Long-Term Care COVID-19 Commission

Via Zoom
on Tuesday, September 22, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 22nd day of September, 2020, 1:30 p.m. to 2:58 p.m.

BEFORE:

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

PRESENTERS:

Samantha Peck, Executive Director, Family Councils Ontario
Tiffany Fearon, Client Services Manager, Family Councils Ontario
Natacha Dupuis, Bilingual Outreach Manager, Family Councils Ontario
Cathleen Edwards, Education Manager, Family Councils Ontario
Lynn Mahoney, Counsel, Gowlings WLG

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

-- Upon commencing at 1:30 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, let me tell you: First of all, as I said before you joined us, thank you, the three of you, for coming.

The way we would like to do it is we'd like to hear what -- we don't have a set pattern of questions. We would like to hear what you have to say. I would just caution you that we'll ask you questions as we go along. We're not trying to be rude, but we just find it better to ask the questions as they come up --

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- rather than wait until the end and go back.

SAMANTHA PECK: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): So we're ready when you are.

SAMANTHA PECK: All right. So perhaps I'll start. I'll tell you just a little bit about our mandate to set the context for the work that we've been doing to support families and hear their concerns through the pandemic.

We are a Ministry of Long-Term Care --

provincial Ministry of Long-Term Care-funded organization. We're a charitable, not-for-profit. We were incorporated in 2015. We have federal incorporation, but we have a provincial mandate, although our work actually goes back to the late 1990s as a program, working with families to, at that time, just assist them with developing their peer-support groups in long-term care.

Over time, our mandate has evolved to supporting public policy development at a provincial level and assisting families and helping them navigate the long-term care system and, still to form, effective peer-support groups within long-term care homes.

These groups, Family Councils, have powers and standing under the Long-Term Care Homes Act in Ontario which gives them certain powers to advise licensees of concerns and recommendations they may have about the functioning of the home.

So we estimate that probably about 80 percent of Ontario's long-term care homes, which is over 600, have Family Council. So there were 500 groups who work with the home, ideally collaboratively and in partnership, to improve the quality of life of people living in those homes.

And so our mandate is to support those groups, to engage in research, policy, analysis, public policy discourse to advance the sector as a whole and to embed the family voices in decision and policy being made in long-term care.

We have a collaborative relationship with the Ministry of Health. They're our funder but also our partner in the public policy work.

COMMISSIONER FRANK MARROCCO (CHAIR): I thought I heard you say earlier you were funded by the Ministry of Long-Term Care and the -- so now you say and Ministry of Health?

SAMANTHA PECK: No, we were funded by the Ministry of Health and Long-Term Care when it was combined. Now we're funded by the Ministry of Long-Term Care, but we have relationships with both ministries depending on what issues specifically we're specifically working on.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

SAMANTHA PECK: It's mostly with Long-Term Care.

And so we're a staff team of four. There's three of us here today. I'm the executive director, have been since January 1st, so nothing

like being a new ED during a pandemic, but I've actually been with Family Councils of Ontario, formerly Family Councils Program, for 12 years now.

Tiffany is our client services manager, responsible for our conflict resolution as well as equity and inclusion portfolios.

And Cathleen Edwards is our education manager who also has research analysis and development in her portfolio as we go.

And then we have a bilingual outreach manager based in Sudbury for work in Northern Ontario. So that's sort of our scope, quite broadly.

COMMISSIONER FRANK MARROCCO (CHAIR): How does somebody become a member?

SAMANTHA PECK: Ah. So FCO is not a membership organization, but for Family Councils at the long-term care homes, membership is defined in legislation as any family member or person of importance to a resident is entitled to be a member of the Family Council.

Well, "person of importance" has been interpreted to mean, and this is supported by the Ministry of Long-Term Care, is that it's family by choice -- so a friend, substitute decision-maker --

or someone who had a resident in a long-term care home but their resident has since passed away, they may continue to be a member of the Family Council, subject to that provision being in the council's terms of reference, so agreed upon by the group.

Staff are not permitted to be member -- home staff are not permitted to be members of the Family Council, nor are people with a contractual relationship to the Ministry of Long-Term Care if they have responsibility for long-term care homes.

Even if a staff person, let's say at a [indecipherable] home has a loved one living in that home, so they're a family member of a resident, they still cannot be a member of the council because their right to be a member is subject to a list of those who are not permitted to be members. And this is to protect the confidentiality and the autonomy of those Family Councils.

The home licensee, usually delegated to the administrator of the home, has duties to consult with the council, report back or respond to concerns within ten days, and to, where possible and feasible, act upon the concerns and the recommendations of the council.

So in the legislation, there's no direction given to Family Councils as to what they have to do. It's all on the onus of the home to fulfill its duties to work with, respond to, protect from interference, and so on to the Family Council.

In terms of the COVID experience, many of the issues that families are concerned about with COVID pre-date it, but these issues have been exacerbated.

So the big one is staffing. Now, long-term care has a staffing crisis. This isn't news. This has been in discussion for a long time. And what we mean by staffing is not only the number of people in a long-term care home but the types of staff and their skills and competencies.

Mostly when we talk about a staffing crisis, it's a lack of PSWs or personal support workers. Those are the folks who provide the vast majority of the hands-on care to the long-term care residents, bathing, assistance at meal times, and so on.

COMMISSIONER FRANK MARROCCO (CHAIR): We met with the association yesterday, so we still have that, but go ahead.

SAMANTHA PECK: What families are concerned about with the lack of PSWs -- oh, Natacha is coming in now. She's just connecting. She's our bilingual outreach manager from Sudbury.

COMMISSIONER FRANK MARROCCO (CHAIR): Hello, Natacha.

NATACHA DUPUIS: Hi. Sorry I'm late.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. There's three commissioners: Myself, Frank Marrocco, Commissioner Coke, and Commissioner Kitts.

SAMANTHA PECK: We're just talking about the issues that families are all concerned about.

