Long-Term Care COVID-19 Commission meeting with WeRPN

Via Zoom
on Friday, September 25, 2020

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7 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14 --- Held via Zoom, with all participants attending
15 remotely, on the 25th day of September, 2020,
16 9:30 a.m. to 11:30 a.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 PRESENTER:
8 Dianne Martin, Executive Director of the Registered
9 Practical Nurses Association of Ontario.
10
11 PARTICIPANTS:
12 Alison Drummond, Assistant Deputy Minister,
13 Long-Term Care Commission Secretariat
14 Dawn Palin Rokosh, Director, Operations, Long-Term
15 Care Commission Secretariat
16
17 ALSO PRESENT:
18
19 Janet Belma, Stenographer/Transcriptionist
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1 -- Upon commencing at 9:30 a.m.
2 DIANNE MARTIN: Good morning.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Good morning. Well, I think everybody's here.
5 DIANNE MARTIN: I have a colleague
6 joining as well, but we can certainly go ahead.
7 She will arrive.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Ms. Martin, if she's coming, we can wait a minute
10 or so. Do you anticipate she's going to be here
11 any minute? Is that the idea?
12 DIANNE MARTIN: She will be here before
13 it changes to 9:31. That's just -- I'd be very
14 surprised if she wasn't, but please call me Dianne.
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay. Well, I guess we should -- you should know
17 I'm Frank Marrocco. I'm one of the commissioners
18 as -- Dr. Jack Kitts --
19 DIANNE MARTIN: Yes.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 -- and Angela Coke.
22 COMMISSIONER ANGELA COKE: Hi.
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 We're the Commission, and Ms. Belma introduced
25 herself already. She's going to take a transcript

1 of this.
2 DIANNE MARTIN: Okay.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 And then the rest of our staff is sort of blacked
5 out but our executive director and counsel and so
6 on.
7 DIANNE MARTIN: Right.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Probably the way to handle this is -- and the way
10 we've been doing it in the past is we'll listen --
11 tell us what you want to tell us. You control
12 that. We may interrupt with questions rather than
13 waiting to the end, so don't think that we're being
14 rude, but it's just more efficient, we think, to be
15 able to ask the questions as we go along.
16 And we will probably take a break
17 around 10:45 in about an hour or an hour and
18 15 minutes, just give everybody a chance to
19 regroup. So if you reach a point around there
20 where you think it's prudent for us to break, just
21 say so, and that's what we will do.
22 DIANNE MARTIN: Okay.
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 So as soon as you're ready -- and I appreciate
25 we're waiting for your colleague -- we are ready.

1 DIANNE MARTIN: Okay. So I have some
2 introductory remarks, which I'll give, but I also
3 have broken down our recommendations into seven
4 areas, so maybe after each area that we've broken
5 it down into would be a good time to really look at
6 that area before moving on to the next one.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Okay. That's fine.
9 DIANNE MARTIN: And I also will tell
10 you I don't -- I live on a farm, and I don't have
11 the greatest broadband, so I'm hoping that we do
12 really well through all of this.
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Well, Dianne, you shouldn't worry about that. I've
15 been driving everybody crazy with the Rogers cable
16 people who keep coming or not showing up, and so
17 we're all -- we all understand that sort of thing.
18 DIANNE MARTIN: Okay. Great. Thank
19 you. Okay. So I will just provide some
20 introductory remarks here.
21 First, I just want to thank you for the
22 opportunity to meet with you today. As the voice
23 of Ontario's Registered Practical Nurses, the
24 largest category of nurses working in long-term
25 care, we are pleased to outline the experiences

1 that many RPNs have faced on the front lines over
2 the past several months fighting this pandemic.
3 These nurses are knowledgeable and
4 passionate professionals who deeply care about the
5 residents that they provide care to. In many
6 cases, the residents are more like family to them.
7 For them, the past several months have
8 been extremely challenging and taken a significant
9 toll both personally and professionally. The
10 pandemic has exposed long-standing cracks in our
11 long-term care system and shone a light on systemic
12 issues that nurses have been calling attention to
13 for years. We are pleased that this commission is
14 going to be examining many of these concerns, and
15 we thank you for this important work.
16 Today, we will be outlining a number of
17 challenges and opportunities and look forward to
18 discussing these issues with you. We are
19 optimistic that your work will result in meaningful
20 change that is long overdue in this sector.
21 So those are my opening remarks, and
22 then I will just start with our first area of
23 recommendation.
24 The first area -- and please feel free
25 to interrupt me with any questions.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Just before you do that, do we have a slide or
3 anything that you can show?
4 DIANNE MARTIN: You have -- you have
5 the -- we have sent you the presentation.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Yes. Yes, I know that. I was just referencing it
8 for --
9 Ms. Belma, do you have that? Can you
10 put that on the screen? That way, I can --
11 otherwise, I'm shuffling papers, and --
12 DIANNE MARTIN: Sure.
13 COURT REPORTER: Sir, did you want me
14 to put that on the screen --
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Yeah, can you put it on the screen for us? Yeah.
17 COURT REPORTER: Okay. Hold on.
18 DIANNE MARTIN: Page 2 has
19 Recommendation 1 -- oh, sorry -- page 1 does.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Just hand on a second, Dianne.
22 COURT REPORTER: I'm sorry. This will
23 just take me a second.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 That's fine. We're not going anywhere.

1 COURT REPORTER: That's good. Can you
2 see that?
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Can now. Thank you.
5 COURT REPORTER: Thank you. It will be
6 hard for me to scroll as I'm writing. I just want
7 you to know that. I'm not sure how the other court
8 reporter handled that, but I can stop, and if you
9 just let me know when to go down, would that work
10 for you?
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Yeah, sure, that's okay. Dianne, you can --
13 Dianne, just ask -- just stop and ask for it to be
14 scrolled down, and then we'll scroll it down and
15 then continue. Is that okay?
16 DIANNE MARTIN: That's fine.
17 COURT REPORTER: I'm going to mute
18 myself for now, okay? But just let me know when to
19 scroll.
20 DIANNE MARTIN: I think if you just go
21 through to the second page, I think that would be
22 where we really get into our recommendation -- the
23 part of our recommendation, yeah. They're under
24 WeRPN recommends. There's information ahead of it,
25 but we have short-term and long-term

1 recommendations. Okay. So I can start with this
2 one, okay?
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Yes, and I should tell you -- you may find it
5 helpful -- we do appreciate the short-term and
6 long-term because we're giving serious thought to
7 reporting on an interim -- making interim
8 recommendations because we're kind of in the middle
9 of this, you know. Typically --
10 DIANNE MARTIN: Yes.
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 -- the thing is -- the event is over, and you're
13 looking back; but we're in the middle of it, so
14 it's caused us to change our approach. So anyway,
15 go ahead. That's fine.
16 DIANNE MARTIN: Okay. Great. So our
17 first area of recommendation is ensuring
18 appropriate staffing levels to meet the needs of
19 residents. In order for long-term care residents
20 to continue to have the best quality care, it's
21 essential to have the right complement of health
22 professionals. So that is both the number of
23 people providing the care and the categories of
24 people providing care so that all the needs can be
25 met.

1 Long-standing staffing shortages were a
2 significant contributing factor in determining how
3 facilities fared in the face of COVID-19, and we
4 had already -- we're quite aware of the staffing
5 difficulties after the long-term care inquiry. So
6 certainly, we weren't expecting it to be so
7 dramatically dramatized so soon after the inquiry
8 just how problematic the staffing levels are, and
9 not just the staffing levels but the ability to
10 attract high-quality, knowledgeable staff to a
11 sector that is treated somewhat differently than
12 the -- for example, the hospital sector.
13 As we enter the second wave, it's vital
14 to -- if we are entering a second wave. I'm
15 reading all sorts of articles of whether this is it
16 or not, but it is vital that the government in
17 partnership with long-term care stakeholders take
18 immediate action to address staffing shortages and
19 over the long-term build a staffing strategy that
20 will put safety, dignity, and quality at the
21 forefront of resident care.
22 We also offer solutions to better
23 retain staff that are already working in the sector
24 through the expansion of pathways and enhancing
25 opportunities to career ladder.

