8 there were telephone inspections. And in the
9 report that they file afterwards, it's called a
10 "Field Visit Report", the inspector noted that
11 workplace parties confirmed that there was
12 screening happening; that all workers are being
13 actively screened. And that this has been taking
14 place for more than three weeks.

15 So shortly after that, SEIU filed an
16 application at the Labour Board, and I think you
17 heard a little bit about that in their
18 presentation. ONA intervened in that, and as part
19 of the settlement, it was agreed that inspectors
20 would actually go in on site in Anson Place.

21 So inspections were still continuing to
22 be done by phone in most places, but in two
23 locations, Anson Place and Altamont, the Ministry
24 of Labour agreed the inspectors would actually go
25 on site.

1 And what we found then, was on the very
2 first inspection, which happened a few days later,
3 nine orders were issued against Anson Place; and
4 three of those related to screening. So where a
5 few days before they had said "workplace parties
6 confirm they're screening", once they were there in
7 person, they were able to see that the screener
8 wasn't wearing eye protection; that they weren't
9 asking the right questions, being that the Ministry
10 of Health was saying needed to be asked. And that
11 they didn't take the -- the screener didn't take
12 the inspector's temperature. So they were able to
13 observe the flaws that were happening. And they
14 never would have known if they weren't there in
15 person.

16 So, obviously, when we get to our
17 recommendations, one of them is going to be that
18 inspections need to be done in person, it's the
19 only effective way to actually see what's happening
20 on the ground.

21 Some other concerns we've had, and I've
22 mentioned, they didn't always speak to the worker
23 who made the complaint. And I think that is a
24 fundamental problem. You need to obviously speak
25 to the person who's raising concerns to understand

1 what they are.

2 And perhaps our largest concern was
3 that inspectors -- the position they took was that
4 they were only required to make sure that employers
5 were complying with the Directives. So they
6 weren't -- despite the fact that directives were
7 subject to OSHA, the position of the Ministry of
8 Labour was that if the employer was complying with
9 the Directives, they were in compliance with OSHA.

10 And because, as we mentioned last day,
11 the Directives provided some wiggle room in terms
12 of saying, you know, "where possible cohort", there
13 were very few orders that were ever issued.

14 So from there, ONA filed a number of
15 different appeals, a lot of them were in the
16 hospital sector, but we did file some in long-term
17 care as well. And during those appeals, again, the
18 Ministry's position was made very clear, that
19 compliance with directives equalled compliance with
20 OSHA.

21 COMMISSIONER MARROCCO: Did the Labour
22 Board rule on that?

23 MS. BUTT: No, and that's another one
24 of our problems. So we were either faced with a
25 situation of trying to resolve them one-off, one by

1 one, which we did in some cases. We do have some
2 that are proceeding, it's just that it's a lengthy
3 process. So there's been no response yet on the
4 fundamental issues.

5 So they were very quick to get a first
6 mediation date, usually within two weeks. But very
7 slow at sort of getting an actual hearing underway
8 to fight the issues. And so we do have one
9 proceeding, but I think the date is still later
10 this fall.

11 Another thing, and I mean, this is kind
12 of hearsay, but we have been told by multiple
13 inspectors that they had to consult before they
14 could make any orders. That there were a few times
15 where they thought maybe they would make an order
16 on PPE, but they were telling us that they had to
17 get instructions. And we heard that this committee
18 was referred to as WRAC, we don't know anything
19 more about it. But we are concerned if it is true,
20 that they weren't able to independently go and make
21 recommendations based on what their inspection was
22 saying needed to be done.

23 And certainly, we do know that the
24 Ministry of Labour was giving some instructions.
25 So one of the files that we settled was right after

1 the injunction decision came down. And so we
2 reached an agreement with the Ministry of Labour
3 that at a minimum they would tell the inspectors
4 that they had to interpret the Directives in
5 accordance with the Morgan decision. So they were
6 providing some guidance, but it was still very
7 limited to, you know, compliance with the
8 Directives is compliance with OSHA.

9 The other problem we have is that
10 inspections can be very slow. So some of them were
11 being done, you know, within a few days. But
12 again, if it's an urgent issue, it was very
13 difficult to get someone in that day.

14 But what is really of concern to
15 us that -- so one of our nurses passed away on
16 May 11th, Brian Beattie. And the investigation by
17 the Ministry of Labour there is still ongoing. So
18 it's been five months. We still don't have any
19 kind of final report. We've been following up
20 every few weeks, and we're just told it's in
21 progress. And this means like we can't even
22 proceed to file an appeal at this stage, because
23 it's still open as an investigation. And so
24 serious concerns that, you know, if we're not
25 getting anything done quickly, the workplace just

1 isn't becoming safer.

2 COMMISSIONER MARROCCO: Apart from
3 telling you that it's underway, did they give you
4 any reason why --

5 MS. BUTT: No.

6 COMMISSIONER MARROCCO: -- it's May,
7 June, July, August -- you know, to write a court
8 decision, you have to write it within six months.
9 They don't have a similar provisions, I guess?

10 MS. BUTT: No, they don't. They
11 usually release an interim report quite quickly.
12 They did release one, but it just looked at one
13 element of the workplace. And they said they had
14 to come back to do more and that hasn't happened.

15 COMMISSIONER MARROCCO: Okay.

16 MS. BUTT: So our main concern is that
17 the lessons of SARS, as they relate to the Ministry
18 of Labour, just haven't been learned.

19 They're not independent, they don't
20 understand infectious diseases, and there was a
21 failure to protect the health and safety of workers
22 at the time they most needed it.

23 The other recommendation that was
24 ignored from SARS was there were no proactive
25 inspections done. So back in January, February,

1 March, when things were gearing up, even in
2 February, when the first long-term care home in
3 BC had the infection, the Ministry of Labour didn't
4 start to do any kind of proactive inspections of
5 long-term care homes. And we're really just
6 reacting to the complaints that they were hearing.

7 So the Ministry of Labour wasn't
8 effective, the Local Public Health wasn't helpful.
9 And that's what ultimately led us to file the
10 injunction in mid-April. At that stage, we were
11 becoming desperate to help our members. And so we
12 did take a highly unusual step of filing the
13 injunction, we filed it against four homes.

14 We could easily have filed it against
15 another 20, but we had to focus on sort of the four
16 worst first. And we will provide you with the
17 Court materials, I was going to ask at the very end
18 how you would like to receive them, whether you
19 want hard copies or electronically.

20 COMMISSIONER MARROCCO: I can answer.
21 If you can provide them electronically, if we want
22 paper copies, we'll do them ourselves.

23 MS. BUTT: Wonderful. And the Court
24 materials have affidavits as to what was happening
25 at the time in the homes, from some of our members

1 and I think they would be helpful to you.

2 Justice Morgan released his decision
3 very quickly, and he was very clear, paragraph 94
4 that:

5 "Where the lives of nurses and
6 patients are placed at risk, the
7 balance of convenience favours those
8 measures that give primacy to the
9 health and safety of medical
10 personnel and those they treat."

11 And so he was very concerned, and it
12 was clear in his questioning as well, about the
13 health and safety of the workers and the residents
14 in the home.

15 So he ordered that the responding homes
16 had to provide nurses with access to fitted N95
17 respirators and other PPE. And clarified that if a
18 nurse assessed that it was necessary, that they
19 were to be provided with that. And he also ordered
20 them to implement the other controls, such as
21 isolating and cohorting residents and staff.

22 That applied to the four homes in the
23 injunction. We obviously tried to have it
24 implemented more broadly. And as part of that,
25 appeared before arbitrator John Stout a few weeks

1 later, and put approximately 150 grievances from a
2 number of -- 150 long-term care homes before him.

3 And so with that, we also have
4 materials from the arbitration that we can provide,
5 and again, there's more affidavits from a larger
6 sample of homes that were put before Arbitrator
7 Stout.