So as outreach manager, Natacha hears also a lot of those concerns and a lot of the heartbreak. I'll let her expound on that in a bit, but I'll just give a high level of the concerns.

So staffing: So families are concerned that without an adequate number of personal support workers that residents will not have the quality of care to which -- the [standard of care] (ph) they should be receiving; so with consequences such as, you know, pressure ulcers from not being turned properly or being left too long in incontinence

briefs because of not being toileted or people not having enough time to eat if there's someone who requires to be fed or to have assistance with eating.

And those things all have real consequences on the quality of life and care a person, who's often quite frail and increasingly lives with dementia, may suffer.

So malnutrition, dehydration, pressure ulcer wounds occurring or increasing. And sometimes it's also about the psychosocial -- or often about the psychosocial well-being. Residents may need encouragement to participate in activities, they may need assistance getting to an activity, things such as that, and then dealing with responsive behaviours from dementia; so wandering, sundowning, all those things that are expressions of unmet need that take time to be supported and to be understood.

And -- yeah?

COMMISSIONER JACK KITTS: Just a quick question about the staffing. So you have to have the right number of people with the right skills and competencies.

SAMANTHA PECK: Yeah.

COMMISSIONER JACK KITTS: Does the acuity of the patients in the home factor into that in terms of the number of people and the skills and competencies, and do you have a way to measure the acuity of one home versus the other or one ward versus the other and staff according to the acuity, or is that not considered?

SAMANTHA PECK: So homes are -- there is an acuity measure called the Case Mix Index, and that most directly affects funding. So that's done at a ministry level.

In Ontario, there are, within the legislation and associated regulations, rules about staffing. What families want is something that is closer to a mandated four hours of care per resident per day. That's not something that's currently done in Ontario.

Now, PSWs have been increasing measures to ensure a higher standard of training for those people for when they enter long-term care. So that's about, you know, the qualifications and competencies.

And then when you look at the needs of residents, those needs have only increased over the past -- even in my time, ten -- say, ten years, the

last decade. People are older, frailer, and sicker, with a higher chance of living with dementia by the time they enter long-term care. In part, that's because people are living longer. Ontarians are living to an older age. It's also in part because of -- and this is, you know, in part a good thing -- an increased attention paid to home and community care.

So people are living in their residences longer. That means, though, by the time they go into long-term care, they have higher needs than they would have ten years ago.

There's a saying: It's something like retirement home folks are the long-term care residents of 10 to 15 years ago. Those who were living in long-term care 10 to 15 years ago would have been more likely in a higher level of acute care. So there are just higher needs, and you have people who may require dialysis, so there's specialized needs there; two-person transfers for bariatric people. So there's a lot that goes along with just PSWs providing care right now.

Also, then, in terms of staffing, it's the nurses. So some rural communities have a really hard time getting registered nurses or

registered practical nurses. It's hard to get geriatricians. Canada as a whole has a lack of geriatricians and physicians who are focused on working with older adults. It's not a sexy career.

So that all, pre-COVID, existed. So issues around attracting and retaining staff -- part of it for PSWs is pay. They do not get paid as much in long-term care as they do compared to hospital.

It's a really hard job. It is, you know, 24 hours a day. You may be working, you know, overnight shifts. It's also that many homes don't offer full-time employment for PSWs. PSWs may not have benefits. So they may be cobbling together a living at multiple sites.

When you look at COVID, then, what we saw at the beginning is there was issues with staff working at multiple sites, so going from home to home. That's an increased infection risk. So that was a big issue. It's since been addressed for the pandemic with the emergency orders from the provincial government limiting the number of sites staff can work at.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you there? I'm trying to

understand that because if I limit the number of people or the number of sites that you can go to...

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I'm solving one problem, which is the transmission of the disease, but doesn't that mean that somebody along the line doesn't have somebody that they need because now the person can't go to the...?

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, okay.

SAMANTHA PECK: So you're solving the problem at that critical juncture, which was -- and so at the beginning of the pandemic, there were three sort of critical issues to address. One was we didn't have enough staff. So then staff were pulled in from school boards, et cetera, so there was a reallocation.

There was also lack of testing available, and staff needed to be tested so often, and that was really difficult, was to get enough tests. That's since been rectified.

And then also at the beginning, one of the critical issues was a lack of understanding of

asymptomatic transmission, plus the presentation of COVID-19 in older adults, which was not the same as with younger folks.

So all of that combined kind of created a perfect storm in long-term care. So we already had a staffing crisis; you layer that all on.

So with the restriction of multiple sites a person could work at, yeah, you did solve part of that problem. You did reduce the risk of transmission from home to home, but then you didn't have, say, enough staff at different sites.

And so homes are bringing in agency staff, which has always happened. Homes have always needed to look to agencies for temporary workers, but those people weren't subject to the same stipulations around multiple sites, so there was still a bit of a loophole there.

But it was because homes can't, in many cases, attract and retain PSWs.

COMMISSIONER FRANK MARROCCO (CHAIR): That's what I was going to ask you. You know, why do people work -- I mean, I can imagine the answer, but that's not good enough.

Why do people work at more than one home? What are their reasons?

SAMANTHA PECK: The reasons being many homes do not offer full-time PSW positions. So you may simply not have enough hours in your week to make a living if you're only working at one home. If one home only offers you 25 hours, I'm just -- and I'm just making up numbers --

COMMISSIONER FRANK MARROCCO (CHAIR): Mm-hm.

SAMANTHA PECK: -- and you need full-time employment, you're going to have to work somewhere else as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Now, do they do that -- from your perspective, do they offer -- let's just take your example, 25 hours. Because that's all they need, or are they offering 25 hours for some other reason?

SAMANTHA PECK: I don't have anything to necessarily back this up concretely. What I've heard anecdotally --

COMMISSIONER FRANK MARROCCO (CHAIR): That is your speculation?