1 So we've given a lot of thought to what
2 is needed by the residents but also what is needed
3 by the staff in order to feel very rewarding
4 experiences when they are working in long-term
5 care, which is --
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Is there -- pardon me for interrupting; but in
8 terms of the shortages, are there people in the
9 labour market who could provide those -- the
10 short -- the skills that you're short of, or is it
11 that there aren't the people?
12 DIANNE MARTIN: Yeah. So can I break
13 it down by category of care provider for you --
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Sure.
16 DIANNE MARTIN: -- because it's a
17 different reality for each category?
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Sure.
20 DIANNE MARTIN: In terms of -- I'll
21 start with nurse practitioners. In terms of nurse
22 practitioners who would be just such a --
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Oh, you've -- Ms. Martin, you froze. So --
25 COURT REPORTER: Sometimes if we just

1 wait a minute, she might come back. She's probably
2 still there.
3 Ma'am, you froze for a minute. You
4 might want to start again.
5 DIANNE MARTIN: I'm sorry?
6 COURT REPORTER: I'm sorry. You froze,
7 and now you're good.
8 DIANNE MARTIN: Oh, I'm sorry.
9 COURT REPORTER: That's okay.
10 DIANNE MARTIN: Okay. One of my
11 neighbours probably logged on to their computer.
12 So nurse practitioners, for example,
13 there are not enough numbers nor enough funding to
14 provide the great care, the advantages in care that
15 they provide in terms of the resolution of primary
16 care issues without having to transport to
17 hospital. So we need more nurse practitioners, and
18 we need clear funding for nurse practitioners to be
19 able to be in the long-term care homes.
20 When you look at RNs broadly across
21 Ontario, the RN situation is such that there's a
22 looming shortage. Some areas are experiencing a
23 shortage, and I'm just going to be very frank with
24 you. Any time there is a shortage of RNs, they
25 will gravitate to the hospitals. It is considered

1 to be the place of the employer of choice for a lot
2 of RNs, and that is a problem when you have a
3 shortage of RNs because we have got some work to do
4 to make the -- make it an employer of choice,
5 long-term care.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Can I ask you --
8 DIANNE MARTIN: Yeah.
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Do you think if there was a greater association
11 between the long-term care homes and the local
12 hospitals that this would enhance the
13 attractiveness of long-term care as an entry point
14 into that market or into that sector, the hospital
15 sector?
16 DIANNE MARTIN: Yes, and I say that
17 because I went to Finland and worked in a long-term
18 care home with a registered -- well, they call them
19 licensed practical nurse, and they had a system
20 that was fully connected to their hospitals; and
21 when the nurse, the registered practical nurse
22 mostly -- the RNs worked Monday to Friday to do
23 more in-depth assessments, but the day-to-day care
24 was provided by registered practical nurses.
25 They had a direct line to the hospital,

1 a direct connection to the staff at the hospital.
2 They were all integrated, and they would call the
3 hospital and be treated very much as colleagues
4 reporting in and problem solving together, and they
5 felt that it prevented a huge amount of transport
6 to hospitals, first of all, but also a very
7 collegial relationship between the -- the nursing
8 staff and -- the nursing staff of the long-term
9 care home and the medical and nursing staff of the
10 hospital.
11 So they really functioned as one unit,
12 and I wouldn't have necessarily thought that that
13 was an idea that would work until I saw it in
14 action, and certainly, the nurses -- and whether
15 this is a direct result or not, the nurses who
16 worked in long-term care were very proud of what
17 they did for a living. They told me their families
18 were proud of them and society value them equally
19 with any other nurses.
20 COMMISSIONER ANGELA COKE: Could I just
21 ask -- sorry.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 No. Go right ahead, Commissioner Coke.
24 COMMISSIONER ANGELA COKE: So just in
25 terms of things like compensation and other sort of

1 work benefits, were those consistent between the
2 two sectors?
3 DIANNE MARTIN: I didn't specifically
4 ask that, but there was a lot of movement between
5 the sectors. It was considered a very relevant
6 career move to move to long-term care from acute
7 care.
8 I know that in Ontario, there's a real
9 reluctance for nurses who even love working with
10 the elderly to leave the hospital sector, both for
11 reputation -- they believe that nurses are more
12 respected in the hospital sector -- but also for
13 reasons of -- also for reasons of HOOPP, our
14 pension plan at the hospital. You don't -- once
15 you're in that, it's a great retainer, right? Once
16 you're in that, you're not leaving that.
17 And then, of course, compensation
18 benefits, ability to find full-time work. Those
19 are all reasons that nurses can be retained and
20 be -- and feel fulfilled within their jobs or
21 recognized by those things within their job.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Thank you.
24 DIANNE MARTIN: Okay. So I've talked
25 about NPs and RNs. Registered practical nurses, we

1 have a lot of them. They are significantly
2 underemployed, and when you have a large number of
3 people, more than you have right now in terms of
4 jobs, then you tend to move to part-time work, and
5 so registered practical nurses at far greater
6 numbers are forced to work two part-time jobs to
7 cobble together a living. And, of course, that
8 gets incredibly problematic when you have a
9 situation where you are trying to prevent an
10 infection from spreading, and you have nurses who
11 work in multiple areas.
12 So the government did the best thing
13 they could do to protect the residents, and that
14 was limit nurses and PSWs, those sorts of workers,
15 to working in one long-term care home.
16 But for registered practical nurses, it
17 was, in fact, cutting their income in half, and
18 this had devastating effects on many of the nurses
19 who have always wanted to work full time but unable
20 to work full time.
21 So that was a significant problem and a
22 lot of hardships suffered by the nurses and who --
23 that same hardship wasn't imposed upon nurses who
24 work in the hospitals.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Can you just help me understand why they get forced
2 into working at more than one place? You know, and
3 the one -- because recognize my experience isn't in
4 the area.
5 DIANNE MARTIN: Yes.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 But there's a shortage of people on the one hand, a
8 surplus of people on the other, but where you have
9 the surplus, they're forced to work at multiple
10 locations, and I get -- I understand that
11 conceptually, but I don't understand why that --
12 what drives that. Why does that happen?
13 DIANNE MARTIN: I think quite simply
14 it's because it is cheaper to have part-time staff
15 than full-time staff in some ways. It also
16 provides you with flexibility. If you had some
17 sort of decrease in need for staffing, you could --
18 you could, you know, adjust your numbers based on
19 your numbers of residents; but also, you know, paid
20 sick time doesn't happen to those -- to the people
21 working part time, those sort of things.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Okay.
24 DIANNE MARTIN: So it's a very
25 different -- from a management perspective, it

1 gives you a lot of flexibility and maybe saves you
2 some money.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 All right. So your suspicion or assessment is that
5 it's financially driven more than -- and it gives
6 you more control over your workplace if you're
7 dealing with part-time staff rather than full-time
8 staff, at least as far as the RPNs are concerned.
9 DIANNE MARTIN: Right.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Would the same apply for the public -- the support
12 workers, do you think, or can you say?
13 DIANNE MARTIN: Well, they're a whole
14 different group because they --
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay.
17 DIANNE MARTIN: -- we graduate many of
18 them, and they get a taste of what we do to them in
19 long-term care in terms of the pressures and the
20 workloads at very little pay, and they leave.
21 So, yes, it is very hard to have PSWs
22 who are a long-term staff in a long-term care home
23 and enough days when you have a full complement of
24 staff show up for work, and that's simply because
25 the working conditions for these, really, RPNs as

1 well in long-term care but particularly PSWs is a
2 very, very difficult job. I don't think any of us
3 can even imagine how difficult it is.
4 And the interesting thing about health
5 care providers is, of course, we like our
6 paychecks, but we're also heavily motivated by
7 outcomes, making a difference in the lives of
8 people; and that is where our joy comes from, and
9 everyone should experience joy in their workplace.
10 So when you are facing those difficult
11 working environments and sort of an unfair level of
12 compensation or working conditions, it can be quite
13 demoralizing. We call it moral distress, and the
14 degree to which our members describe the moral
15 distress that they experience when they know that
16 the residents under their care are receiving really
17 substandard care that they wouldn't wish for their
18 own families, we see people leave because that's
19 very hard.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Okay.
22 DIANNE MARTIN: Okay?
23 So if you like, I'll just give you a
24 list of our short-term solutions to this. We need
25 to increase funding for long-term care to enable

1 facilities to hire the appropriate number of staff
2 to deliver the care necessary to meet resident
3 needs. We have looked over RNAO'S recommendation
4 for four hours of care per resident per day. We do
5 think that that number makes a great deal of sense.
6 We've sort of mapped it out with different staffing
7 per shift and what that would look like and who's
8 doing what with the residents and how many
9 residents they are doing it for, and we do think
10 the hours make a lot of sense. Four hours would be
11 up from the current estimate of 2.71.
12 We don't necessarily agree on the high
13 levels of administrative roles that RNAO has talked
14 about. We do think that we need a great deal of
15 hands-on care. When you look at practical nurses
16 and PSWs and we think about what they do with the
17 residents in terms of feeding them, bathing them,
18 toileting them, you need enough people to ensure
19 the comfort of people during those activities and
20 that they don't have to wait for those activities
21 or that they're being fed in a rush when they have
22 swallowing issues and all of those sort of things.
23 You actually need more hands that understand the
24 role.
25 We think that there should be a

1 staffing mix that ensures long-term care residents
2 to receive a high quality of care provided by
3 practitioners with the appropriate knowledge to
4 effectively respond to today's environment, and we
5 have an appendix in there that you can look at that
6 we have created to talk about staffing mixes.
7 What I would ask you to recognize is
8 that there is no one superior care provider in a
9 long-term care environment. You know, RNs aren't
10 better than practical nurses, and practical nurses
11 are not better than PSWs. All of them are highly
12 skilled within their roles, and we need enough of
13 them to do their roles really well, but we have to
14 create that culture in long-term care of
15 recognizing that this is a team of people that are
16 incredibly important, and I certainly don't think
17 that my job is to move the role of the practical
18 nurse forward but rather to describe a team who
19 actually meets all the needs, you know, in a very
20 dignified and comfortable manner, and that's going
21 to require all of the members of the team.
22 In cases where staffing needs are
23 urgent, we would leverage Ontario's nurses,
24 students, and other allied health professionals,
25 physiotherapists, occupational therapists,