8 In terms of arbitration, generally the
9 process can be quite slow. So Arbitrator Stout
10 actually freed up time on weekends so that we could
11 get this done. Normally, if I were to contact him
12 and ask for a date, he's booking in 2023. So
13 arbitration is not always that efficient. It takes
14 time to get dates, it takes time to put all the
15 evidence in, like any other legal proceeding.

16 COMMISSIONER MARROCCO: Can I stop you
17 there for a minute?

18 MS. BUTT: Yes.

19 COMMISSIONER MARROCCO: So you file a
20 grievance and you and whoever, agree that he's the
21 arbitrator you want, you can't get him until 2023?

22 MS. BUTT: That's right. He is busy.
23 There are some who have availability sooner.

24 COMMISSIONER MARROCCO: The question
25 is, why is that?

1 MS. BUTT: They tend to be newer. Less
2 experienced, less familiar with the sector. So,
3 yes. Yeah, 2023 at least, if not later.

4 And the other thing with the grievance
5 is the process. So you file the grievance, you
6 then have to have a step two meeting, and if you're
7 lucky is done within two weeks, but it's usually
8 done within a month. And then there's a chance to
9 respond and then it gets referred to arbitration.
10 And so normally, the earliest you can get even a
11 date would be a few months down the road.

12 COMMISSIONER MARROCCO: Okay.

13 MS. BUTT: So arbitration has its
14 problems. But as I said, Arbitrator Stout realized
15 how important this was, booked a weekend and we
16 were able to get an award at the end of that.

17 And so Arbitrator Stout incorporated
18 Justice Morgan's orders into his decision. He
19 ordered the homes to ensure that they had
20 sufficient supply of fit tested N95s that were
21 readily available. And that has been something
22 that we have been -- there's been challenges in
23 implementation on that.

24 He also ordered that employees who test
25 positive, were not to work unless they had two

1 consecutive negative tests 24 hours apart or until
2 14 days had elapsed after symptom onset, if they
3 were symptom-free.

4 And he ordered that because it had been
5 a major point of contention between the parties.
6 And again, because the Directives weren't always
7 consistent and clear, that was ordered.

8 And he also, and I think this is very
9 important. He noted that in addition to all of the
10 AGMPs, the Aerosol-Generating Medical Procedures
11 that were listed in the Directives, nurses should
12 be considering the fact that -- of resident
13 behaviors when they do their point-of-care risk
14 assessment.

15 So considering that there's a lot of
16 spitting, and the sort of expression of body
17 fluids, I think is how he put it in his award, and
18 that that's something that needs to be taken into
19 consideration in the long-term care sector.

20 So we got the decision, and that was in
21 early May. And since that time, we have had many
22 implementation issues. So we're still hearing from
23 homes that they don't have ready access to N95s,
24 and we're having to -- we've had to return to him a
25 number of times to force employers to comply. And

1 in fact, we are going back before him this week.
2 Not every nursing home was part of the Stout award,
3 so right now we're dealing with one home that isn't
4 part of it. And with respect to that one, we've
5 got a conference call with him this week to then
6 try and set up a date to get something urgently
7 done to respond.

8 We're just -- I think ONA's main
9 concern is, there's really no way to enforce these.
10 You know, we get these calls all the time from our
11 members saying that, you know, we don't have N95s.
12 Or last night I was denied an N95. And there's
13 really no way to get a quick resolution to that.

14 We do have a number of recommendations,
15 and again, these are more short term. We have a
16 number of thoughts as well in the long-term about
17 changes in the Occupational Health and Safety Act
18 that might be helpful, but we wanted to focus on
19 sort of short term what could be done.

20 Nick, do you have the PowerPoint
21 recommendations?

22 MR. BAXTER: I do I will share them
23 right now.

24 MS. BUTT: Great.

25 So the first recommendation is for some

1 sort of general oversight provision. So we need a
2 system and a process to ensure timely enforcement
3 of the Directives. And as part of that, we believe
4 that the HPPA needs to be amended to provide some
5 whistleblower protection.

6 One of the things we've been thinking
7 about is, is there a way to establish some sort of
8 hotline that workers can call, and there's someone
9 who answers and can investigate their concerns
10 right away.

11 We know in other industries, sometimes
12 law firms are set up that do that. I think it's
13 something that needs to be considered, and a lot of
14 our nurses are also facing significant reprisals in
15 the workplace for coming forward. Both in
16 providing the affidavits to the Stout award, and in
17 other cases they've experienced significant
18 reprisals in the workplace.

19 COMMISSIONER MARROCCO: I know you said
20 that there was no whistleblower protection. But is
21 there not protection under the Occupational Health
22 and Safety Act for a whistleblower? How does that
23 work?

24 MS. BUTT: There is a provision in the
25 Occupational Health and Safety Act that does say

1 there should be no reprisals. It's not well enforced.

2 COMMISSIONER MARROCCO: Okay.

3 MS. BUTT: I'm not sure Marcia, if you
4 have anything to add to that. But in my experience
5 it's been poorly enforced, and again, by the time
6 we get there -- it's very reactive and our members
7 by that time have been disciplined or terminated,
8 and it's very hard to sort of enforce that.

9 Go ahead.

10 MS. MATHERS: It's Bev. Similarly, the
11 Long-Term Care Homes Act has some whistleblower
12 protection. ONA, when we made submissions on the
13 original bill, didn't believe the whistleblower
14 protection went far enough, particularly, in the
15 areas of patient advocacy; and still don't believe
16 it does.

17 And in fact, the remedies under that
18 act are quite insufficient. And the remedies under
19 the grievance arbitration process for ONA members
20 are certainly more substantive. But all of them,
21 even the ones under the Occupational Health and
22 Safety Act, take a significant amount of time. And
23 if a member is terminated, they have no wages for a
24 long period of time as a result of trying to do the
25 right thing.

1 MS. BUTT: I did take a look, I don't
2 believe there's anything similar to that under the
3 HPPA, and that's a definite gap.

4 MS. BARRY: If I can just add to that,
5 I think the aspect of anonymity is important for a
6 lot of the healthcare workers because a reprisal
7 can be difficult to establish, I think a lot of
8 workers are afraid of sort of soft reprisals that
9 are harder to link to the fact that they've taken
10 action under OSHA or under the Long-Term Care Home
11 Act.

12 So a form of whistleblower protection
13 like a hotline, where complaints can be made
14 anonymously I think would help.

15 MS. BUTT: The next set of
16 recommendations. So first of all, the MOL should
17 be conducting a proactive inspection, we refer to
18 it as a blitz, in long-term care homes. And that
19 would be including unannounced inspections.

20 Things that need to be looked at is the
21 internal responsibility system, the functioning of
22 the Joint Health and Safety Committee. Are they
23 meeting regularly? Are they meeting at all? We've
24 heard some homes haven't had a meeting in a long
25 time.

1 Checking to look and see that all
2 policies and measures and procedures that are
3 required under the Act are taking place. Checking
4 to see that they have a supply of PPE, and that
5 staff have been trained in it. And that homes are
6 acting in accordance with the precautionary
7 principles.

8 We think even at this stage, even going
9 into the second wave, getting the Ministry in there
10 quickly to do these inspections proactively would
11 be helpful. Especially, as we see homes are --
12 that didn't have an outbreak in the first wave, are
13 now experiencing outbreaks. And so they don't have
14 the experience necessarily that the other homes
15 have had to build on. So I think this is
16 particularly important.

17 Next one. And then in terms of actual
18 inspections that are complaint-based. As I have
19 said a few times, they need to be done in person on
20 site. They need to speak to the workers, including
21 the worker who made the call. They need to
22 exercise independent judgment in decision making.

23 Explain the rationale for not issuing
24 an order, and complete their investigations in a
25 timely manner. Particularly, those being conducted

1 as the one with respect to the death, they need to
2 be done in a much more timely manner.

3 The next one I can't emphasize enough.
4 They need to inspect to fully enforce the Act and
5 not just the Directives.

6 And again, we think that they should be
7 done on site, and that they can wear appropriate
8 PPE to go in. It's safe for our members, it should
9 be safe for the inspectors.