SAMANTHA PECK: This is my speculation --

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

SAMANTHA PECK: -- based on pure anecdote that part of it is to avoid paying benefits because that's a cost to the long-term care home, and that money has to come out of somewhere. And part of it might just be that, you know, homes are going to need some part-time people just to cover some shifts. That's just a reality of having, you know, 24-hour scheduling.

But I think a lot of it is that homes don't necessarily get enough money to pay for all of the PSW hours that they need. So that's a systemic issue. And then some homes will just prefer or for whatever reason try to cut costs by eliminating benefit packages.

COMMISSIONER FRANK MARROCCO (CHAIR): So are the PSWs unionized in these places or not?

SAMANTHA PECK: It depends. It really depends. What --

COMMISSIONER FRANK MARROCCO (CHAIR): But being unionized doesn't -- sorry. But being unionized doesn't stop this practice from happening?

SAMANTHA PECK: To the best of my understanding, it doesn't stop it.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

SAMANTHA PECK: Now, there are also, in terms of PSW pay and benefits, discrepancies between not-for-profit, for-profit, and municipal homes.

So municipalities -- the one I'm most familiar with is the City of Toronto -- because they have increased monies in the budget from the municipality, they pay PSWs more than a for-profit or a small independent home may. So then you have increased tension within the sector, looking at operator type in terms of what the pay and scheduling availability is there. So that may have an impact on the ability of some homes to recruit and retain staff.

PSWs also -- it's not really seen as a great career option. It's, in some cases, literally back-breaking work. It's hard. You don't have the same degree of professionalization. So, you know, PSWs have a lower number of hours they need to complete to be able to work as a PSW. It's not seen with the same status as an RN or an RPN. And I'm not saying they should be the same. I'm just saying that PSWs aren't well-respected within the sector, and part of that comes with, you

know, some lower pay.

There's also the impact, mostly in PSWs, of many of those people are women from racialized communities. And so part of that has to do with newcomer women in Ontario for employment being strongly encouraged to go into PSW work because it's needed and because it's seen as an easy option.

What that creates -- and once again, this is speculation and anecdotal; I don't have firm evidence to back this up, just anecdotes -- is that it creates a culture in long-term care that is exacerbated by the gender and race divide, the racialization divide of staff. And leadership is often -- and I'm going to speak about this quite bluntly -- is older white men. Not that it's a bad thing; it's just the way it is.

COMMISSIONER FRANK MARROCCO (CHAIR): I mean, I hope it's not just automatically. That would be bad for me.

SAMANTHA PECK: No, it's just an observation.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

SAMANTHA PECK: But many PSWs, and

especially PSWs, are racialized women. So there's a power imbalance. You don't see a lot of those people come up through the ranks, in part because there isn't much of a rank to go up through with PSWs, but there's still a gender and race divide and PSWs experiencing racism from their peers and in some cases from families, which also then leads them to leave either that home or the sector as a whole. Because who wants to work somewhere where you're delivering difficult, intimate, hands-on care and facing dehumanization on a regular basis?

So there's a lot at play that is contributing to a poor experience for PSWs, so underpaid, under-appreciated, no career laddering or path, impacts of systemic and institutionalized racism. Caregiving is often women's work, and, you know, there's a historical background as to why that's often devalued. But those are all the things that sort of are creating a perfect storm within long-term care.

And then you layer on top of that a global pandemic and people feeling unsafe to go to work, and that relates to those other two points -- actually, three other points: So lack of testing. So people not knowing if they were symptomatic --

if they were ill or not and not being able to get testing.

Lack of personal protective equipment was a huge challenge at the beginning of the pandemic. Homes did not have enough masks, gloves, and gowns. So they were -- so this is known that there was an increased need to get more PPE into long-term care homes. That's why there were drives; the government was pushing for it.

There's also anecdotes in the media of hoarding of PPE and it not being given to PSWs or having to reuse it when, really, they were the ones who were being most likely to get infected from working with a resident.

And because we didn't have enough information on presentation and symptomology in older adults of COVID, we may have a PSW who's overworked and underpaid, who doesn't have the PPE that they need because it isn't being given to them, doesn't have access to a COVID test, might be working with someone, an older adult who is asymptomatic but infected and they don't know it which creates this incredible culture of fear because who wants to go to work and potentially die.

Plus, you know, the power imbalance that comes with being sort of the lowest on the ladder and the other culture -- you know, I'm saying culture of long-term care, so the entire thing, not just ethnic, racial, gender, and so on that goes with being, you know, a PSW.

So the staffing crisis was really exacerbated by COVID, but it was by no means created by COVID.

There have been studies, commissions, planning tables going back years that have highlighted that long-term care has a staffing crisis. And it's only getting worse.

COMMISSIONER FRANK MARROCCO (CHAIR): Why do you think nobody was able to do anything about it or at least anything significant about it?

SAMANTHA PECK: So I wouldn't say they weren't able. I say it was a choice. So this is a system that people created, so they had a choice about what to do about it. So I think the reason why nothing has been done so far is health, A, is the biggest portfolio in Ontario. There's already a good chunk of change in the provincial coffers. It's only going to increase as the population ages.

We have an aging population. That just

is what it is. So we're going to have more folks who require more care. Long-term care has a long waiting list. It's an expensive problem to fix. So there's that part of it.

But it's also a broader challenge around ageism, so people not wanting to go into caring for older adults. You see that with the number of geriatricians per person in Canada compared to other -- perhaps the Nordic countries. It's a lot lower here.

You know, staff can get paid more in community or hospital, so there's attracting people that could work in long-term care. So part of it, it's expensive to fix; there have been other priorities in the province. You also have this ongoing tension between the province and the feds. Long-term care isn't in the Canada Health Act, so that might be seen as an indicator that it's not as important.

And then, so how do you increase the funds that we need for long-term care to be delivered well?

There's also -- right now, there is ongoing culture change in long-term care, which is a good thing, where we're moving towards

resident-centered, family-centered experience where -- you know, smaller homes and so on, but all of that comes with a price tag, and it's not cheap. So finding that money is difficult.