1 et cetera, who would bring relevant experience and
2 knowledge of the health system.
3 We're getting better at this in this
4 province. I heard yesterday that in Hamilton,
5 paramedics will be running some flu shot clinics.
6 It's brilliant. We don't have to use the
7 traditional mindset of who is doing what to meet
8 the needs. So when we look at long-term care, we
9 can certainly in a crisis like we just faced use
10 imaginative ways to bring people in who understand
11 the care of the elderly in some way and use those
12 skills in a way that complements and helps solve
13 some of the problems.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Dianne, just a minute. Commissioner Kitts?
16 COMMISSIONER JACK KITTS: Yeah, just
17 back to the four hours of care and the, no one is
18 superior to the other if you match the skill set to
19 the need of the patient, I think that's what you
20 said, right?
21 DIANNE MARTIN: Yes.
22 COMMISSIONER JACK KITTS: So is it
23 likely that some residents will need four hours of
24 an RPN and others four hours of a PSW, and others
25 will need a mixture of that, and that's where the

1 four hours comes in?
2 DIANNE MARTIN: Okay. That's a really
3 good question. All residents will -- PSWs do not
4 provide nursing care. All residents will need some
5 level of nursing care, and all residents will need
6 some level of personal support. So there will be
7 no one who can have all of their care from a PSW.
8 What we've designed in our role
9 descriptions, which are an appendix that you can
10 look at, is a recognition that the difference
11 between -- that nursing care is something different
12 than personal care. Everyone's got to work
13 together, but the difference between an RN and an
14 RPN is clinical. It is not -- and I'm going to get
15 to that when we talk about one of our
16 recommendations on leadership, but the difference
17 in the roles is clinical. RNs bring a skill set
18 that allows them to deal with very acute situations
19 that have an unpredictable situation.
20 So if someone falls in a long-term care
21 home and breaks a hip, you're going to want to have
22 -- or is suddenly in respiratory distress, you're
23 going to want to have an RN who can assess at that
24 clinical level.
25 The day-to-day care of nurses is

1 certainly most appropriate for registered practical
2 nurses. Registered practical nurses provide care
3 to people who are on a predictable trajectory of
4 care. They're very knowledgeable. They can handle
5 certainly a level of unpredictability, quite a
6 large level of complexity; but right now, they
7 can't even do nursing care because they're busy
8 doing the tasks of nursing. It's two different
9 things, and I can talk about that if you like.
10 But I think if you think of it in terms
11 of every resident needing personal care, every
12 resident needing nursing care, and then recognize
13 that there's where your difference will come in.
14 Some residents will need the minimum of nursing
15 care. Some residents will need a lot more nursing
16 care to support them because in long-term care
17 homes these days, we have people with tracheotomies
18 -- tracheostomies, I should say, a variety of
19 things that are more nurse labour intensive.
20 So, yes, you do have to figure out how
21 care is being provided by ensuring that nurses are
22 focusing more on the patients who need a greater
23 level of nursing care and that PSWs are more
24 heavily involved in the residents who need a
25 greater level of support with the activities of

1 daily living.
2 COMMISSIONER JACK KITTS: Okay. So I
3 think what you just said there, you call the
4 patient -- the residents that need nursing care
5 patients and the residents that our PSWs are -- are
6 residents.
7 Is the acuity such that they truly are
8 patients and residents and can't be treated the
9 same?
10 DIANNE MARTIN: I didn't mean to use
11 the word, patients. I think they're all residents,
12 and I think when you -- I'm a hospital nurse is my
13 background, so the 'P' word comes out of my mouth
14 all the time; but I think that as soon as we start
15 thinking of people more as patients than residents,
16 we end up forgetting this is their home.
17 COMMISSIONER JACK KITTS: Right.
18 DIANNE MARTIN: So I wouldn't go that
19 direction even though I did, you know, in what I
20 said.
21 COMMISSIONER JACK KITTS: But if we
22 did --
23 DIANNE MARTIN: But they weren't
24 closely -- yeah.
25 COMMISSIONER JACK KITTS: If we did, it

1 would make sense that the patients received four
2 hours of nursing care and the residents receive a
3 PSW.
4 DIANNE MARTIN: Yes.
5 COMMISSIONER JACK KITTS: Calling them
6 all residents implies they're all similar in some
7 way.
8 DIANNE MARTIN: Right. I mean, that is
9 -- I've never thought of it through that
10 perspective, but that would be one way to identify
11 the people who need the greater level of nursing
12 care. I don't know if it would be my chosen way of
13 doing it, but it would be one way of doing it.
14 It doesn't matter at the end of the
15 day. We have to recognize the people who need
16 nursing care as opposed to PSW care. We have to
17 recognize the ratio of hours of resident care to
18 PSW care. We do it in the hospitals. We recognize
19 that people need -- certain circumstances need all
20 their care from an RN. We recognize in our rehab
21 units, we need most of our care from RPNs. We do,
22 do that, but it will be important to do that in
23 long-term care because right now nurses are only
24 doing -- and I'll explain what I mean about nursing
25 tasks.

1 Giving medications is a nursing task,
2 but that's not nursing. I mean I could teach the
3 family members to give the medications. What is
4 nursing is an assessment of a patient every day or
5 every time you're doing something new for them,
6 thinking about what's different and what problems
7 need to be solved, asking them if it's appropriate,
8 what is most important to you today, developing a
9 plan, implementing -- which might be a medication,
10 you know, and getting the medications given, but
11 then evaluating the effect of their medications,
12 evaluating the effects of their -- all the other
13 treatments that we're doing. And right now we're
14 so busy giving the medications, for example, that
15 we don't do with any of the other stuff, which is
16 what makes nurses, nurses.
17 So that's been really problematic, and
18 we do have to find a way to identify the people
19 that need nursing care, meaning full assessments,
20 evaluations of their needs, and creating of a plan
21 with the interdisciplinary team if necessary, the
22 physician, the other people that you have.
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Can I just follow up on that for a minute? Do you
25 think that there exists today in the long-term care

1 homes people who have the ability to triage or the
2 ability to do what you just said, you know, look at
3 the individual residents and decide what kind of
4 care they need?
5 DIANNE MARTIN: No.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Okay.
8 DIANNE MARTIN: And I think we --
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Well, that's clear.
11 DIANNE MARTIN: I think we have not --
12 I think we have done very little, if anything, to
13 set up a system that decides who and how the care
14 will be provided based on patient needs. I think
15 that we don't necessarily -- there's some brilliant
16 people. I mean, there's some brilliant people that
17 work in long-term care that I find very
18 encouraging, but I think there is -- I want to be
19 really fair to the people that work in long-term
20 care, but I think it can be a default position for
21 people who don't love it or loved it and don't love
22 it anymore.
23 And I just think that what we need in
24 those situations are innovative change makers who
25 look at a situation and say there's a better way to

1 use the staff here, or we are not meeting needs
2 based on a variety of things, and how you get that
3 is by making it an employer of choice.
4 I have a daughter who is an ICU nurse;
5 and when she graduated school, she loved the
6 elderly and wanted to work in long-term care, and
7 people were horrified because "she's a very smart
8 girl," and I think that that is an example of the
9 attitudes that have been around for a very long
10 time; and she is a really smart girl, and long-term
11 care needed her, but ICU got her.
12 So I think that's just a personal
13 antidote, but I think that that's an example of how
14 we have been living in long-term care. We need
15 those people who can solve those problems that you
16 had asked about.
17 COMMISSIONER JACK KITTS: This -- I'm
18 not sure what the word is, divide or whatever, or
19 lack of recognition, I would say, of nurses to
20 RPNs, is that -- are you referring to hospital
21 nurses, or are you talking about RNs in the homes
22 not treating the RPNs as equals?
23 DIANNE MARTIN: I actually wasn't
24 talking about that. I was talking about society
25 saying to -- I wasn't very clear -- to nurses, why

1 would you want to work in long-term care?
2 So my daughter is an RN, but the
3 opinion was that other RNs mostly, that, well, if
4 you are really good at your job, you're going to
5 need to go to a hospital, so RPNs do that to each
6 other as well. If you're the Wayne Gretzky of
7 practical nursing, people are going to say you need
8 to be in a hospital, and we need -- that's the
9 attitude we need to change, so that's not between
10 RN and RPN. That is, among our society or our
11 profession, there is a feeling that those of us who
12 are stellar at our job should be in the hospital
13 setting.
14 There is dynamics between RNs and RPNs
15 but not as dramatic as you might think. We save
16 that for provincial leadership. But between RNs
17 and RPNs, they actually work together really very,
18 very well; and that's not to say that we don't have
19 issues with nursing, nursing's attitude towards
20 PSWs, and we at WeRPN have been working really hard
21 to help our practical nurses learn to really value
22 the input of their PSWs who are really up close and
23 personal with the residents and can share observations.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Okay.