10 We haven't talked about Ministry of
11 Long-Term Care inspections, because we know you've
12 heard a lot about them. We think they need to be
13 done in-person on-site. There were times we
14 advised our members to call the Ministry of
15 Long-Term Care to report abuse or neglect. For
16 example, when we heard they weren't cohorting. But
17 we don't know what happened with those calls, but
18 we do know those calls have been made and were
19 made.

20 MS. MATHERS: Well, we know, Nicole.
21 So ONA actually wrote, and did a complaint to
22 Ministry of Long-Term Care for River Glen Haven and
23 Vicki, we finally have the Ministry of Long-Term
24 Care inspectors circle back to us, months later,
25 after they had been into River Glen Haven, and that

1 was well after their outbreak, and only to tell us
2 that the issues that we have highlighted for them
3 were in fact founded and true.

4 But the Ministry of Long-Term Care
5 inspectors, like the Ministry of Labour inspectors,
6 were also only making phone calls and inspecting
7 that way, during the outbreaks didn't have shoes on
8 the ground. And it wasn't until after the military
9 report came out, that the Ford Government ordered
10 them back in to do inspections.

11 COMMISSIONER MARROCCO: Do you think
12 there's a problem around the fact there seemed to
13 be a multitude of inspectors? Ministry of Labour,
14 it seems in order to activate them, it needs to be
15 a worker who is complaining. And if you are a
16 resident and not a worker living in a long-term
17 care facility, that you have to complain to the
18 long-term care inspector, to use a shorthand. And
19 so do you find this -- have you run into this as a
20 difficulty or not?

21 MS. MATHERS: I was going to say, it's
22 fragmented to be sure. And the interesting thing
23 about it, though, is they have different powers and
24 they look at different issues. So for instance,
25 with Ministry long-term care inspectors haven't

1 been in doing their proactive inspections which had
2 been stopped, they should have noticed,
3 particularly if they were out there, January,
4 February and in early March, they would have
5 noticed these homes had insufficient infection
6 control plans in place.

7 Because that is under the resident
8 quality inspection, the big RQI inspections, those
9 are one of the pieces they inspect. But again,
10 those RQI inspections have all but ceased. And
11 I'll let Nicole speak to particularly Ministry of
12 Long-Term Care.

13 MS. BUTT: What I was going to say, I
14 know that the SARS Commission recommended, and we
15 still think it's a very good idea, that there be
16 teams that are, you know, have Ministry of Labour,
17 Ministry of Long-Term Care, or Ministry of Health
18 inspectors on them, that can sort of proactively go
19 in and inspect and enforce that way. And I think
20 that's something we'd be looking at again.

21 COMMISSIONER MARROCCO: Okay. Do you
22 know why they didn't do it?

23 MS. BUTT: No. No. I mean, all I can
24 guess is that after a while people became
25 complacent, and didn't. There's a number -- you

1 know, again, more systematically, there were
2 recommendations that there be someone from the
3 Ministry of Labour sitting on PIDAC. And in the
4 SARS report it actually says they committed to
5 doing that.

6 And if you look at the composition of
7 PIDAC right now, they're all doctors working in
8 hospitals or Public Health, and nobody is bringing
9 that sort of worker occupational health perspective
10 forward. So I think a lot of those recommendations
11 just got -- just weren't followed up on.

12 MS. MATHERS: I think, too, in Ministry
13 of Labour, there is a shortage of inspectors who
14 have been trained on healthcare and trained on
15 infectious diseases investigations. And I think
16 that became obvious.

17 I know at one point we had inspectors
18 into one of our sites in London, and it was an
19 industrial health and safety inspector. Yeah, it
20 was an Industrial Ministry of Labour inspector that
21 was in, who knew nothing about infectious disease
22 spread.

23 MS. BUTT: OSHA generally doesn't
24 address infectious diseases at all. And that's
25 again something long-term we're thinking of

1 recommending, would be some sort of legislation in
2 OSHA specifically addressing this type of
3 situation. Because even simple things like getting
4 notification of a worker's illness.

5 It's very clear under the Act that if
6 someone dies, or is critically injured, which
7 includes your life being placed in jeopardy, that
8 notice has to be given immediately.

9 Well, the position taken by the
10 Ministry of Labour is that if there's a death,
11 fine, that's covered. But, you know, if you are
12 hospitalized and on a ventilator, that isn't
13 considered a critical injury and those notices
14 don't happen under that section.

15 So there's a whole lot of things that
16 just aren't understood and taken into consideration
17 under OSHA, that I think long-term needs to be
18 looked at.

19 Did you have any more questions sort of
20 on the enforcement side of things?

21 COMMISSIONER MARROCCO: I don't think
22 we do.

23 MS. BUTT: Okay. Then we wanted to
24 continue, last day we had more we wanted to say
25 about what was happening in long-term care homes,

1 specifically, with respect to leadership and
2 communication and IPAC more, and so maybe we'll
3 turn over to that.

4 Cathryn, I think, are you up next.

5 MS. HOY: Yes. So I'm going to try to
6 be quick, because I know there's a lot to get
7 through.

8 Our members have pointed to two main
9 issues, in addition to the staffing crisis that
10 they believe contributed to the severity of the
11 outbreaks in long-term care.

12 A failure on the part of the leadership
13 to proactively prepare, communicate and failure to
14 implement the common IPAC and Health and Safety
15 measures. So I'll talk about a few of these issues
16 and then I'll turn it over to Vicki to talk about
17 IPAC and Health and Safety.

18 When we looked at many of the worst hit
19 homes, leadership was simply absent physically.
20 While the RNs were walking into very dangerous
21 circumstances to care for the residents, many of
22 them were just walking out. Including the
23 administrators, the director of care, the
24 physicians, funeral directors, and other supports.

25 Many administrators, director of care

1 and other managers just disappeared on daycations
2 or leaves, or they stayed in their offices and
3 rarely ventured onto floors.

4 So an example is Scarborough Health
5 Network, noted at their Extendicare Guildwood. The
6 administrator, the assistant administrator, the
7 director of care and program manager were off for
8 extended periods of time. And the infection
9 control lead, and quality lead just stopped coming
10 to work.

11 So while replacements were sent, there
12 were gaps in leadership because the new leaders did
13 not know the home, the residents, the family or the
14 staff, and that's very problematic.

15 So in other cases, while leaders remain
16 physically present in the home, they failed to
17 lead. We heard from many, many nurses that they
18 were the ones proposing the measures to the
19 director of care administrator. Sometimes their
20 ideas would be implemented, but many times they
21 were not.

22 So for example, in early March, it was
23 suggested that they set up an extra handwashing
24 station, and a set aside space in the home to be
25 used for isolating residents. Her suggestions were

1 not implemented, and she was told that she was fear
2 mongering. That's just terrible.

3 Furthermore, communication, many homes
4 particularly those worse hit by the outbreaks was
5 just abysmal. We heard from many staff members,
6 from different homes that they were not even being
7 advised when residents were tested positive for
8 COVID, instead, they actually learned from families
9 that someone had tested positive.

10 So in turn, we know that communication
11 from the homes to the families were problematic.
12 And I just want to share, I have a brother in
13 long-term care. An agency worker came to work in
14 his home due to the staffing shortages, and that
15 agency worker was found to be positive for COVID.

16 So the practice of using agency nurse
17 that could hop all over the place, put my brother
18 at risk, as well as each one of the residents he
19 lives with, and the residents at the next home that
20 that agency worker would go to. So communication
21 is key here. Because that home did not communicate
22 with the family, who I am the family, I was put at
23 risk. I dropped off his monthly care package, so I
24 made contact with the home.

25 So if I had had a communication, I

1 would not have been at that home. So for me going
2 to that home, they put me at risk, and every single
3 person I came into contact with. So lack of
4 communication seems simple. But it has a domino
5 effect, especially in this environment.