And also, we don't want to -- most people don't want to think about long-term care. So socially, culturally, it's not something that gets a lot of buzz, unlike the reproductive health right now or caring for children. Both of those things are important, but so is supporting the experience of older adults.

So I think there's a few issues at play both in terms of practical but also as in -- just the impacts of ageism in our society, not wanting to think about long-term care.

So getting voters to, let's say, from a political standpoint, vote for a platform that will radically increase the funds to long-term care could be a hard sell. I know that, you know, if I were running for office, let's say, I could see it as being a hard sell for people because it's not as sexy a sell as let's take care of children or, you know, any other multitude of social issues. It's important, but it's not top of mind for people.

So I think you can't talk about issues

in long-term care without talking about staffing because that's -- you know, what we saw in the Gillese inquiry around serial killings in long-term care that pointed to staffing, and previous inquiries, works, tables talked about staffing.

So during COVID, that was one of the big conversations, but then the others were around things that have been mostly fixed right now: So the availability of PPE, testing -- although testing is still an issue. I was on the phone just this afternoon talking to a family member about the long lineups to get tested for COVID because it's still an -- it's a barrier still within long-term care.

So that's -- any questions about staffing?

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, I do have -- well, does somebody, one of the other commissioners have a question? Commissioner Kitts?

COMMISSIONER JACK KITTS: Yeah, when we speak about staffing, it always goes to personal support workers.

And so my question is, is that the key that needs to be fixed, or is there staffing

shortages and problems across the gamut of nurses, RNs, NPs, RPNs? When you're talking about staffing in the home, is it really about PSWs?

SAMANTHA PECK: I'd say it's mostly about PSWs -- and maybe I'll call on Natacha for this; I'll give you a sec. In Northern Ontario, there are also challenges around attracting other clinical staff that also need to be addressed because it's different.

Natacha, do you have anything that you want to add to that?

NATACHA DUPUIS: Well, PSW in the North is the major challenge in long-term care because they end up going to bigger cities where they can get paid more money. So they're not making much more than minimum wage. So nursing and RPNs -- RNs and RPNs tend to not be so much of an issue up North. It's mostly, I would say, a good 90 percent PSWs, the lack of them.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you think -- it was suggested to us that there are foreign-trained professional people who would be able to contribute, and for one reason or another, are excluded somehow. Did you have a

sense of that?

SAMANTHA PECK: Um --

COMMISSIONER FRANK MARROCCO (CHAIR): Any one of you?

SAMANTHA PECK: Somewhat. That there are folks who come in from other countries who -- as they are pushed into PSW work, but then what I've heard is that -- again, anecdotally, that many of those PSWs actually have been -- I've heard that some have been nurses or physicians in their previous country of residence, but -- and this is sort of a broader issue is around recognition of credentials from outside of Canada.

And so those folks are, you know, directed towards PSW or other work within long-term care. It could be environmental, dietary, and so on but are then put to the bottom of the ladder again, when really, if we had better recognition of foreign credentials, those folks could be playing a role in long-term care more in line with their skill set.

Because there are very capable people who come to Canada and who could have a better role to play in long-term care. Not saying that PSWs aren't very valuable, but if you have someone who,

you know, was a registered dietitian or a registered nurse, I can see that they'd have a better role to play in long-term care.

COMMISSIONER FRANK MARROCCO (CHAIR): But they would play it as a personal support worker or another role?

SAMANTHA PECK: I think they could have another role. If you have a foreign-trained nurse who comes to Canada and we had appropriate on-boarding and recognition of credentials, they could be working as a nurse in long-term care. And that would help with the other aspects of the staffing crisis around nursing, around, perhaps, dietitians, around medical directors in long-term care, which is hard to get -- physicians in long-term care -- as well.

I think, of course, paired with that recognition of foreign credentials and on-boarding to the Canadian Health System is looking at the impacts of racialization on the staff experience.

Tiff, I'm going to call on you for this.

Tiffany is our lead for our diversity equity inclusion work and has been doing a lot of work and exploration around the experiences of

mostly racialized peoples in long-term care. Yeah.

TIFFANY FEARON: Okay. So I'm happy to provide a bit of feedback on that.

I think whether it's an experience of the residents or the families or the staff, sometimes there's a lack of understanding of the diverse experiences that comes with racialized individuals, and I think it's that lack of recognition for their backgrounds, their experiences, the culture aspects, the way that we interpret different things: There's a lot of miscommunication there.

So for the resident experience, we have to think about residents that might not speak English as a first language and how that's going to impact the level of care that they receive as well as how they are going to be treated and understood by the staff that's taking care of them.

And then when we look at the staff experience, as Samantha mentioned, a lot of them are women that come from racialized communities. The majority of them are women from Caribbean or African ethnicities, as well as Asian, South-Asian women, and some of their experiences aren't closely noted.

There's been experiences of racism towards them as they're taking care of residents, whether that be from the residents or their families making the work experience not very tolerable. But for many of them, that's really the only jobs that they can get, and there's hours that they're able to pick up.

Also, as Sam stated earlier, most of them are working various jobs. There is many of them that are agency workers, so they can't depend on full-time work, and I think that presented a really big issue during this pandemic because many of them depended on having two, three, or four jobs at different homes to make ends meet.

And from the family perspective, when it comes to that diversity, they want to ensure that their loved one is receiving the type of care that they would have received if they were at home with their own families. And a lot of the times, they're not able to, say, get cultural celebrations or recognition or cultural foods that would enhance the experience that they would have had if they were living at home.

So I think it's a very intersectional topic where there's a lot of things that we have to

think about from the resident, family, and staff perspective and ensuring that everyone, whether you're working in long-term care or living in a long-term care home, that you can have an experience that's based on equity and equality.

SAMANTHA PECK: Mm-hm. So I have -- yeah, go ahead.

COMMISSIONER JACK KITTS: Yeah, just back to the PSWs and the international graduates from various health positions and Health Force Ontario and all that, do you see anything that's happening now or about to happen that is going to help to relieve this PSW shortage?