1 DIANNE MARTIN: Shall I go on with my
2 short-term?
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Go ahead.
5 DIANNE MARTIN: Okay. We think that
6 there needs to be better connecting with nurse
7 volunteers. There were many retired nurses who
8 wanted to do something, to do anything. Nurses run
9 towards a crisis, and we think that we weren't
10 prepared on how we can in a crisis leverage that
11 sort of thing. Each of the professional
12 associations put up our own portal where we --
13 where nurses who wanted to engage in this sort of
14 thing could look for -- we made it free for
15 employers to post what they needed, particularly in
16 long-term care, and we connected that to our nurses
17 so that they could see where they could go and
18 provide care. So we think we need to do a better
19 job of really centralizing the ability to mobilize
20 people.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Can I -- I'm not sure this question follows what
23 you've been saying, but did you look at -- it was
24 suggested to us -- let me put it this way -- that
25 there might be foreign-trained professionals here

1 who are not in the -- not carrying out their
2 profession. They can't get recognized for one
3 reason or another and that they would be a useful
4 resource at least in terms of public -- or personal
5 support workers.
6 DIANNE MARTIN: Yes.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Do you -- based on your experience, do you have a
9 view on that?
10 DIANNE MARTIN: So, you know, I think
11 you have to be very careful. If you were a nurse
12 in -- an RN in the Philippines and you come to
13 Ontario, you're likely going to eventually get
14 registered as an RPN.
15 I think that we have to recognize that
16 educational differences are different from country
17 to country and that regulated health professionals
18 have to work to standards, and we can never let
19 those standards sort of be used in -- we cannot
20 take exceptions to those standards.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 M-hm.
23 DIANNE MARTIN: But there should have
24 been a way to have them certainly mobilize them as
25 PSWs. So PSWs of various backgrounds, I mean, a

1 lot of us were PSWs right up until we finished our
2 RN training, so there's some very skilled people
3 out there, and employers should be supported to
4 access those people in the PSW role. I would have
5 -- if I was an employer, I would have been looking
6 for all of that.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 All right.
9 DIANNE MARTIN: Okay?
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 So that seems kind of a reasonable thought from
12 your perspective.
13 DIANNE MARTIN: Oh, for sure. Yes,
14 absolutely.
15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay.
17 DIANNE MARTIN: Next as a short-term
18 goal, we would limit COVID-19 delays in
19 professional registration exams to remove barriers
20 and maximize the supply of professionals entering
21 the health care system.
22 We had multiple problems at the very
23 time that we needed to graduate numbers with
24 organizations not allowing students in for their
25 final practicum placements. Exam writing was a bit

1 of an issue. There was all sorts of issues to
2 those people in their final stage of their nursing,
3 whether it was RN or RPN, actually finish it, and
4 that's a really big challenge in terms of it has
5 lasting impacts because all of those people that
6 should have graduated are just now getting
7 graduated. It's more of an issue in the RN group
8 to be honest with you; but, certainly, we have an
9 educational system where we are not part of the
10 staffing of any organization, but we are -- the
11 organization has us as students because it's
12 important, and there's sort of an ethical
13 obligation to support students.
14 There is not a lot in it for the
15 employer; and if you look at England, they have a
16 new way of career laddering people and educating
17 nurses that is an apprenticeship model; and, also,
18 I think it would be very interesting to look at,
19 but that's -- now I'm getting into the long-term
20 solutions, but it would be interesting looking at
21 changing the way we educate people so that we have
22 this supply of people who actually work for us as
23 employers and are able to provide care in these
24 situations rather than being someone that must be
25 supervised.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Just a second, Dianne.
3 Commissioner Kitts?
4 COMMISSIONER JACK KITTS: Who would be
5 responsible for making that happen, the second and
6 last bullet? Where's the bottleneck there?
7 DIANNE MARTIN: Yeah, so it's really at
8 the organizational level more so than the schools
9 but also the schools. So the schools need -- the
10 schools need policies to keep their students safe.
11 They need -- insurance is a problem too. We notice
12 that people don't want to bring students in because
13 what if they get sick? What if they make someone
14 sick? Like, the whole personal liability insurance
15 and then the insurance of the school themselves;
16 but also the employers did not need one more person
17 in their building that wasn't able to work
18 independently to care for people.
19 So I think that the problem solving was
20 so overwhelming that this problem was easier just
21 to say, okay, no students right now. So we have to
22 approach that a little differently in the
23 short-term saying we must have students. Here's
24 the policies.
25 When you look at what the government

1 came out with in terms of directives, there was --
2 there wasn't much in the way of directives that
3 addressed here's how you have students in your
4 environment right now because the crisis was too
5 big. I'm not being critical of the government. It
6 was a very difficult time, but that sort of thing
7 would have been very helpful.
8 And then our final short-term is
9 enhance opportunities for staff to gain specialized
10 skills through micro-credentialling. One of the --
11 micro-credentialling, and I'm sure you know what it
12 is, but I'll just say it's when you take a
13 short-term course where you learn a specific skill,
14 and then you carry that credential with you.
15 And, for example, during this time, it
16 would have been nice if we would have had
17 micro-credentialling in terms of prevention
18 control. Our members told us that PSWs because
19 infection control at this level is not really part
20 of the environment where PSWs worked previously,
21 they didn't know what to do with their -- putting
22 on and taking off your PPE is a specific -- happens
23 in a specific way.
24 And PSWs, they would see them driving
25 home in their cars with their masks and their gowns

1 on after caring for people with COVID-19; and so
2 the staff were saying we need education for our
3 PSWs. I would like to see that happen through a
4 micro-credential where PSWs go to this six-week
5 online program part time or however you want to do
6 it -- I'm just illustrating what it might be --
7 where they learn the very simple principles of
8 infection control within a pandemic or an outbreak
9 of some sort within their home.
10 For RPNs, we could have a little bit
11 more significant infection control piece where we
12 really study airborne versus droplet, and we all
13 learn that in school; but, I mean, I was a child
14 birth nurse for 26 years. I knew very little about
15 it by the time I finished that work.
16 So, you know, just really carrying that
17 micro -- a recent micro-credential in those things
18 would be incredibly important, and that should be
19 being set up right now. We should be setting up a
20 micro-credential program for PSWs, one for RPNs and
21 RNs, and whoever else may need one in the
22 multidisciplinary team particularly about infection
23 control, and there's any number of them.
24 You could do one for a respiratory --
25 supporting residents through respiratory illness.

1 It's a very uncomfortable illness, and it's very --
2 it can be a very -- my understanding -- I haven't
3 witnessed it, but it can be a very difficult death.
4 How do we support people through that so that the
5 quality is there?
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 And who would do that?
8 DIANNE MARTIN: Well, it could be
9 anyone. We could set it up through the Colleges
10 Ontario. You wouldn't need universities for
11 that -- Colleges Ontario. You could have
12 professional associations such as ourselves. We
13 provide a lot of education to practical nurses. We
14 could set up an agreed-upon program. We should
15 have funding from the government so that the people
16 who work in the long-term care homes where this
17 outbreak was wouldn't need to reach into their own
18 pockets. Don't forget. PSWs make $16 an hour.
19 They wouldn't have to reach into their own pockets.
20 They would just need to take this micro-credential
21 program so that they could be one of those people
22 who has that micro-credential, but it could be
23 provided through a number of individuals.
24 COMMISSIONER JACK KITTS: Do you think
25 this might be one area where working closely with

1 the hospitals, they have the IPAC specialists who
2 part of their responsibility like a hub and spoke
3 make sure that the long-term care homes have the
4 appropriate training and preparation?
5 DIANNE MARTIN: Absolutely.
6 Absolutely. Like I said, having witnessed it and
7 the consultation between the long-term care and the
8 hospital in Finland, it's a great idea. Yeah,
9 absolutely.
10 We have a couple of long-term staffing
11 suggestions, and we need to address the existing
12 compensation disparities, wages, benefits,
13 full-time positions between long-term care and
14 other health sectors to ensure long-term care is
15 viewed as an attractive sector and help retain
16 qualified professionals. We've already talked
17 about that.
18 We need to develop a robust staffing
19 strategy, which, of course, we are working on
20 post-inquiry, and all of us are putting our
21 submissions in to the government about that
22 staffing strategy that they have developed. We're
23 doing that to ensure that Ontario has a pipeline to
24 educate the right numbers of qualified staff to
25 care for residents, and we want to address

1 retention by providing existing staff with
2 opportunities to enhance their education, so
3 credentialing in infection control and those sorts
4 of things but also through career laddering to
5 opportunities that enable staff to transition from
6 PSWs to RPN and RPN to RN.
7 What we know is in each category of
8 professional, there are people who want to study to
9 be the very best they can be in that category, and
10 there are people who want to career ladder to --
11 and certainly that's what I did. I did 19 years as
12 a practical nurse before I became an RN, so there
13 are people who have a vision that they'd like to
14 career ladder.
15 Right now, we have a system that does
16 little to help a PSW become an RPN. They basically
17 have to start at the beginning of the RPN program.
18 It's almost similar from RPN to RN, and we've got
19 barriers up, certainly cost barriers, and not
20 enough recognition for the previous education that
21 they have.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Is there -- let me just stop you there for a
24 minute. Is there -- is it the professional
25 colleges or -- that would be -- is there an element

1 of turf protection that's creating these barriers?
2 It's certainly -- it's been known to arise in other
3 professions.
4 DIANNE MARTIN: Yes, for sure there is.
5 You know, the universities, for example, if you are
6 an RPN, a highly-skilled RPN, you can in three plus
7 years become an RN even though the full program is
8 only four. If you are an engineer, you can do it
9 in two at U of T.
10 So that's obviously a thought process
11 that U of T has a second entry. You've got a
12 previous degree of any sort, you can apply to be in
13 the second entry program which is only two years.
14 RPNs are not eligible for that program, so, sure,
15 of course there is. That's a long-standing thing
16 for a lot of professions. We are taking some steps
17 towards sort of addressing that.
18 Recently, the government approved in
19 principle for colleges in Ontario to be degree
20 granting for Bachelor of Science in nursing
21 programs. So what I said to Colleges Ontario when
22 that happened, and I said, well, the very next
23 thing is I'm going to be asking you to please
24 create integrated programs so that your RPN program
25 flows right into -- your program content flows