6 So I want to stress, because you've
7 heard about staffing. Agency is not the answer.
8 Homes should be staffed with their own staff and
9 communication is key.

10 So in addition to changes in direction,
11 corporate policies, we're not always communicated
12 to the frontline. Those that work on evenings and
13 nights, they received even less information.

14 Now this isn't true of all the homes,
15 we did hear of some inspiring examples of strong
16 leadership and how it really did make a difference
17 to the staff. And we can actually learn from these
18 examples going into the second wave, or we are in
19 the second wave.

20 Some measures that worked included
21 daily huddles and a communication binder for staff
22 to review; very simple.

23 So one of our recommendations is the
24 administrators, DONs, so director of nursing,
25 assistant director of nursing, should communicate

1 with families and substitute decision makers.

2 Our members have told us that they
3 spend an incredible amount of time on the phone
4 with families. This is critical work, but with
5 staffing so, so short, it has fallen on the
6 frontline nursing staff to do.

7 So during any outbreak, the director of
8 nursing and the administrator must be present,
9 full-time, amongst altering times of day they are
10 in the home to provide leadership and direction at
11 times other than Monday to Friday during the
12 daytime. Staff work 24-7, communication needs to
13 be across shifts.

14 The role of the medical director needs
15 to be clarified, so that it is clear that they are
16 expected to attend the home in-person during an
17 outbreak.

18 Licensees are required to immediately
19 notify all employees when a resident or employee
20 tests positive for COVID-19 to stop the spread.

21 A flagging system must be developed to
22 indicate which residents have COVID-19. This
23 includes a sign on the door to the room, a sign
24 above the bed, and a wristband, so that if a
25 resident wanders, staff are aware of the resident's

1 status. Flagging systems are currently used for so
2 many different methods, so this is just in
3 addition.

4 Daily huddles on every shift should be
5 held to discuss new or updated policies,
6 procedures, and measures. Huddles should also
7 include new and emerging treatment and care
8 protocols, particularly for emerging diseases.
9 Example, the COVID that we're experiencing now, how
10 to provide supportive care. Information should be
11 documented in a binder or on an electronic
12 platform, so that it can be shared with staff
13 working on evenings and night shifts, and everyone
14 knows where it is.

15 The care plan for all residents needs
16 to be updated immediately, to reflect the
17 resident's wishes regarding enhanced care and
18 alternate care settings.

19 Just because a patient is DNR, does not
20 mean that their illness should not require medical
21 management.

22 So another example is Windsor Field
23 Hospital, Windsor-Essex County Health Units Medical
24 Officer of Health, described contacting every
25 family to discuss their wishes. Updating care

1 plans in advance would save so much time, and allow
2 affected residents to be transferred and isolated
3 much more quickly and efficiently.

4 I'm going to turn it over to Vicki
5 shortly, but I just wanted to add something because
6 I think examples speak so loud. So you heard us
7 speaking about staffing, you're going to hear it
8 again later. So I also had a mother in long-term
9 care until August. I want to share with you, there
10 was one registered nurse on nights, 130-plus
11 residents.

12 They are not only that registered
13 nurse, they are the manager, they are the staffing
14 clerk, and they are the maintenance person. They
15 shovel snow, actually, in the wintertime. And day
16 shift is not much better.

17 And that was a home for the aged, and
18 nursing homes are staffed far less. My mom was
19 palliative. So I stayed in that home for eight
20 days, 24-7. And for her passing, she required
21 extra, extra care for eight days. I can't say
22 enough about how wonderful the staff were. But,
23 they were overworked, they were double shifted,
24 they had no days off, and many shifts had staffing
25 shortages. The number one priority, in any care,

1 but long-term care should be meeting the care of
2 the residents, and not increasing dollars to
3 shareholders. Staffing, and the right staff, not
4 just bodies, should be our foremost thought in
5 long-term care.

6 So I just want to ask you one thing,
7 and I say this with the utmost respect. Tomorrow
8 morning when you all get up, I want you to set your
9 phone for six minutes. That's how much time each
10 of you will have to get up, get showered, get your
11 hair done and all other aspects of personal care.
12 And I'm talking dressed and out the door from start
13 to finish. I'm sure you're going to find it a
14 challenge. Now imagine that you're bedridden,
15 probably in soiled briefs, or you just have issues
16 with mobility. Can you imagine getting ready in
17 six minutes? Because that's all the time that is
18 given to the staff, for people like my brother and
19 mom, who need to get up. So treasure your six
20 minutes tomorrow, and I'd love to know how it works
21 out.

22 So I'm going to pass it over to Vicki,
23 and I thank you for your time.

24 COMMISSIONER MARROCCO: I think you can
25 assume it didn't work out well.

1 MS. HOY: Yeah, it didn't work out
2 well. But I think sometimes you really need to put
3 things into perspective, to understand how hard the
4 staff work and how short they are.

5 And these are the people of Ontario
6 that have given to all of us, and I truly believe
7 they deserve more.

8 MS. MC KENNA: Absolutely true,
9 Cathryn, thank you.

10 I want to talk a bit about IPAC, and I
11 know we keep talking on and off about it, but I
12 want to spend more time on it. And we are hard on
13 this issue, because it is critical. It is
14 imperative that IPAC is a big, what I'm hoping will
15 be a major recommendation. And this is a
16 short-term situation that needs to be remedied.
17 This is something that needs to be done right away.

18 So I will say this. That overall, the
19 change in leadership within the homes, they fail to
20 proactively prepare and to implement basic
21 infection control measures. Such as screening,
22 isolating, cohorting, providing PPE. You've heard
23 that, and we'll talk about it off and on.

24 It was really difficult to understand,
25 because long-term care deals with outbreaks all the

1 time. And if you have a loved one, or a family
2 member, or a friend in long-term care and you've
3 visited them over the last number of years, you
4 will often -- I myself going there, arrive to find
5 a sign on the door to say, we're in outbreak. This
6 is the situation.

7 You know, so I actually, in my years in
8 nursing when this all started, I thought, okay, you
9 know, long-term care, they'll be on it. They're
10 going to be prepared, they'll be planning
11 everything, you know, things will be in place.

12 But I'll say that when the news broke
13 in January, and the outbreaks in Washington State
14 and BC began in February and in early March, we at
15 the long-term care homes were slow to react. It
16 seems like they froze. They were waiting to be
17 told what to do by Government, instead of applying
18 IPAC principles proactively and early.

19 They weren't prepared to take the steps
20 to prevent the virus from entering the home or to
21 address it once it was there. And there are some
22 best practices, there are some really good examples
23 of where that did not take place, where nursing
24 home administrators stepped up early in staff.
25 They did things before Public Health told them they

1 needed to do, or before the Government told them
2 anything, they knew what to do. But many, many
3 others did not.

4 So here are some of the key issues.
5 Training. Most IPAC training seems to be done via
6 e-learning, or given when there's a policy to read.
7 Now across the homes, our members reported in the
8 survey that we did, where we had over a thousand
9 nurses who work in long-term care respond.

10 33 percent of them said they only
11 received a policy to read.

12 30 percent said they received a webinar
13 or had some e-learning modules to do.

14 5 percent said they received absolutely
15 no information or training at all.

16 21 percent said they received in-person
17 training with practice on the donning and doffing
18 of personal protective equipment.

19 And that we all know, I know as a
20 nurse, that the donning and doffing practice and
21 drilling is a skill and it is something that has to
22 be practiced, and it isn't a one-off.

23 Staff were required to work while they
24 were sick and infectious or return to work after
25 they had two negative tests, or after the 14 days

1 after symptom onset.

2 In the homes that have outbreak,
3 17.5 percent of the nurses who tested positive for
4 COVID said they were required to return to work
5 while they were still symptomatic.

6 36.9, almost 37 percent say they were
7 required to return to work before receiving two
8 negative tests as was the direction.