SAMANTHA PECK: I'll throw it to Cathleen in a sec, but I think there's a couple things that have been innovative in long-term care.

So in-home training that is paid. So that is mostly for personal support workers so that they can learn and earn money at the same time. And they'd be supervised, of course -- you know, high standards -- but to have living classrooms in which people can learn on the job, it's better for people for whom they can't afford to be unpaid while going through schooling. So I think that's one.

Cathleen, you've got some other examples as well.

CATHLEEN EDWARDS: Yeah, I'll share a really good, strong example. It's called the Green House Project. It's based off of the Eden Alternative out of the United States. It's very popular in the United States. They have a mix of for-profit, non-profit, charitable homes.

And there are statistics. They've actually done research on COVID-19 in Green House homes compared to non-Green House homes in the States, and there's a significantly lower risk of being infected and having an outbreak of COVID-19 in those homes.

But one of the features tied to staffing that's really innovative is that they cross-train staff. So a PSW is not just a PSW. Yes, they do provide that care, but they also provide recreation. They also provide, you know, laundry services. They also provide cooking and meals and dietary support.

So it's a role called a Shahbazim, which is basically they're cross-trained to do every single role because what happens in Green Houses is that each unit is built as its own kind

of neighbourhood. So it would house 10 to 12 individuals who would live there. It has an open-concept kitchen and laundry room and family room. They eat at this big, long communal dining room table that has enough room that staff can also join the residents at meals. Residents can engage in helping to prepare and cook meals. They can support cleaning. They can support laundry.

But when you're thinking about COVID-19 and a lot of the other things that leads to potential cross-contamination and infection protocol, they really have it kind of nipped in the bud because you're not having unnecessary traffic coming through where you live.

So again, just thinking about long-term care homes as the residents' home: When you're at your house, you don't have -- well, right now you might have your family traipsing through because everyone's home, but typically you wouldn't have, like, your neighbour walking through, you know, your kitchen as you're doing something because they need it to get -- it's the shortest way for them to get to the school or the park or whatever.

But in the traditional design for long-term care homes, that's what happens

sometimes. To get to one specific neighbourhood of the home, you actually have to go through another neighbourhood of the home. So that in itself creates, you know, infection control issues because you are getting that cross-contamination of someone going through that space that doesn't need to when they're delivering food to that specific area, when they're delivering laundry to that specific area.

So by cross-training your staff, you're empowering them to basically focus on what the residents need. So if the residents are hungry, you have them help make food, and you make meals when the resident is hungry. You would do laundry because they need laundry done.

And again, because it's all on-unit and onsite, you're minimizing that cross-contamination. So it's very much focused on valuing the -- they call them "elders," but valuing the life and the skills and the history of that older adult, forming that trusting relationship, that knowing relationship. So empowering the staff to understand the residents they're working with, to get to know them and take that extra little bit of time to talk to them because they recognize that they're not quite themselves that day, that they're

having a rough day.

And if you talk to the staff who really do embrace the Green House approach, they're much more satisfied. There's much less turnover because they're empowered. They're recognized as experts. They know the residents because they live with them every day. Because of the design of their job with the flexibility to spend the time with what they recognize is what that resident needs, they aren't worried about, you know, I only have five minutes; how do you nicely say to them, I have to back away because I need to do something else.

Anecdotally, I can say, so I taught in Durham College in the Activation, Coordination and Gerontology Program, which was a post-graduate certificate for people who'd work in recreation. We had a lot of PSWs who would opt to leave their careers to take that specific course, and the reason they said they were doing it, for a few reasons is, one, as they got older, their health was failing.

It's a very labour-intensive job, repetitive strain injuries. It's tough because you're on your feet a lot. If you injure yourself, you don't really have the time to -- you know, to

take it easy because it's a team-based environment. So if you have a restriction, that means someone else has to pick up your load.

And so in the team itself of PSWs, it kind of creates that resentment, oh, they're taking -- you know, even though there's a legitimate reason, it just creates that tension between the teams, and that really takes away from them working efficiently within that specific home and that specific area.

They would also opt to do it just because they felt the guilt of not being able to take the time to dedicate to that person. They wanted to build those relationships, and typically, the PSWs I've met, they do it because they like working with people. They care about people. They're good people, but they're frustrated with the rules and policies of not having the time to show that person they care.

COMMISSIONER JACK KITTS: Okay.

SAMANTHA PECK: Good point.

COMMISSIONER JACK KITTS: Have these programs begun, and what is the forecasted impact on PSWs in the homes and in what time period?

SAMANTHA PECK: So I'm not sure -- I

don't think we have any Ontario-based data around that, but what we have -- what the sort of anticipated outcomes, I think, are is really, as Cathleen has alluded to, is that if you have a -- so you have cross-trained people, meaning that if you have -- you know, your environmental services or your laundry person is unavailable, others can step in to still ensure that there is the proper care being given.

Smaller home neighbourhoods or units that have dedicated staff are already essentially cohorted so that if you have an outbreak of whatever it is -- if it's influenza, it's enteric, it's COVID -- you've got a greater chance of minimizing viral spread because you already limit the number of staff who are in a place.

And looking at, for COVID asymptomatic or the presentation of COVID in older adults, we know if someone presents with more sort of lethargy and other symptoms. If you have staff who really know that resident well, they may be more able to pick up on unusual behaviour in that resident; therefore, being able to see if maybe something's happening.

And, I mean, it could be, you know,

prioritizing getting that resident tested for whatever the illness currently spreading is. So I think it has great potential for infection prevention and control to have standards, meeting high standards of care because you have cross-trained people.

You have resident-centered care, which increases quality of life for residents, meaning specifically, reduction of isolation and boredom. So if someone can actually engage with the activities of their household, they're less likely to be bored or to feel lonely, I mean, because it's also more normal. In a household, you often contribute to the running of that little community, so it's got better resident outcomes.