1 right into your RN program so that we don't have
2 this disparity of recognition for your previous
3 knowledge and experience. So we are trying to take
4 some steps towards that.
5 The other -- I will just say the other
6 benefit of having colleges as degree granting is --
7 the other advantage to that is that colleges are
8 more widely spaced in Ontario. We're in the remote
9 areas and attract more First Nations and others,
10 people who are older in -- people who have -- are
11 more visible minorities. Those are all greater
12 in -- in the communities of the community college.
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 So a person would gain entry to the ladder, get on
15 the ladder --
16 DIANNE MARTIN: Yeah.
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 -- as a personal support worker.
19 DIANNE MARTIN: M-hm.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 And then through a process of continuing education
22 and so on, move as far as their ambition and
23 ability takes them?
24 DIANNE MARTIN: Yes.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Is that the idea?
2 DIANNE MARTIN: Although I wouldn't --
3 I wouldn't say it was ambition. It would be where
4 they find fulfillment in their career. I don't
5 think that's ambition. I think --
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Well, that's a gentler -- that's a gentler way of
8 -- I accept that. I accept that.
9 DIANNE MARTIN: Right. Okay. I
10 wouldn't call the RPNs who choose to remain RPNs
11 because they love what they do; I wouldn't call
12 them non ambitious, so --
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Oh, I see.
15 DIANNE MARTIN: -- okay -- because a
16 lot of them are continually seeking out education
17 and that sort of thing, but I think we need to just
18 honour people's desire to have a fulsome career
19 however they wish to have it especially when it's
20 in ways that retain them in the professions but
21 also have them providing care while they're doing
22 that.
23 We have a program. RNAO has it for
24 RNs -- WeRPN has it for RPNs where the government
25 supports nurses to seek continuing education to the

1 tune of about $1,500 a year.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Dianne, you froze again. Dianne, you froze.
4 DIANNE MARTIN: Oh.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 So could you just repeat the last minute or so of
7 what you said.
8 DIANNE MARTIN: Okay. So I was saying
9 that the government has this program through our --
10 oh, sorry. Someone came in the door. I'm really
11 in my head spaces here.
12 COURT REPORTER: I'd let you know what
13 you last said, ma'am, if you'd like?
14 DIANNE MARTIN: Yeah, do it.
15 THE COURT REPORTER: Just the last
16 sentence.
17 DIANNE MARTIN: Okay.
18 THE COURT REPORTER: So you had said:
19 (By reading).
20 "...supports nurses to seek
21 continuing education to the tune of
22 about $1,500 a year."
23 And that's all that we ended up with.
24 DIANNE MARTIN: Okay. Okay. So a
25 large -- probably half of our funding, there's a

1 pressure, so everyone who applies doesn't get
2 funded; but about half of our funding funds
3 practical nurses to become BSCN, and the other half
4 of the funding funds RPNs who are looking to obtain
5 excellence within the role of practical nursing,
6 and we think that fund could be enhanced
7 particularly to support -- there's no such fund for
8 PSWs, but we think it could be enhanced so that it
9 supports PSWs to move to RPN and then on if they
10 like as far as masters and PhD if that's what their
11 dream is, so an enhancement of that program would
12 be good.
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 How would you if you were pursuing that, who -- it
15 strikes me that the various regulatory bodies would
16 have to cooperate in that and -- to make sure that
17 you could climb up the ladder, and I guess that
18 brought me to the thought of, well, who governs the
19 personal support -- how do you do that for the
20 personal support workers so that there's an
21 interconnectedness between the various regulatory
22 bodies that allows you to move up?
23 DIANNE MARTIN: M-hm. I don't think --
24 I don't think it is the regulatory bodies because
25 the regulatory bodies allow you in when you have

1 graduated from an accredited program and written
2 the exam.
3 So I think it's how do you get into the
4 program, and so in that case, it will be colleges
5 and universities. And I think, for example, if a
6 college was looking to take PSWs to RPN as a real
7 attractive reason to stay in the profession, I
8 think they would have to say, from these accredited
9 PSW programs, if you've graduated from one of these
10 programs and maybe some learning assessment to
11 establish your skills, then we'll take you into our
12 program. So it's really not -- it's really not
13 regulatory.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 The regulatory body, then, has a set of credentials
16 and automatically recognizes?
17 DIANNE MARTIN: They recognize
18 accredited programs, so if I'm at Georgian College
19 studying to be a practical nurse, the College of
20 Nurses doesn't care how I got into Georgian or what
21 I did before I went to Georgian. They care that
22 Georgian's program is accredited by them, and I
23 graduated from it, and then I wrote a national
24 exam; but what came before that or how I got into
25 the program is not something that the college

1 concerns themselves with.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Okay.
4 DIANNE MARTIN: So that is our
5 long-term solutions for our recommendation number 1
6 and that -- which is staffing, so if you have any
7 other questions about staffing, I'm happy to take
8 them.
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 I don't. I don't think we do.
11 DIANNE MARTIN: Okay. So I'll move on
12 to number 2, which is improving the channels of
13 communication with long-term care. So nurses
14 reported challenges, accessing clear Public Health
15 guidance in long-term care. Yeah, that's good.
16 It became apparent that long-term care
17 leadership, management, and ownership in various
18 facilities were not always provided with the same
19 information leading to confusion and inconsistent
20 adoption of ministry guidance.
21 In some levels, information shared with
22 leadership was not disseminated to staffing levels;
23 and, for example, at the beginning of the pandemic,
24 nurses were not provided with clear guidance from
25 management about the appropriate PPE they should be

1 using to keep their residents and themselves safe.
2 We had a daily newsletter with all of
3 that -- a very comprehensive newsletter with all of
4 that information, so we feel that RPNs, our
5 members, were very well informed on exactly what
6 they should be doing in each sector; but that
7 information wasn't always accessed or shared with
8 their leaders, which led to a variety of problems
9 that I will talk about later.
10 But there just was no consistency on
11 how that was provided. I'm very proud of the fact
12 that I think our members were well informed, but
13 that's not all RPNs. That's about a third to a
14 half of RPNs are our members, and many -- it was
15 just confusion about what they should be doing.
16 So in order to ensure accurate
17 information is disseminated to the sector in a
18 timely manner, it is essential to improve
19 communication channels across long-term care.
20 So we heard a lot of -- we also had
21 a -- I had a once-a-week FaceTime live event in the
22 evenings, and the confusion and the rumours and all
23 of that was rampant, and so we used those sessions
24 to correct a lot of the thinking, and we used those
25 moments to direct people on how -- not our

1 recommendations but how to access the -- you know,
2 sort of robust recommendations or quality
3 recommendations from the government.
4 We don't believe that the leadership --
5 and we'll talk about leadership as one of our
6 recommendations -- but we don't believe in them as
7 the recipients of the knowledge to be disseminated
8 as they see fit to these staff. We believe that
9 whatever information is available should be
10 available to everyone who is working in the sector.
11 You know, the right answers are the right answers.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Yes. Commissioner Coke?
14 COMMISSIONER ANGELA COKE: So, sorry,
15 just to clarify, the trickle-down effect wasn't
16 trickling down, so more direct communication is
17 what you are saying?
18 DIANNE MARTIN: Yes, and I will say,
19 having spent some time in a professional practice
20 role in a hospital, my first leadership role,
21 getting information to trickle down is a challenge,
22 so I have to be careful about placing blame on the
23 owners and managers. That can be a real challenge
24 to be -- think you have disseminated beautifully
25 and then have people who have no idea what you're

1 talking about, so to be fair, that's always a
2 challenge in health care.
3 COMMISSIONER JACK KITTS: Let me just --
4 DIANNE MARTIN: Yeah.
5 COMMISSIONER JACK KITTS: So you're
6 saying improving channels of communication with
7 long-term care, between long-term care and I think
8 you say I think local Public Health, Ministry of
9 Health, and owners and management; is that -- so
10 it's improving channels to long-term care staff
11 from Public Health, local Public Health, from
12 Ministry of Health, the province, and
13 owners/managers? Is that what this alludes to?
14 DIANNE MARTIN: I think in a pandemic
15 -- and I was a point-of-care nurse during SARS,
16 which wasn't a pandemic, but it was a problem -- I
17 think transparency is the thing that gets the
18 problem solved.
19 So when the government, whether it be
20 Ministry of Health -- and by that, I mean also the
21 Ministry of Long-Term Care -- and Public Health
22 release the recommendations or the information, do
23 we need an N95 or do we not need, those -- ideally,
24 all of that information, should be accessible
25 through a portal where you are welcome to access

1 regardless of your role in health care probably the
2 public as well, and there should be encouragement
3 every day to the PSWs, the nurses, others to -- to
4 access that information so that everyone's able to
5 access the same information. We think that that
6 would be important.
7 So how we've put it in our
8 recommendations is we would -- we think that
9 creating a portal dedicated to long-term care to
10 ensure a one-stop shop that would house up-to-date
11 resources for leadership, staff, and families; and
12 in doing so, the level of transparency would
13 hopefully help people. And by the way, it needs to
14 be a two-way street. We need to be able to tell --
15 we need a clear process to be able to tell
16 Public Health and government and others, and I will
17 talk about -- in accountability, I will talk about
18 this again in a moment, but I need to be able tell
19 you: I haven't seen a mask in a week. You know,
20 my owner says that me wearing a mask is scaring the
21 patients with dementia, and I can't wear one. That
22 happened.
23 And of course that's true, but there is
24 no perfect solution here. We have to wear the
25 masks, so there has to be somewhere, you know, a