9 And 22.7 say they were required to
10 return to work before two weeks having lapsed since
11 their first positive test.

12 So that is in a quick nutshell, some of
13 the situations, and what our nurses are reporting
14 from the frontline.

15 So Bev, do you want to talk a bit about
16 cohorting.

17 MS. MATHERS: Thanks, Vicki. One of
18 the other challenges we dealt with is failure to
19 isolate and cohort residents.

20 So beginning in early April, we
21 received numerous reports that homes were not
22 complying with Directives 3 and 5, and that
23 specifically, they were not isolating and cohorting
24 residents.

25 We brought evidence in the injunction

1 to support that homes were not doing that. And
2 this was continued even after Justice Morgan
3 ordered homes to cohort. And in fact, I'll pick on
4 the Anson Place again, because well, sadly it is so
5 easy to pick on.

6 But the reality of the situation is,
7 Justice Morgan ruled on Anson Place and yet weeks
8 after his award, our night nurse and a PSW who
9 hadn't seen a manager in weeks, took it upon
10 themselves, also on a nightshift, to cohort the
11 residents. And decided if they were terminated
12 because of it, it was probably just as well,
13 because the environment was unsustainable.

14 At Scarborough Health Network, they
15 were assigned to come in and support Sienna
16 Altamont. In their interim report, Scarborough
17 Health Network said that cohorting was not
18 completed until after they were in the home and
19 that it was done on July -- sorry let me say that
20 again. It was done on June 15th and 16th.

21 So that was weeks and weeks after the
22 beginning of the outbreak at Altamont. In our
23 survey, 20 percent of respondents said that
24 residents exhibiting COVID symptoms are not
25 isolated, and 40 percent of respondents stated that

1 staff cohorting was not implemented either.

2 So I'll move then to talk about
3 cohorting of staff, and say that many homes also
4 did not cohort staff. While it's true we're
5 focused on the RNs, this also was not done with the
6 PSWs.

7 At times this was simply a function of
8 the fact that they were so critically short-staffed
9 they simply couldn't assign staff to only work with
10 residents who were diagnosed with COVID-19. But
11 even where they did try to cohort staff, that it
12 was virtually impossible for RNs. If the home only
13 has one RN, it becomes then impossible to cohort
14 them with only the negative or positives with only
15 one in the building. And we see this on many
16 evenings and nightshift where they can't do it.

17 So, you know, the unfortunate thing
18 about not cohorting both staff and residents is, we
19 have learned just how easy it is to spread COVID,
20 and how not cohorting has likely contributed to the
21 spread of COVID in these homes. And with that,
22 I'll turn it back over to Cathryn.

23 MS. HOY: So the homes did not have
24 sufficient supply of PPE, gloves, gowns, goggles,
25 shields, surgical masks, and N95 respirators.

1 So this meant that at times, staff are
2 not wearing PPE, or they were wearing the same PPE
3 in between residents, which is totally contrary to
4 infection control measures. Or, they were actually
5 making their own. And if you're on Facebook, I'm
6 sure you've seen it, some of our members literally
7 had to wear garbage bags.

8 So we will provide you with a copy of
9 the survey report, but it's very clear from the
10 survey that in homes without outbreaks there were
11 definite supply issues with all types of PPE.

12 26 percent reported supply issues with
13 the impermeable gowns; almost 35 percent with face
14 shields; almost 70 reported restrictions on their
15 use of N95s; and 30 percent saying that they were
16 explicitly denied N95s.

17 So the nurses face constant battle each
18 and every day just to get an N95.

19 They were told they can only wear them
20 if they were performing AGMPs. Many employers took
21 the position that AGMPs were not performed in
22 long-term care.

23 Just a sidenote, I asked for the
24 suction machine for my mother, but I was told it
25 was locked up, it was an order from the Ministry of

1 Health. My mom needed that suction machine, so who
2 do I question? Was it a proper order, or did they
3 not have N95s, or did they not want to give N95s?

4 So when a hospital took over, they
5 reinforced this messaging. Homes locked up N95s,
6 so they could not be accessed by our nurses when
7 needed. And this was particularly problematic on
8 evenings and night shifts.

9 When the DOC did come to work, but they
10 went home, they had the keys. So other homes did
11 make N95s available, but not necessarily in the
12 sizes needed by the staff. So if a worker was
13 provided with a N95, and it's the wrong size, it
14 will not seal and it will not provide the airborne
15 protection that they need.

16 So even now we're still receiving
17 frequent reports that nurses cannot access the N95s
18 when needed, or that they're being provided with
19 one N95 to last the entire shift.

20 Tests for N95s was not conducted for
21 staff prior to the arrival of COVID-19. We know of
22 several homes that are still doing their first
23 round of fit testing in the second wave. At least
24 one home has advised its staff a few years ago that
25 they would have to pay for fit testing themselves.

1 Many others are now redoing the fit testing,
2 because the new models of N95s have been introduced
3 in the workplace.

4 So I will hand this over now to Nicole.

5 MS. BUTT: Thank you. What I wanted to
6 speak about briefly right now is to provide a
7 recent example of how this is still happening.

8 So this happened during the first wave,
9 but it's still a concern. And I did mention we're
10 going before Arbitrator Stout this week, but I
11 wanted to give a few details about what we're being
12 told is happening right now in the second wave.

13 So, first of all, a small home is
14 having its first outbreak right now. Nurses have
15 told us that first they were being provided with
16 only two surgical masks and one N95 for a full
17 shift. They are not cohorting staff. And last
18 week a nurse told us that she was denied an N95.
19 That the ADOC and a manager from the hospital that
20 has been brought in to manage, both told her she
21 can only have the N95 if she was doing an AGMP;
22 which is clearly not what the Directive says. And
23 so she was denied that N95.

24 We then wrote a demand letter, telling
25 them that they had to cohort. That they can't be

1 denying N95s, in accordance with Directive 5. And
2 a few days ago, we received a response from a
3 senior manager at the hospital, who's been seconded
4 to support the home. And this is a problem that we
5 see a lot. The hospitals are helpful, but they
6 don't always understand the context of long-term
7 care.

8 And her e-mail to us has made us
9 extremely concerned. So she indicated that they've
10 had a meeting with staff to review required
11 precautions for routine care of COVID-19 residents,
12 which as you are aware, is droplet contact
13 precautions.

14 And she clearly explained to the staff
15 that the evidence is that this is an illness that's
16 predominantly transmitted through droplets. And,
17 you know, this is discouraging members who are
18 hearing this message and might want to do their
19 PCRA and decide they need to have the N95.

20 She also shared with the staff that the
21 increase in healthcare worker cases are
22 predominantly due to community contact; through
23 contact with friends and families; or because
24 workers are not being truthful about their
25 symptoms; or they're not complying with infection

1 prevention and control protocols in place.

2 So again, there's this sense that, you
3 know, it's not the fault of the home, it's the
4 fault of the workers who are, you know, getting
5 this in the community and bringing it into the
6 home.

7 She also claims that N95s are in short
8 supply, which is contrary to what the Government
9 has been telling us repeatedly, recently. And she
10 says that most vendors are no longer willing to
11 provide these to long-term care homes in order to
12 divert supplies to facilities that are high-risk
13 environments due to the frequency of regular
14 aerosol-generating procedures, like the ICU,
15 emergency and surgical, and trauma suites.

16 So we're very concerned about what's
17 happening in this home, but we also think it's
18 happening in other homes. This is consistent with
19 the messaging that we've heard over and over again.

20 It's not consistent with the
21 Precautionary Principle. It downplays the risk to
22 staff in long-term care, where the majority of
23 healthcare worker infections have happened. And
24 the reality is that long-term care is a high-risk
25 environment. Around the world that's been

1 recognized.

2 So we're in a situation now -- sorry,
3 it also disregards what Arbitrator Stout recognized
4 in his award that residents exhibit those behaviors
5 like spitting and coughing that can endanger our
6 members. And that's actually been, you know, it's
7 been recognized by Stout. Certainly, the new
8 directive speaks to proximity to the members, or to
9 the residents as being something to be considered
10 in doing the point of care risk assessment.