And the conditions of work are the conditions of care. Dr. Pat Armstrong from York University says that regularly when she's speaking mostly about experiences of PSWs and other frontline workers, that if they are satisfied with the conditions of their work -- so they have cross-training opportunities, they are paid well, they have good scheduling, they can make a connection with the resident -- that has positive care outcomes.

So models of care like Green House, Eden, what was called Butterfly, which is now Meaningful-something out of the U.K., there is some evidence to some of them, but they haven't been rigorously tested in Ontario or, as far as I'm aware, other Canadian jurisdictions. So it's very much an emerging area of implementation and research.

CATHLEEN EDWARDS: I can speak to the Green House, a little bit about why in Canada and especially in Ontario it is such a struggle to implement. It's because of how we fund building.

Because there's a specific number of rooms, every room -- the other thing about Green House is every single room is private and has their private bathroom. So that's another aspect. You're just, you know, minimizing that cross-contamination.

But I was on a Green House-led webinar with architects, and they spoke about just the design requirements in Ontario. And typically, they find 15 -- 15 beds, 16 beds, so two units of 16 built together stacked tends to be the one that financially makes the most money and is actually something that can be feasibly funded.

If we went to the actual Green House approach and looked at the design requirements they have, the funding structure within Ontario would need to be significantly changed. But again, a lot of the practices that it does -- I think cross-training specifically and empowering your frontline staff who really are, like, you know, the workhorse of your organization, those are things that you just -- you think about how could we adapt that, then, and the cross-training of -- so you can't give full-time hours as a PSW. Could you split it between PSW and kitchen staff, right? When are your peak times? And then making a full-time role, but it's split between both.

But I will say the Green House approach, they did say that there was a home that they are building and designing in Newfoundland. So it does work in a smaller community for a smaller home or for a home that has the flexibility to fund it to be built in a proper architectural design because there are specific requirements within Green House Project.

But it definitely does -- they are doing research in the States. They have done some studies based off of COVID on how their homes are

faring, and just off the basic data, looking at cases and comparing deaths and outbreaks compared to the standard design for homes. They've done significantly better.

SAMANTHA PECK: Mm-hm. Part of it is the separate washrooms as well. I believe for infection prevention and control because then you -- it's just more contained.

So if you have a person within this, say, eight-person unit who's ill, it's a lot easier to provide -- and that it's identified quickly to manage that spread. They can stay in their room. You can have the infection prevention measures at the door. They're not sharing a bathroom.

So those are things where -- but as Cathleen pointed out, the Ontario design standards and funding don't support that. We're still in the phase of redeveloping old four-bed wards.

And some of the early data coming out of the Ontario experience for COVID is that the homes that had higher infection and death rates, it's not so much about the for-profit, not-for-profit, municipal licensee or licence. It's about the age of the home, so that homes that had four-bed wards fared worse because you couldn't

limit infection spread. In some cases, it was just people were -- their beds were separated by a curtain, which doesn't contribute to very good infection prevention.

So there's, you know, the issues around staffing and the funding to go with that is part of it. How we use the people that are in homes is another part, so -- and their work experience.

And then it's also about physical design of homes. And those things all together have a big impact on the resident and staff experience and also around infection prevention and control.

COMMISSIONER JACK KITTS: Are you saying, really, that unless we change the environment and the respect and the whole culture towards PSWs, you're not hopeful that we're going to be able to recruit, and if we do recruit, we won't be able to retain them? Is that basically --

SAMANTHA PECK: Yeah.

CATHLEEN EDWARDS: Absolutely.

SAMANTHA PECK: That's a good way to put it. So, I mean, if it were me and I were looking for a job, I'd work at McDonald's sooner than I'd work as a PSW. At least --

COMMISSIONER JACK KITTS: Okay. Thank you.

SAMANTHA PECK: Yeah, because we need to pay them more. We need to make long-term comparable to other healthcare sectors, but we also need to make the experience better so people stay.

People don't just stay in a job for money. Most people don't. But you also have PSWs and nurses and others who are trying to raise a family or who they, themselves, are taking care of and providing care to someone at home.

So if we want people to stay in a tough job, we need to pay them well and make it so they want to come to work.

COMMISSIONER ANGELA COKE: So you've given us a very clear picture of what is happening in terms of the PSWs, and obviously the numbers and the environment and everything else is a big issue.

I'm just interested in your thoughts on two things: Do we have the right mix of staff? Not just the PSWs. We're talking about people having a lot more clinical issues, a lot more acute issues. Do we have enough of the right mix of people in those homes?

And I'm also interested in your

thoughts about minimum standards of care and what you think should be that minimum standard.

SAMANTHA PECK: So I think in terms of the staff complement, we've done some research on the experiences at homes and families that have access to social workers or social service workers in long-term care.

And in homes, what we found where families did have that and residents had that, they had a better emotional experience. There was less conflict between families, residents, and staff because the social workers were the ones who were equipped to do sort of that conflict resolution and management work and could help families and residents who were struggling, helping them access to outside services, so counselling or just different mental health resources.

Not all homes have a social worker because it's not required under legislation. So I think that's one area where that would help the experience, and I'm thinking of examples such as where a home staff and a family member disagree on something that has to do with clinical care, and for whatever reason, they can't come to a resolution themselves. So they'd be able to bring

in the social worker, who may not have the medical experience but can help facilitate a resolution wherein the staff feel heard and respected, so do the families, and the outcome to residents are, to them, getting the best care because sometimes staff and families may disagree.

So right now, we're hearing a lot about de-prescribing medication or appropriate prescribing for things around antipsychotics and other medications, and sometimes that's a tough sell for families. It might be the right clinical decision; for example, sleeping pills overnight wherein someone in the morning is quite groggy, could increase their chances of fall, they may be eating less because they're so tired in the morning.

So those are things where if we taper someone off a sleeping pill, they may be more awake, more alert, more ready to engage in activities and to eat more in the morning, but a family may be like, oh, I'm worried that Mom's not going to get enough sleep, so let's not do that.