1 two-way street of communication where we can say, I
2 feel like something's happening here that isn't
3 right.
4 Our second recommendation there is we
5 encountered long-term care homes that were just
6 doing an amazing job and didn't have any outbreak.
7 I think it's -- I can't remember the name of the
8 one in Ottawa. I had it the other day, and then I
9 had forgotten, Duncan maybe. Maybe Dr. Kitts
10 knows. But there's a long-term care home that
11 engaged in the most amazing leadership and policy
12 making and support and communication. We think
13 long-term care homes should have a place to share
14 best practices. We should not have long-term care
15 homes reinventing a wheel that's been beautifully
16 invented by another long-term care home.
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Could -- I'm not sure whether Dr. Kitts knows the
19 long-term care home that you're referring to or
20 not, but I think it might be useful for us to know,
21 to get a couple of examples of what your
22 association thinks was exemplary leadership in this
23 area.
24 DIANNE MARTIN: Yes, okay.
25 COMMISSIONER JACK KITTS: Yeah, no, I

1 don't -- I don't know the home.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Oh, okay.
4 DIANNE MARTIN: Okay. So I can
5 certainly get you the name, but someone saw their
6 policies and asked their leaders, can we share
7 these, and she said, of course; and I read them,
8 and they were really very, very good; and, of
9 course, they were constantly changing, which is
10 what made them excellent, which is what we needed
11 in long-term care, because as you know, we didn't
12 know much in the beginning. So certainly I can get
13 that to you.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Thank you.
16 DIANNE MARTIN: Okay. And we should
17 encourage long-term care facilities to establish
18 policies and procedures to disseminate key
19 information across the organization in a timely
20 manner; and like I said, I recognize that the
21 larger the organization, the trickier that is.
22 We have nurses who only work night
23 shift, so if you think you're going to go and visit
24 your nurses and make sure that they have seen all
25 of this, it's not going to work very well on night

1 shift. You have to be really imaginative to
2 disseminate information in a large organization,
3 but it's going to be important.
4 So that is the -- that's our second
5 recommendation on improving channels of
6 communication with long-term care.
7 And it's 10:39, so would that be a good
8 time to take a break?
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Is it a good time for you because it probably works
11 for us, I think?
12 DIANNE MARTIN: Yes, it's fine with me.
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Okay. So we'll take ten minutes.
15 DIANNE MARTIN: Okay.
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Don't ring off. Just turn off the video and mute
18 the sound, but don't disconnect, please.
19 DIANNE MARTIN: Okay.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Otherwise, we may not get you back.
22 (BREAK)
23 DIANNE MARTIN: I'll continue with our
24 area number 3, Implementing Robust Infection,
25 Prevention, and Control Protocols.

1 During a pandemic, maintaining a strong
2 pandemic infection control measure is essential.
3 This was a critical factor that differentiated the
4 facilities that were able to control the spread of
5 COVID-19 from those with high infection rates among
6 residents and staff.
7 There are a number of measures put in
8 place provincially that help curb the spread.
9 Introducing robust screening measures for everyone
10 entering long-term care, implementing regular two
11 times a month testing of all staff, limiting staff
12 to one facility, minimizing visitors, cohorting
13 staffing to units and residents, areas to produce
14 unnecessary resident exposure to contagions,
15 isolating of infected residents where possible, and
16 enhancing cleaning protocols.
17 The knowledge of staff also played an
18 essential role in curbing the spread of the virus.
19 Infection, prevention, and control is an essential
20 part of nursing education. Other staff such as
21 PSWs may be less familiar with the steps necessary
22 to prevent the spread of the virus.
23 So our recommendations here are that
24 every long-term care facility implement robust
25 infection control, prevention, and control

1 measures, and that's going to be -- need to be done
2 by leaders inside the long-term care home hopefully
3 with a sharing of those measures for the highest
4 quality and consistency across the province.
5 All long-term care facilities need to
6 identify, educate, and recruit infection,
7 prevention, and control leaders to monitor,
8 evaluate, and ensure adherence to protocols. So
9 there needs to be the expert within the
10 organization. There needs to be people who are
11 designated to be the experts, and those people need
12 to be -- there needs to be more than one, and they
13 need to be distributed among various shifts so that
14 there is always someone who can say, you know, I
15 think we need to -- we're not doing this right, or
16 I think I see something different happening, and
17 we're going to have to access different cohorting
18 of residents, you know, recognizing the symptoms
19 and making sure that they are in one area, that
20 nurses aren't -- as much as possible, nurses and
21 PSWs aren't caring for people who have COVID and
22 people who don't. That's not always going to be a
23 perfect science, but it should be the goal.
24 All staff should be required to
25 undertake basic infection prevention and control

1 education, so as I was talking earlier about the
2 micro-credentialling.
3 The Ministry needs to implement
4 oversight measures to ensure adherence to a minimum
5 standard throughout unannounced inspections. It is
6 -- unannounced inspections are -- that doesn't feel
7 good to staff, but these are unusual times, and we
8 have residents who are counting on us to not do
9 something or fail to do something that's going to
10 cause them to end their life in this way. So we
11 all have to live with extraordinary measures.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Did the -- can I just ask you about that? When
14 there is an inspection or pre COVID, did you know
15 when this inspector was coming?
16 DIANNE MARTIN: That's a really good
17 question because, of course, there's been long-term
18 care inspections for some time. I have no idea,
19 but that's a question for long-term care operators.
20 I don't know --
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 But you did have some experience, I thought you
23 said, early on in your career.
24 DIANNE MARTIN: Well, I've got a
25 41-year career, so there wasn't inspection.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Mine's longer than that actually.
3 DIANNE MARTIN: So I did not -- I did
4 work initially in long-term care, but that was in
5 the -- around 1980, and I don't -- there was no
6 inspections, so...
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Oh, okay. Very good.
9 DIANNE MARTIN: Thanks for pointing
10 that out. Anyway. So --
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Let me ask the question a different way. In terms
13 of the membership, is there -- do you have any
14 sense of whether they think that these inspections
15 are telegraphed or not?
16 DIANNE MARTIN: Again, I have no idea.
17 That's a really good question.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Okay.
20 DIANNE MARTIN: I don't know.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Okay.
23 DIANNE MARTIN: We -- we would like to
24 see wherever possible facilities limit the number
25 of residents sharing rooms.

1 And the next point is I think
2 incredibly important. Facilities need to adopt
3 innovative approaches to allow visitors while
4 protecting resident safety.
5 Probably the most heartbreaking or
6 cruel thing that we did during this wasn't --
7 wouldn't be an unannounced inspection. It's
8 restricting visitors to our elderly. That was
9 traumatizing to the elderly. That was traumatizing
10 to their families; and, certainly, we saw some
11 places that managed to get around that. We're
12 going to have to figure out ways to allow -- we had
13 examples of people who were -- would feed their
14 parents every meal, would go in and feed every
15 meal. We need to provide them with the protective
16 equipment so they can continue to do that. That is
17 incredibly important.
18 But then we saw other organizations
19 that created a very comfortable living room
20 situation with a glass partition down the middle,
21 and you can put all the grandchildren, stream them
22 in one at a time or whatever in to see them so that
23 they can have that -- quite often, the family and
24 the grandchildren and those sorts of people are the
25 reason for being and for living, and we have to

1 create innovative ways for our people to continue
2 those visits, or we are doing such a cruel thing to
3 people in an effort to keep them alive, and I think
4 we can do better.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 There is a question. Dianne, just a moment.
7 There's a question.
8 DIANNE MARTIN: Yes.
9 COMMISSIONER JACK KITTS: Yeah, when I
10 look at your recommendations for this area, every
11 one's a statement. You know, every long-term care
12 facility implement facilities identified, required.
13 Your second last bullet, you softened
14 and said, whenever possible, facilities should
15 limit the number of residents sharing rooms.
16 Do you really mean that, or is it -- do
17 you have a number that shouldn't be surpassed?
18 DIANNE MARTIN: We don't have a number.
19 So, ideally, we would like long-term care, each
20 resident to have their own room. We're not talking
21 about those who have COVID-19. We're just talking
22 long-term care homes in general, it would be lovely
23 if all could have a room. That's not going to
24 always be possible to have rooms where they don't
25 share, but more than two to a room is going to be

1 too many and where possible --
2 COMMISSIONER JACK KITTS (CHAIR): Can
3 I ask you -- why do you think it'll never be
4 possible to have one resident per room?
5 DIANNE MARTIN: I think -- well, that's
6 an assumption on my part. You're asking a really
7 good question. I think that we came up with that
8 as a result of the ageing population.
9 Now, if you look at one of our
10 recommendations that's coming up, it is supporting
11 ageing at home, so you're right. There will be
12 solutions that could potentially lead us to having
13 enough room for everyone to have their own space in
14 a long-term care home, yes. Yeah.
15 COMMISSIONER JACK KITTS (CHAIR): Okay.
16 Thank you.
17 DIANNE MARTIN: I would agree with
18 that. Any other questions about that particular
19 infection control piece?
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 No, I don't think so.
22 DIANNE MARTIN: So our area number 4
23 is Strengthening Long-Term Care and Leadership.
24 Leadership played a significant role in the care
25 provided to residents in long-term care.