11 And so we've got a situation where
12 members are being denied N95s, but they're also
13 being actively discouraged and being made to feel
14 guilty for asking for them in the first place.
15 Fundamentally, that is a problem and it puts every
16 one in the home at increased risk.

17 So we've set up a conference call, as I
18 said with Arbitrator Stout. But again, we don't
19 know how quickly these issues can get resolved.
20 And in the meantime, you know, this goes to
21 enforcement. Our members are still going there to
22 work every single shift, and they're in trouble.

23 This is a situation where, you know, I
24 think last I heard, they had close to 30 residents
25 and staff who were sick.

1 MS. MC KENNA: It's Vicki. Yeah, I
2 just have to come in to say, you know, when you
3 hear these stories, it's no surprise that Ontario
4 has some of the highest healthcare worker
5 infections and long-term care resident transmission
6 and death.

7 When you look across the country and in
8 other jurisdictions around the world. We are not
9 in good stead here. And it's situations like this,
10 that it's no big surprise that workers are getting
11 ill, the residents are becoming ill, and you know
12 this is -- we had Directive 5, we've been through
13 this with Government, Public Health was involved,
14 the Chief Medical Officer of Health, and still we
15 continue to reach, you know, to get to resistance
16 like this with employers. And it's just -- it's
17 unacceptable and it's outrageous. Anyway, sorry, I
18 couldn't sit still any longer.

19 MS. BUTT: I think, fundamentally, the
20 problem is that by continuing to reinforce it's
21 just droplet and contact, when there's certainly a
22 divide between experts. At a minimum I think it's
23 fair to say there's a divide, and it's not
24 universally accepted that transmission can't be
25 airborne. That by not putting that in writing to

1 the workers, they're not hearing that they should
2 be wearing those N95s, and that's why the
3 Precautionary Principle is so fundamentally
4 important.

5 We wanted to just quickly go through a
6 few recommendations that we have on IPAC and then
7 speak very briefly at the end about a
8 recommendation on mental health, and then we're
9 finished.

10 Vicki, did you want to start?

11 MS. MC KENNA: Yes, I'll try and be
12 brief. We'll provide certainly more detail in the
13 recommendations for all to review.

14 It is, in our view, every home must
15 have a registered nurse who has infection control
16 practitioner status, that is their title; that they
17 are trained and they are certified.

18 There are programs out there, there's
19 programs at Centennial College in Toronto, at
20 Queen's in Kingston, they're everywhere. There are
21 novice infection control prevention programs that
22 are available and easily accessible. And ideally,
23 the specialist would also agree to, at some point
24 be certified, so they would hold the proper
25 certifications and have access to the updates and

1 be in the know on what the most recent and updated
2 information is.

3 And there was a recommendation of
4 exactly this for infection control practitioners
5 that they passed to the Central Park Lodge Inquest
6 in 1999, so this isn't new. This is not a new
7 recommendation.

8 IPAC practitioners should have the
9 authority to make effective decisions about
10 infection, prevention and control in the workplace.
11 They shouldn't be beholden to an administrator or
12 director of care when it comes to decisions about
13 infection control.

14 We also believe that training is really
15 important and mentioned it earlier, but all staff
16 must receive comprehensive training. They've got
17 to know the basic IPAC thinkables. It should be
18 done in person, it should include training. And
19 training that includes testing on drilling, and
20 donning and doffing of the personal protective
21 equipment. And it has to be reviewed on a regular
22 basis, at least annually, no matter what.

23 The training, as I said annually, but
24 you never know when an infection may occur, just
25 like we're in the midst of right now. When that

1 happens, they need to make sure their staff are
2 updated and trained at the moment, in the ready so
3 that they're ready to go.

4 There should be training and disease
5 process, especially at new diseases and infections
6 that are causing outbreaks. We should ensure that
7 our management staff can regularly attend training,
8 licensees must pay for the cost of training and
9 cover staff salaries during training and backfill
10 shifts.

11 So the staff training, you know, needs
12 to be supported both at the frontline staff, the
13 administrative staff, and this also leads to -- we
14 won't get into it at this very moment, but similar
15 recommendations that came out of the long-term care
16 inquiries, that have come out of other inquests
17 where training seemed to be deficient in the
18 administrative side, in particular, on long-term
19 care, but also the support staff training and
20 updating.

21 In order to keep viruses out of home,
22 the Directives, we believe, must mandate. We must
23 have mandates that are clear.

24 So Bev, you're going to talk a little
25 bit about those.

1 MS. MATHERS: I will, thanks, Vicki.

2 So that admissions and readmissions to
3 homes, these residents must be tested within
4 48 hours prior to the admission or readmission.
5 And residents who leave the building or grounds,
6 should be isolated for 14 days upon return.

7 And this is really about keeping the
8 virus out of the homes. It is about the iron ring
9 we keep Government talk about, but never really
10 enforce.

11 In hot zones, admissions should simply
12 cease and residents should not be permitted to
13 leave the grounds.

14 Staff and residents should be tested
15 every two weeks in a manner that is the least
16 intrusive.

17 For instance, sputum testing instead of
18 NP swabbing. And results must be received by the
19 homes in 48 hours. Therefore, homes must receive
20 either priority testing or the new fast testing
21 mechanism.

22 I will say to you that ONA and the
23 nursing homes have actually been writing to
24 Government and requesting this, as well as Vicki
25 and I raising this with the Minister of Health,

1 Christine Elliott, since early September.

2 And to date, we have no response at all
3 to our questions about rapid testing or less
4 intrusive testing.

5 Agency staff, staff obtained through
6 Government, health human resource matching tool,
7 students, private family, caregivers, sitters,
8 companions, essential caregivers and family tests,
9 visitors must also be tested, and they must
10 demonstrate proof of a negative test before they
11 enter the home.

12 We know that in some of the homes that
13 in fact the infection has come in, either via a
14 student, through an agency staff, or through
15 private caregivers. And this simply can't be
16 allowed to happen, and there shouldn't be a double
17 standard in who gets tested and who gets exempt.

18 And while we understand there are
19 challenges with testing, the fact of the matter is
20 our homes should be of the highest priority.

21 Our next set of recommendations are
22 part-time employees who choose to work in a single
23 long-term care home should be provided with
24 full-time hours. They should not be penalized and
25 lose income because they can now only work in one

1 home.

2 Licensee operators must not offer
3 shifts to agency or full-time employees at overtime
4 until all those part-time employees have been
5 offered all of the available hours.

6 We continue to hear horrible stories of
7 our members who continue to lose income as a result
8 of the emergency orders. Agency workers should be
9 permitted to only work in one healthcare facility
10 while provisions of Bill 195 remain in place,
11 and/or the World Health Organization declares an
12 end to the pandemic, whichever is the latter.

13 We don't think agency workers should be
14 treated any differently than the permanent
15 employees of the homes.

16 Moving on to the next regulated health
17 professionals and other healthcare employees
18 diagnosed with COVID-19, will not return to work
19 until they have either received two negative tests,
20 or until 14 days have elapsed from symptom onset;
21 if they are symptom-free.

22 We are very concerned that on
23 October 1st, that Public Health Ontario changed the
24 guidance to healthcare facilities again, and are
25 now allowing employees to go back into healthcare

1 facilities, ten days after symptom onset.

2 We don't know why that happened. There
3 was no public announcement about it. There is no
4 change in the science that we are aware of, and
5 there's been no explanation. But why would we put
6 residents at risk of catching an infection from a
7 healthcare worker, who knew they were positive, but
8 their employers are now changing the policies and
9 forcing them back to work again after ten days.

10 Every home must identify and prepare
11 rooms that are available to be used for isolation.
12 We are recommending that there be at least one
13 private room available for every 32 residents. And
14 this would preventatively deal with -- they could
15 be treated as infirmary beds, it could contain
16 symptomatic residents with early isolation, it
17 allows cohorting of staff as well.