Bringing in someone to facilitate a conversation wherein each side has an opportunity to share their clinical expertise as a staff, but

their expertise as a family member -- you know, as the family member, and they come to a better resolution with better care outcomes. So that's one thing. And also, those people are generally the people with the real conflict and facilitation skills in the home. Administrators and directors of care may not have that expertise. So that's one thing.

Homes that have registered or that have -- so there's RNs, there's RPNs, and then nurse practitioners. There have been efforts to improve the availability of nurse practitioners in long-term care, which the Ministry probably has more data on this, but we've heard that it's quite positively received in long-term care homes.

And when you have some of those nurse practitioners, it can better support people with very specific and high-clinical needs around dialysis. So people don't need to leave their home to go to hospital for dialysis. So it could be specialized units within long-term care, and it's a push towards that for taking dialysis.

People who are -- larger people who are bariatric which require more support for management of pressure ulcers and other poor health outcomes,

with nurse practitioners, that can help greatly as well because they'd be in the home. The physicians aren't in the home every day. So they'd often be, you know, managing multiple homes, depending on the size, the number of beds in a home.

So I'd say two other areas that really improve outcomes for residents and families would be social work and nurse practitioners.

COMMISSIONER ANGELA COKE: And the standards of care?

SAMANTHA PECK: So standards of care: This is something that we've actually gone back and forth on over time.

We know there have been different bills and different pushes to have a minimum for four hours per resident per day. And so while we think that increasing the number of hours that residents receive of hands-on care every day, assigning a specific number to it may cause homes to see that as a minimum.

So there are going to be residents who require less care; same thing, in part -- I'm making up numbers -- three hours versus four. Then there are residents, really, who require five hours versus four.

So while a standard's good, we need to make it so that we're not aiming for the minimum and that the number of hours of care are looked at appropriately so it's, what does that resident actually need? So having those care needs clearly identified. Who is best able to meet them? So not putting all of the work on PSWs, but do they need -- are we including occupational therapy and things like that in that number? How do we monitor that? How are we tracking that in a way that isn't adding to the paperwork burden of frontline staff? So how do we track, and how are we tracking outcomes?

So I think the simple answer is, yes, a higher standard -- or a standard of hours of care is a good thing. We'd like to see standardization, but I don't want it to be for the sake of it because it needs to have meaningful outcomes to residents that improve their quality of life that isn't just adding more paperwork to frontline staff.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I don't know if there's any further questions.

SAMANTHA PECK: So there's one other topic I would like to touch on --

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

SAMANTHA PECK: -- that's been of real concern to families during the pandemic, and that's been the visitor restrictions.

Now, that was put into place in mid-March wherein, pretty much overnight, homes were closed to families and caregivers. At that time, that was the right decision. I stand by it because -- for the aforementioned perfect storm of COVID; so PPE, testing, presentation, staffing, and so on.

And families at the time did understand the reason, even though they were heartbroken. The day before I did get the heads-up that it was going to happen because of our relationship with the Ministry. So right decision at the time.

The fact that it's taken us -- and I'm saying "us," you know, as a whole in the long-term care sector -- so April, May, June, about six months to have families safely coming back into the long-term care home is way too long.

And so families, by about the two-month

mark, were starting to get really, really upset for a few reasons. One is just, they've been caregivers to their person pre-dating when they moved into long-term care, and when someone moves into long-term care, their relationship with who their primary caregiver was or their family changes, but it doesn't stop. But it does change. So that person, that family member may not be giving as much hands-on care.

But because of the aforementioned staffing issues, families of long-term care residents, many were still going into the home for hours a day to provide care. So that would be assistance at mealtimes, making sure that, you know, Tiffany's mom ate enough at lunch. Or it could be a resident with responsive behaviours would only eat if assisted by a family member. Could also have been assistance with toileting or engagement in activities.

So these family members who were providing care were shut out. So that meant not only was the care needs of residents were affected because you also had staff getting sick. You had issues having enough staff, and now they've lost their family. So it's the care outcomes there.

And then the psychosocial well-being of residents really did suffer. So, you know, we had be hearing, you know, if COVID doesn't kill them, the boredom and the isolation will. They were --

COMMISSIONER FRANK MARROCCO (CHAIR): How long do you think it should have taken to deal with the problem?

SAMANTHA PECK: I think, in hindsight -- of course, that's always, you know, we're blessed with 20/20 -- in hindsight -- and we started pushing for a plan. It didn't even need to be let's open homes tomorrow, but we needed a plan probably about the two-month mark because residents were suffering, so their care needs and their emotional well-being.

We were hearing families who were doing window visits saying, my mom doesn't recognize me anymore. She can't hold up the phone anymore. So those were real indicators of decline.

And then there was also the breaking of public trust in the long-term care system because there was no plan about how to safely reintegrate and reopen those doors. If there had been a plan -- and what they were pushing for was just develop a plan. It doesn't need to be that we

implement it tomorrow or next week, but families need to know you're working on it. And this is to the government: Families needed to know that the province was working on it.

And in a way, that recognized the value of family engagement in long-term care, so as care partners who delivered care to residents, but also as Ontarians who have an interest, you know, a vested interest in long-term care, and for families, they often fulfilled, you know, their democratic engagement in the healthcare sector by being the eyes and ears of the public in long-term care.

And so with Family Councils, it was through their engagement and the execution of their powers to advise licensees of concerns or recommendations. They can't do that without being in the long-term care home and with having very limited communication with the home leadership.

So families felt ignored, isolated. They felt that they weren't valued. And after all of this work being done in the Ontario healthcare system around patient-resident-family engagement, this was a huge step back. So families just felt that they weren't important anymore.

COMMISSIONER FRANK MARROCCO (CHAIR): The danger that resulted in the restrictions on visiting --

SAMANTHA PECK: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- do you have a sense of when that -- was that ever brought under control? I mean, because, you know, we were talking about two months, and I guess what I was trying to figure out is, well, if the risk is the same, then the outcome would presumably be the same.