1 In many instances, facilities that
2 fared the worst in the face of COVID-19 did not
3 have leadership that was equipped to respond
4 effectively to a complex crisis of this nature.
5 Improving the leadership capacity in
6 long-term care could have dramatic -- could assist
7 dramatically in enhancing the ability of the
8 facilities to respond effectively during the second
9 wave.
10 So what we recommend in this area is
11 that we develop specific supports to enhance the
12 capacity of long-term care facility leadership.
13 This could include quality improvement and
14 measurement based on best practices; best practices
15 are going to continue to be of growing importance;
16 analyzing and Improving Organizational Care
17 Delivery Processes: It takes -- I think it was
18 Dr. Kitts that asked the question earlier about the
19 people, do we have sort of the ability to assign
20 staff and the amount of time each staff is spending
21 with residents by their acuity level?
22 And one of the things that we're
23 talking about is ensuring that there's people there
24 that can do it. Sometimes the decisions are made
25 by owners who don't have a health-care background,

1 and those decisions, I'm sure, are made with the
2 best intentions; but without the background, then,
3 the leadership background, it doesn't necessarily
4 create a very good environment.
5 And I would also say that sometimes we
6 assume that because someone is a fantastic
7 practitioner that they're going to be an even
8 better leader, and being a great practitioner
9 doesn't necessarily mean that you're going to be a
10 great leader. There's some of the most amazing
11 nurses in the world who wouldn't necessarily thrive
12 in the leadership role, same with physicians, same
13 with others, so we have to find the right people
14 with the right skill set to be leaders in long-term
15 care.
16 COMMISSIONER ANGELA COKE: Can I just
17 ask a question?
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Sorry.
20 DIANNE MARTIN: Yes.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 When you say leaders, how do you mean that? In the
23 facility, who's in charge of the facility or who's
24 in -- what does that mean?
25 DIANNE MARTIN: Okay. So I have a

1 masters degree in leadership. I chose that instead
2 of an MBA, so I have a lot of thoughts about this.
3 I'll try to limit them to what is relevant, but, so
4 there's -- I use leaders to describe both
5 management titled people in leadership but also
6 front-line people who are the people who impact an
7 organization's quality, and the reason I do that is
8 because the skills are the same. You know, change
9 management, communication skills, they're all the
10 same, so I could mean either.
11 In this particular circumstance, I mean
12 the people who are the titled leaders, the people
13 who are Directors of Care, that sort of -- even a
14 shift supervisor, they're going to need some -- the
15 leadership skills.
16 If I am an owner, for example, I might
17 have those skills, but probably my best choice is
18 to have a Director of Care who has those skills and
19 defer to them in terms of saying, you know, now we
20 have an outbreak; I'm going to need you to create
21 robust policies for this outbreak. That should be
22 the role of the owners and operators, and then what
23 they will need is a clinical leader to really
24 create and implement the -- with the knowledge base
25 necessary for those sorts of policies.

1 But also recognizing that all staff
2 with leadership abilities, especially those that
3 are involved in the interface between care provider
4 and resident, and I mean nurses, PSWs, sort of
5 enhancing or encouraging the leadership attributes
6 in those people would be incredibly important.
7 We had -- and I'm going to mention this
8 under accountability again -- but we had two RPNs
9 in Ontario who were working for homes that the
10 owners were making the decisions. They would --
11 one of them was a Director of Care. The owners
12 were making the decisions about how they were going
13 to approach things, and this particular RPN knew
14 that they were not engaging in appropriate
15 infection control measures and even had symptomatic
16 people working because there was no one else to
17 work, and she was very upset about it. She talked
18 to them about it at length and then finally phoned
19 Public Health and said there's a problem in our
20 long-term care home and was immediately fired from
21 her position.
22 So that person who is, you know,
23 closely involved with the right feet-to-the-ground
24 level, we have to make sure that they have
25 leadership skills -- that we develop their

1 leadership skills as much as possible and then use
2 them.
3 That was -- that's an extreme story,
4 but to some degree, nurses were often overruled by
5 operators and owners when they tried to engage in
6 implementing their nursing knowledge.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Dianne, there's a question from Commissioner Coke.
9 COMMISSIONER ANGELA COKE: Just one
10 comment and a question: I'm assuming, you know,
11 also when you talk about wanting this to be an
12 employer of choice, then the leadership skills
13 would be important in terms of developing the right
14 type of culture and work environment for everybody.
15 DIANNE MARTIN: Yeah.
16 COMMISSIONER ANGELA COKE: But my
17 question was related to something else you had
18 mentioned, and I'm just -- each resident has to
19 have a care plan as I understand it?
20 DIANNE MARTIN: Yes.
21 COMMISSIONER ANGELA COKE: And so I'm
22 curious: Is that developed in a collaborative way?
23 DIANNE MARTIN: So I don't know. I'm
24 going to tell you that that's true of every sector,
25 and I've only worked in one organization where

1 every day, the plan of care was pulled out for
2 every patient, and we just discussed and made
3 adjustments.
4 My fear that -- is that we have
5 long-term care homes where there is a routine plan
6 of care put in place, and then on the day-to-day
7 care, that is not discussed, and that will go back
8 to the communication piece where you need nurses --
9 we call them huddles in hospitals, but in long-term
10 care, we would probably just call them a case
11 because patients are there a lot longer -- the
12 residents are there a lot longer -- I would
13 probably just call them a case review, but,
14 certainly, that case should be reviewed.
15 I suspect if you went into a long-term
16 care home, you would see that there was things in
17 the care plan that had been resolved, or there were
18 issues with the client or the resident that had
19 never made it to the plan of care. I personally am
20 a big fan of plans of care and think they are
21 underutilized and certainly under maintained in
22 terms of making them address the issues that are
23 the issues of the day including the question -- I
24 always had my nurses ask this question: What is
25 most important to you today? And they're going to

1 tell you something pretty surprising. It won't be
2 what you think, but that's what you need to make
3 happen, and that should be part of the plan of care
4 as well.
5 COMMISSIONER ANGELA COKE: Thank you.
6 DIANNE MARTIN: So I can't remember
7 where I was now.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 You were about to start enhancing accountability, I
10 think. You were --
11 DIANNE MARTIN: Okay. Oh, no.
12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 You were dealing with enabling leaders to build
14 high-functioning teams.
15 DIANNE MARTIN: Oh, right. Optimizing
16 models of care is one of our recommendations, and
17 you need someone with a strong nursing knowledge of
18 how care -- the various ways that care can be
19 provided so that there are no cracks in your system
20 so that there is no element of a patient's care
21 that can fall into a crack.
22 So you need knowledgeable nurses. You
23 need to stop funneling them all into the hospitals.
24 We need to really help nurses understand that this
25 is incredibly rewarding work where we need their

1 brains working every day to make this -- this is
2 not something that doesn't use nursing skills.
3 It's something that will develop more nursing
4 skills than any other type of nursing, and we need
5 to start to getting that message out, and then we
6 need to use those very intelligent people to design
7 models of care that meet those needs.
8 Leveraging Health Care Professionals to
9 full scope of practice: We still have
10 organizations across every sector that have
11 personal beliefs about who should be doing what
12 rather than using, you know, our empirical
13 knowledge of what is best roles for each type of
14 care provider, and we just have to have more
15 support, certainly your report and other government
16 areas, to ensure that you fully understand each
17 professional scope of practice and that you use it
18 fully. I think that's a really important piece.
19 And we need to enable leaders to build
20 high-functioning teams by supporting them to coach
21 and engage staff, and that means we're going to
22 have to -- I talk about this all the time; people
23 are probably tired of it -- but engaging in a
24 nonhierarchical environment where people are free
25 to dissent. People are free to say we need to have

1 a meeting. I can call a meeting as a PSW. We need
2 to have a meeting to discuss something that I think
3 is a problem. We need to start creating those
4 kinds of working environments.
5 So that ends the strengthening
6 long-term care leadership section. If there's no
7 questions, I'll move on.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 I think, Jack, you're on mute, but I don't think
10 there are any questions.
11 COMMISSIONER JACK KITTS: No, I'm good.
12 Thank you.
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Okay.
15 DIANNE MARTIN: So I'm going to move to
16 enhancing accountability in the long-term care
17 sector. And there we go. You've got it up there.
18 Thank you.
19 In the early stages of the pandemic, we
20 heard disturbing stories of nurses being
21 reprimanded for urging facility owners or
22 management to follow provincial guidelines or put
23 in place enhanced infection, prevention, and
24 control measures.
25 So this is much of what I talked about

1 previously where we were really upset to hear this.
2 It was probably one of the most frustrating things
3 that our nurses -- access to PPE was the most
4 frustrating, but second would be the inability --
5 the inability to see disaster happening and have
6 their voice heard to identify it and correct it.
7 What we recommend is enhancing the
8 capacity of the Patient Ombudsman to ensure nurses
9 and other health professionals have an avenue to
10 voice concerns about practices within their
11 facility without fear of reprisal.
12 And, of course, health care wide, this
13 should be -- should be something that we have
14 access to as health care practitioners, but it has
15 never been more important or we have never failed
16 greater at this than we did in long-term care
17 during the first wave.
18 Currently, the Office of the Patient
19 Ombudsman is experiencing a high volume of
20 complaints leading to delays and follow-up. Adding
21 capacity to this important resource will help
22 ensure that concerns can be addressed in a timely
23 manner and ultimately protect residents; and, of
24 course, this is for all practitioners, families,
25 residents themselves because I think the visitor

1 issue would have been solved a lot sooner if the --
2 if there had been a place where families could say,
3 you need to develop a process through which you can
4 keep your resident safe, but I can see my loved one
5 just as often as I ever have. We need a place for
6 all of that to go.
7 And that is that section, the
8 accountability section, if there's any questions
9 about that?
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 I don't think so.
12 DIANNE MARTIN: Okay. So section
13 number 6, Ensuring Appropriate Supplies of PPE: At
14 the beginning of the pandemic, nurses experienced
15 tremendous levels of stress and uncertainty and
16 risked potential exposure to the virus as a result
17 of shortages of personal protective equipment.
18 Across Ontario's long-term care
19 facilities, access and guidance on appropriate PPE
20 varied substantially. Early on, some nurses were
21 instructed not to wear masks because it would scare
22 the residents. Many nurses in long-term care
23 reported being provided with only one surgical mask
24 per shift or, worse, one mask to be reused for
25 several shifts.