18 Currently the inability of homes to
19 isolate symptomatic residents was a major cause of
20 spread in the first wave. We're seeing that
21 continue in the second. And in addition to these
22 isolation rooms for symptomatic or positive
23 residents, we are again saying that anyone who is
24 newly admitted or readmitted to a home also be
25 isolated for 14 days. We just think that these are

1 commonsense approaches to preventing the disease
2 spread.

3 We are worried that in some cases,
4 there is -- and we understand the pressure that
5 hospitals are under to free up beds, we do. But we
6 cannot, as we did in the first wave, push people
7 out into the long-term care homes and leave the
8 homes without any flexibility in their beds.

9 Our next recommendation is that a
10 resident should not be placed in a room with more
11 than one other resident. This includes not only
12 one admission, only new admissions and
13 readmissions, but also those who are currently
14 occupying ward rooms.

15 Ward rooms should be converted into
16 semiprivate rooms as soon as possible through
17 attrition. And that doesn't mean to us, attrition
18 in that very room. But it could mean attrition in
19 another room that could be converted into a
20 semiprivate room, and with some juggling in the
21 home, that attrition couldn't happen sooner.

22 We did learn in the first wave, that
23 curtains do not provide a protection from COVID.
24 I'm not really sure why that had to be a lesson,
25 but it was. And we have heard that in order to get

1 around the provisions of Directive 3, at least one
2 home has considered moving residents who are
3 currently in semiprivate or private rooms into a
4 ward room so that new admissions or readmissions
5 can be placed there. And this is contrary to the
6 intent of that directive.

7 Ward rooms are just simply not safe
8 during a pandemic. And in fact, as the homes are
9 rebuilt moving forward, semiprivate, three-person,
10 four-person rooms should be eliminated entirely.

11 Residents should not be placed in rooms
12 with more than one other resident. I think I have
13 covered this already.

14 Moving on then, the Ministry of
15 Long-Term Care must provide funding to ensure that
16 employees who quarantine or isolate due to an
17 exposure are paid for their time off, and that
18 part-time and casual employees receive sick pay.
19 Otherwise, sadly, it leads to some employees lying,
20 and coming to work sick so that they can pay their
21 bills.

22 Isolating and cohorting residents and
23 staff must be mandatory.

24 The current directive still state that
25 isolating and cohorting is to be done only when

1 possible, and we believe this needs to change now.

2 Our next recommendation is that every
3 long-term care home must have an adequate supply of
4 personal protective equipment, including: Gloves,
5 gowns, goggles, face shields, surgical masks, and
6 NIOSH approved fit tested N95 respirators or
7 equivalent or better protection.

8 At a minimum, an adequate supply of PPE
9 would be a three-month supply. We know the
10 Ministry in their fall announcement, announced they
11 were providing two-month's supply. It truly needs
12 to be three months to get us through these phases
13 and they have to have plans about how they're
14 getting more.

15 PPE must be readily accessible to all
16 health professionals and other healthcare workers
17 in the homes. They cannot be locked up, they have
18 to be available.

19 The home will provide weekly updates on
20 its supply during the pandemic to Joint Health and
21 Safety Committees and trade unions.

22 This weekly update will include the
23 number of each type of PPE, including the relevant
24 model numbers of N95 masks. After the pandemic the
25 home will report on its supply at every Joint

1 Health and Safety Committee meeting.

2 We must ensure that our workers have
3 access to the type of N95 masks or equivalent that
4 fit them and that they have been fit tested for.

5 And that any time a home receives a new
6 model, that those N95s then have to be fit tested
7 again, so that we can ensure that the airborne
8 protection that the masks are supposed to provide
9 are indeed providing.

10 The next recommendation is that the
11 Provincial Government should create and maintain a
12 Provincial stockpile of PPE. Data should be
13 publicly available, in realtime, including the type
14 and numbers of PPE in stock and expiration dates.

15 We heard this past weekend that there
16 is a shortage of a particular stock of N95 masks,
17 the type at the home that Unity is helping with --
18 Unity Hospital is helping with now in Toronto,
19 there is a shortage of masks. To which we have
20 been told by Government, is not true. So we're not
21 understanding where the gaps are, and why there are
22 still inadequate supplies of PPE around.

23 And then the final recommendation we
24 want to make under IPAC and Health and Safety, is
25 that the field hospital model which was so

1 successful in Windsor, should be used
2 province-wide. In the alternative, long-term care
3 homes must move residents into hospital or a
4 dedicated facility for treating COVID-19.

5 I have to say, and I sat through much
6 of the testimony at the Wettlaufer Inquiry, and I
7 have to say again, that this notion that our
8 seniors go to long-term care homes to spend the end
9 of their life, does not mean that they should go
10 there to spend the end of their life and catch a
11 disease, or have something else happen to them that
12 expedites the end of their life. And that there's
13 no quality of care, or respect, or dignity for them
14 in those last days.

15 Not all of these residents should have
16 died, that died from COVID, should have died from
17 COVID. They should have been transferred to
18 hospital to be cared for. And our nurses are
19 simply devastated by that. And I have to say that
20 it really has been unacceptable, that this notion
21 existed that no one was to be moved to hospital.

22 And with that, I will turn it over to
23 Vicki to talk about mental health.

24 MS. MC KENNA: Okay. Thanks, Bev.

25 I'll just speak quickly about this. It

1 is a really important issue and it's not -- I know
2 it's one that is often heard in the media and in
3 reports just generally.

4 But the effects of COVID-19 on people's
5 mental health is significant. And it is really
6 clear, I believe, from the video that we showed
7 last week, how COVID-19 has significantly
8 traumatized the registered nurses that you heard on
9 that date and many, many others.

10 We've heard from the nurses that
11 they've had to require time off for adjustment
12 disorders, really, depression, anxiety,
13 posttraumatic stress they're being diagnosed with
14 now. And this is all as a result, and we believe,
15 directly from their experiences working with
16 patients with COVID-19 and in facilities of
17 long-term care that are ill prepared.

18 Not only did our nurses get sick, but
19 we've heard stories of how they had, you know, how
20 they had given COVID-19, or transmitted it
21 inadvertently to family members, to their spouses,
22 to their children, to their parents.

23 The trauma that these nurses are
24 experiencing is real, and we have to address it.
25 And for that reason, we're making the

1 recommendation about providing them with the mental
2 health support for those workers. Many of them who
3 work are part-time, they have no benefits, they
4 have no paid sick leave.

5 So mental health support needs to be
6 and must be provided to employees who worked
7 through the pandemic, including counseling to be
8 available to employees for a period, we believe, of
9 up to two years; and that's something that should
10 happen now.

11 Our recommendation is that it be done
12 through WSIB. And any long-term care worker who
13 worked during the pandemic should have a claim to
14 be able to be activated and approved. Providing
15 the benefits through WSIB is appropriate, we
16 believe, as the mental health injuries that
17 occurred in the healthcare workers clearly fall in
18 the scope of workplace injury, in our belief, and,
19 therefore, under WSIA.

20 It also ensures that all workers in
21 long-term care would have access to benefits, which
22 are generally not provided to part-time and casual
23 employees, and even full-time employees they are
24 limited in long-term care.

25 So I really do want to thank you very

1 much for the time you've spent with us. Registered
2 nurses are required to work in dangerous
3 circumstances without proper protection.

4 They were required to do their very
5 best, and they did. With skeletal staff, tasked
6 with providing care to acutely ill residents with
7 almost none of the supports that they would have
8 had, had they been in a hospital.

9 They've become ill in unprecedented
10 numbers. One sick healthcare worker is one too
11 many in our view. And in this case, thousands have
12 become ill, and the second wave is only just
13 starting.

14 We have to do better. We can do better
15 and do it now. And it's time to make those
16 choices. And to prioritize the lives of residents,
17 and the safety of nurses and healthcare workers who
18 provide that care for them.