1 Over the past several months, the
2 government has rightly taken proactive steps to
3 create new supply chains for PPE. As we move into
4 the fall, it will be essential that those supply
5 chains are maintained and long-term care staff and
6 residents continue to access the supplies they
7 need.
8 So in terms of our members, the members
9 who worked in hospitals said, I feel -- I feel like
10 I have what I need, and I feel safe for the most
11 part, not ideal. I would like to be able to change
12 my mask every four hours, but they were not afraid;
13 but the long-term care members were very afraid
14 that they would get the disease, take it home to
15 their homes where they have, in some circumstances,
16 very at-high-risk people living in their homes.
17 So we felt that this was just -- first
18 of all, the province was not prepared for a
19 pandemic, but the -- the way that PPE was
20 prioritized to hospitals was for me appalling. I
21 say that as someone who has a daughter who works in
22 ICU. I think that we did a really poor job of
23 protecting equally across the board.
24 Then there was an incident where I
25 don't know if you're familiar with directive number

1 5 from the government, and it talked about PPE, and
2 it went through several iterations that each were
3 released and in effect for a period of time and
4 then maybe were changed, and directive number 5 in
5 one iteration guaranteed access to a different
6 level of PPE for members of ONA, the registered
7 nurses union. It specifically said that they would
8 be guaranteed a certain level of protection.
9 And I think that one of the worst
10 things we can do in a pandemic is stakeholder
11 management as opposed to principled and ethical
12 decisionmaking about such things as PPE. I and my
13 members, I have to tell you were incredibly,
14 incredibly upset about that. It was eventually
15 changed. There was, I think, a lot of pushback
16 from a lot of organizations; but just the fact that
17 we would suggest that members of a certain union
18 would be guaranteed PPE when others weren't has to
19 be one of our biggest areas of regret through the
20 pandemic.
21 So our recommendation is that we ensure
22 all staff and residents are provided with the
23 appropriate PPE on a priority basis. In instances
24 where shortages occur in certain regions,
25 additional measures should be taken to ensure that

1 long-term care receives available supplies
2 urgently.
3 And I would suggest that when -- in the
4 beginning when industries were donating large
5 supplies, huge supplies in some circumstances, to
6 their local hospital or that sort of thing, that
7 the government require -- and this is a tough
8 one -- but the government require that any
9 donations of PPE be shared with the government so
10 the government can prioritize where it goes.
11 I -- it bothered me a lot to read about
12 massive donations to various organizations when I
13 knew long-term care homes in that very area had
14 access to nothing.
15 And that's -- that's that section if
16 you have any questions about that?
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Well, I do have one question. You said it should
19 be available. Was there -- I thought I took from
20 what you said that there was some priority to
21 making it available in the home? Maybe I
22 misunderstood.
23 DIANNE MARTIN: Do you mean eventually,
24 or do you mean in the beginning? I don't really
25 understand the question.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 No. I was trying to pick up on a comment you made
3 that it should be made available according to --
4 according to a priority of some kind, I thought you
5 said.
6 DIANNE MARTIN: No. Yes, I guess. The
7 priority should be equal access for people.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Oh, okay. Okay. Fine.
10 DIANNE MARTIN: Yeah. Yeah. I think
11 that there was a prioritization of hospitals.
12 That's certainly what I heard from our members. I
13 didn't have any members from hospital say to me,
14 I'm really concerned. Some of them talked about
15 the discomfort of wearing a single mask for too
16 long.
17 But the concern that they weren't safe,
18 I didn't really hear that in the hospital system,
19 but I certainly heard it -- when I would hold those
20 Facebook-live events every Tuesday evening, it was
21 almost entirely long-term care nurses distressed
22 about their inability to access PPE.
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Okay.
25 DIANNE MARTIN: So I think that if

1 there was a prioritization, there was an
2 inappropriate one.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 All right.
5 DIANNE MARTIN: Maybe not -- I should
6 maybe clarify maybe not without fault. I mean, I
7 think we all thought like SARS that it was going to
8 be hospitals that were going to fight this battle;
9 but once we realized that wasn't the case, we
10 should have acted more quickly to share that PPE.
11 All right. Well, I'll move on to our
12 last area then: Enabling More Residents to Age at
13 Home. So increasing numbers of Ontarians identify
14 that they would prefer to age in their homes for as
15 long as possible. For those who are able with the
16 right support, home care can be a viable
17 alternative to long-term care.
18 Against the backdrop of the pandemic,
19 the case for improving access to the home continues
20 to grow. At home, older Ontarians are less likely
21 to be exposed to COVID-19 than those who live in
22 long-term care. As Ontario demographic shift and
23 our population ages, we will see increased
24 pressures on our already strained long-term care
25 sector.

1 And I probably should say that to
2 Dr. Kitt's point earlier, this is going to hinge on
3 PSWs. Many times, residents enter long-term care
4 because of their inability to manage their
5 activities of daily living. So that's heavily a
6 PSW role that we have to make sure that we enhance
7 in home care with the intention, very intentionally
8 to make sure that people can stay in their homes as
9 long as possible.
10 So what we recommend is enhancing
11 access to home care to alleviate the pressure on
12 the long-term care system while enabling Ontarians
13 who are able to do so to remain in their homes for
14 as long as possible. That's an ideal.
15 I also think it would be an investment
16 that would be cost effective. It might not be
17 cheaper, but I don't think the cost would be nearly
18 as high as one would think it would be, and yet the
19 quality of life might be substantially improved.
20 Certainly, it's so much easier to
21 protect someone from a pandemic when they're in
22 their own home and the people entering the home
23 have to -- all you have to do is protect that
24 resident from yourself as a care provider. You
25 don't need to protect that resident from other

1 residents, that sort of thing.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Okay.
4 DIANNE MARTIN: So we think that is
5 important.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Okay.
8 DIANNE MARTIN: It also solves the
9 visitor issue, yeah.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 I don't think there are any questions.
12 DIANNE MARTIN: Right. Okay.
13 So that is -- that's our
14 recommendations. We have some appendix that we've
15 shared with you for you to consider. We've got an
16 appendix that looks at proposed staffing and what
17 it would look like, and you'll see that our
18 emphasis is really on increasing, you know, PSWs
19 and RPNs. We do think that each day clinically we
20 need access to an RN to deal with the serious
21 clinical things that may arise. If they don't
22 arise, they need to be out there helping the daily
23 care with everyone.
24 But it really is about if you have --
25 if you have a patient with COVID who is -- has

1 dementia and is someone who wanders, and, you know,
2 you want to be able to supply the staff to make
3 sure that they are able to do what they need to do
4 but safely without infecting other residents, all
5 that hinges on staffing, and definitely nursing
6 care is needed of both kinds. But PSWs are
7 incredibly important, and I worry that we forget
8 about the importance of them.
9 The second appendix that we have, we
10 even included role descriptions of what we think
11 these people should be doing in their jobs. There
12 is one for PSWs, RNs, RPNs, and an administrative
13 role that would be held by whichever nurse has the
14 skills that we talked about previously in
15 leadership.
16 For example, I have two RPNs who work
17 for me who have degrees in health care
18 administration, and they're working on masters, or
19 one of them is working on her master's degree on
20 health care administration now. She's not an RN.
21 She's an RPN, but she is an excellent leader, so we
22 don't -- we see the clinical roles as being
23 different than administrative roles; and once
24 again, just because you're an amazing clinician
25 doesn't necessarily mean that you are the best

1 person in the building for the leadership role.
2 So those are other appendix that we
3 have added, and that is the end of our
4 presentation.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 I don't -- I, first of all, thank you very much for
7 a very thorough presentation. I think we all found
8 it very informative, and it's very helpful to hear
9 the voice of people who are actually -- had a
10 living experience with this because it's important
11 for our recommendations to be at that level.
12 So thank you for the -- for the effort
13 that went into the presentation, and it will be
14 very helpful to us. We may be back to you if you
15 don't mind --
16 DIANNE MARTIN: Certainly.
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 -- if questions come up or we want clarification,
19 or we want to ask you about something that's
20 occurred to us. But in any way --
21 DIANNE MARTIN: Absolutely.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 -- and on behalf of the Commission, thank you very
24 much.
25 DIANNE MARTIN: Thank you, and thank

1 you very much for doing this work. I'm really --
2 it makes us very hopeful, and we look forward to
3 your report.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Thank you.
6 COMMISSIONER JACK KITTS: Thank you.
7 COMMISSIONER ANGELA COKE: Thank you.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Bye-bye.
10 DIANNE MARTIN: Thank you. Bye.
11 COURT REPORTER: Thank you, everyone.
12 -- Adjourned at 11:30 a.m.
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1 REPORTER'S CERTIFICATE
2
3 I, JANET BELMA, CSR, Certified
4 Shorthand Reporter, certify:
5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;
9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;
13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.
16
17
18 Dated this 28th day of September, 2020.
19
20
21
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