19 So I know Nicole has a few wrap up
20 points. I know we kind of broke our goal, but this
21 is so, so important to us and the people that we
22 represent, the nurses. And they want you to know
23 how much they love working in long-term care, and
24 the residents are like their families, as you've
25 heard them say. And they are desperate for some

1 support and systems to be put in place so they can
2 properly care for people and to protect them and of
3 course we want them protected as well.

4 Nicole?

5 MS. BUTT: Before I finish up, were
6 there any questions or anything --

7 COMMISSIONER MARROCCO: I did have one
8 question.

9 We were told that it's -- I don't know
10 if "traumatic" is the right word. But it's
11 difficult moving someone to a field hospital from
12 their room, or their residence.

13 And, you know, if a person is
14 sympathetic to that hospital model, did the nurses
15 think that it's -- I mean, what's your experience
16 with people who, like in that Windsor model, we
17 were all told it was successful, but was this a
18 real issue moving the people or not?

19 MS. MC KENNA: I'll just say first off,
20 best I know and what I have heard from the field,
21 no. But what I will say is, anytime you move a
22 resident in long-term care who's been in a room for
23 a period of time, it's upsetting, it is. We're not
24 going to pretend it isn't. It is a different
25 environment. And particularly if dementia is part

1 of the condition that you're dealing with, even
2 more so probably.

3 But what I also heard is for the
4 residents who didn't have to move, right? They
5 only moved COVID positive patients out. And those
6 people were very ill, those people were very ill
7 when they were moved. So I didn't hear that the
8 residents had as much difficulty as they would
9 have, you know, that they were ill. Is what I'm
10 saying.

11 They were so ill, that in most cases
12 they, you know, the movement really didn't have the
13 same impact, had it been, you know, their usual
14 day-to-day and they were getting shifted to a new
15 room, that's disruptive. And it probably, once the
16 people started to recover, then they realized they
17 weren't in their usual location, there was
18 probably, you know, some difficulty maybe at first.

19 But some of the nurses that worked in
20 that field hospital, told us, it was the -- it's
21 been the highlight of their career to be able to
22 spend time with people. They were up-staffed, and
23 those residents had more staff around them than
24 they ever would have had in a nursing home.

25 And actually I didn't, you know, at

1 least not from what I know, and Nicole and Marcia
2 may have heard differently in your interviews with
3 staff, but I did not hear that.

4 MS. BUTT: I think you also need to
5 consider what the alternative is, because they were
6 very sick. And being very sick alone without the
7 care you need is going to be infinitely worse than
8 the disruption of being moved out.

9 COMMISSIONER MARROCCO: I understand
10 that. I just wanted to ask the question, because
11 obviously you have some experience with this, just
12 to satisfy myself that I asked. I get it.

13 MS. BARRY: If I could add one final
14 point. I think the staffing makes the big
15 difference. And one of the things I was told about
16 the field hospital was actually every resident who
17 was transferred was provided with an iPad to
18 communicate with their family.

19 When you compare that to the very
20 thinly staffed homes and those very heartbreaking
21 stories that we've heard about people, you know,
22 dying alone with no family around, I think as
23 Nicole says, we're balancing the lesser of two
24 evils. And certainly there would be some
25 disruption in the move, but I think when you sort

1 of consider for those residents who did pass, you
2 know, they were able to die with some contact,
3 better contact with their family and some more
4 dignity than in the homes that were just so badly
5 understaffed at that time.

6 MS. MC KENNA: I think, too, what the
7 nurses said. Because at every bedside there was an
8 iPad, the resident, the individual may not have
9 been able to actually use the iPad, they had that
10 access to the family for them right there, that
11 they could just pick up and use with them. Because
12 many residents in long-term care (poor audio -
13 connection difficulties) --

14 COMMISSIONER MARROCCO: Yes, all right.

15 MS. MC KENNA: -- the nurses were able
16 to make that connection with the staff, and they
17 set aside the funds and had iPads at every bedside,
18 purely for patient communication with their family
19 for the resident to be able to communicate, or the
20 nurses to assist that communication.

21 That was something that I think, I at
22 least heard from many, many, families and you know
23 throughout, how desperate they were. And Cathryn
24 herself has had a personal experience with family
25 and being able to contact. I think it's critical.

1 I think that's, you know, those personal touches,
2 those piece are hugely important to people when
3 they're ill no matter where they are, I think, but
4 in this case for sure.

5 COMMISSIONER MARROCCO: Thank you.
6 Anything further?

7 MS. BUTT: The only thing I wanted to
8 ask about was sort of your next steps and sort of
9 timing.

10 So we're going to send you tomorrow a
11 copy of our PowerPoint and a written document with
12 our recommendations. And some of the other
13 materials we've talked about throughout. But I
14 wasn't sure in terms of, we do have probably some
15 written submissions on long-term things we'd like
16 to provide to you and we didn't know the timing
17 looked like for you.

18 COMMISSIONER MARROCCO: The long-term,
19 we'll turn attention very shortly to long-term, but
20 we don't have -- we don't have that short time
21 horizon.

22 We're not feeling quite the same way
23 about that as we were about the short term. I
24 wouldn't concern yourself unduly about that. If
25 you can get it to us in the next little while, it

1 should be fine.

2 MS. BUTT: The next question is the
3 plans for speaking to staff directly. I know on
4 your website they say they can provide a written
5 statement, but is there going to be an opportunity
6 to speak?

7 COMMISSIONER MARROCCO: As I
8 understand, there was an issue around
9 confidentiality.

10 MS. BUTT: Yes.

11 COMMISSIONER MARROCCO: And I think, I
12 don't want to speak too quickly, but I think it's
13 going to be resolved. And I think we're going to
14 have control over what's confidential and what
15 isn't. But rumors are one thing, until we see it
16 in black and white, that's another.

17 But I think that's going to happen
18 shortly. And if that's the case, then we'll be
19 able to consider as a commission, the three of us,
20 any requests for confidentiality.

21 But I'm a bit more optimistic now that
22 we're going to get a timely answer than I was when
23 you were here the last time.

24 MS. BUTT: Great.

25 COMMISSIONER MARROCCO: And I speak for

1 the three of us who have talked about this, we do
2 want to give people the opportunity to talk to us
3 in confidence, if that's what they want to do.

4 Notwithstanding the fact that we're
5 trying to be as transparent as we can in terms of
6 what we're hearing and so on. But that's
7 necessary. We think it's necessary, and we're
8 trying to work it out.

9 MS. BUTT: Perfect.

10 COMMISSIONER MARROCCO: But I think
11 we'll be okay.

12 MS. BUTT: Okay, that's wonderful.
13 Thank you. I think that was everything we had.

14 COMMISSIONER MARROCCO: Thank you very
15 much. Thanks for all the work and the presentation
16 was a work of listening to it. I can imagine how
17 much work you put into it, but it's very much --
18 it's very helpful for us, and you do represent
19 people with very practical experience.

20 To the extent that your submissions, or
21 argument or statement is consistent with something
22 we're thinking, it gives us a certain confidence
23 that it's grounded in reality, and not in theory,
24 and that's important to us. So thank you again.

25 MS. BUTT: Great thank you. Very much.

1 -- Meeting adjourned at 2:33 p.m.

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REPORTER'S CERTIFICATE

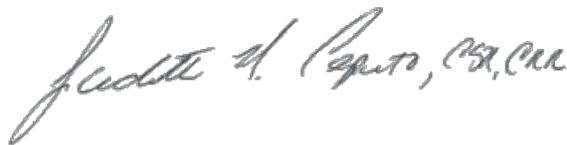
I, JUDITH M. CAPUTO, RPR, CSR, CRR,
Certified Shorthand Reporter, certify;

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

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

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

Dated this 21st day of October, 2020.



NEESONS, A VERITEXT COMPANY

PER: JUDITH M. CAPUTO, RPR, CSR, CRR

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