And so I'm trying to figure out whether it's planning, just the failure to have a plan in place that people could hang on to while they were going through this, or whether, from your perspective, it got less dangerous after a couple of months.

SAMANTHA PECK: So I think the lack of a plan was wrong, but also, it did get less dangerous.

So going back to the main issues at the beginning of the pandemic, so presentation in older adults, PPE, staffing, and testing, those were solved by about the summer. And then as we saw the decrease in positive tests with the increase of

testing and then homes had access to PPE, we knew much better how COVID presented in older adults, those issues were solved to the best possible -- so it wasn't perfect. There was still risk, but families really felt -- and we had been hearing this from our sector partners, some of our sector partners as well -- at that point, we could balance risk and access. Going one way or the other doesn't positively impact the resident experience.

So when we had those things sort of under control, and that would have been, you know, in the summer, it was time to reopen homes to families. And it came in stages with a few false starts, but where we are now, wherein each resident or their substitute decision-maker if the resident is incapable names two essential caregivers, those people have open access to the home.

The home has to train them on use of personal protective equipment and IPAC, infection prevention and control, and to provide masks to those families and then to have screening and all of that to make it safe. That's a very reasonable plan, and that's what families had been telling us they wanted. They wanted access, but they wanted to do it safely because they didn't want to put

anyone at risk, not themselves. Many caregivers themselves are older adults with some underlying health conditions.

They didn't want to put the other residents in the home at risk, nor their communities or their families at home. Families wanted to be trusted to do the right thing and for the system to enable them to do so.

We're still figuring out as a sector some of the hiccups with that in order how to appropriately train families on using personal protective equipment and so on to ensure that all have the same sort of standard of education and support. So it is about the government not having a plan. But then [indecipherable] that plan.

COMMISSIONER FRANK MARROCCO (CHAIR): And I don't want to monopolize the questioning, so please -- but when you were trying to advocate for this, where did you think you had to go to get somebody to do this?

SAMANTHA PECK: So --

COMMISSIONER FRANK MARROCCO (CHAIR): Or was there a problem with that?

SAMANTHA PECK: There wasn't a problem with it at the bureaucrat level, so the staff and

the Ministry. Brian Pollard, who is now in a different area of the Ministry, I have a great relationship with. He was very receptive and understanding of the family concerns, but his hands were tied because of getting information from the Chief Medical Officer and what the Premier wanted to do and so on.

So we had a very open door to the Ministry staff, and we've developed better relationships -- actually, now a very good relationship with Minister Fullerton's staff.

But it was still -- I think the bureaucrats, and I'm once again just saying, they probably felt that their hands were tied too because they didn't want any more people to die, and there was horrible media coverage of the deaths in long-term care. And I'm not saying that it wasn't horrible. People died. People died. Staff died. Mostly residents. And no one wanted that to happen.

But also no one wants people to die of decline from not being able to see their family or to die alone.

Can you imagine being married to someone for 40 years or having this be your parent,

and you're with them, you know, 30 hours a week, because you're caring for them because you love them, and at the end, they die alone because you weren't allowed in?

Because while you were supposed to be -- because even previous to this version of the visiting policy, there was an exemption for visits to people who were palliative and end of life. Homes fought that, we heard. People died alone with -- and, you know, with perhaps a personal support worker or a nurse or someone dietary by their side, but it wasn't their family.

COMMISSIONER FRANK MARROCCO (CHAIR): And, of course, if you're the personal support worker, you're going to need some help with that because --

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- that's going to leave a mark.

SAMANTHA PECK: And it does. And, I mean, long-term care staff, they develop strong and deep relationships with the people that they're caring for. So they go through a loss, and that's a whole other issue that is increasing in attention within long-term care.

But during COVID, I don't really know how much support staff were given when someone they cared for died, and especially with homes that faced tens of deaths, you know, many, many, many deaths. Like, that's got to be -- that's got to be devastating because -- and I don't think there's any malice on the part of frontline staff. I think they were all doing their best.

But that might feel worse to do everything you can in your clinical ability and still lose half of your home population and for -- and not being able to have those families come in and try to help or try to at least be there with residents and families.

So I think -- I think -- so basically, the visiting policy we have in place now is good on paper. The implementation is still lagging across the province with some homes being more strict in terms of their processes and what's in the guideline, which is a problem.

I think -- you know, I think the government eventually got it right. I really do.

COMMISSIONER FRANK MARROCCO (CHAIR): So it's a guideline. So then individual homes can treat it as a guideline and --

SAMANTHA PECK: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- do what they think they need to do, but they're not bound by it. So you can agree with the guideline but not agree with what the reality is.

SAMANTHA PECK: Yeah, and so some homes kind of play around the margins where they'll do some -- like, limit how family -- how much time families have or things like that.

That is being addressed with the government, and we are in regular conversation with them to say, this is what's happening at these sites so they can deal with it. So that is important. They are taking it seriously.

There have been some instances of conflict between a directive and the policy that goes with it where they don't always agree or public health advice and what the Ministry is saying. So there's a bit of tension sometimes there with whether it's the Chief Public Health Officer or local public health units giving conflicting advice versus the Ministry.

But I think we are making progress. We're trying to restore -- the sector's trying to restore trust with the families and invite them

back in, and I think the policy and the guideline that's out now is good, and it does have most of what we asked for on behalf of families. So the government did listen.

I'm just sad it took so long. I'm sad that in, you know, June, we didn't have more talking about how, you know, the government's working on it. I think that really -- people were frustrated and angry that there wasn't at least something coming that they could hold on to.

COMMISSIONER FRANK MARROCCO (CHAIR): What did you understand the process to be to get a change? So two months go by, and you start to feel that the restrictions on visiting should be changed. So you speak to whoever that person was that you said --

SAMANTHA PECK: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- was your contact, but that person can't make the decision. They've got to go somewhere else. Did you ever -- I mean, how did that work itself -- what were you getting back, then, as this was...?

SAMANTHA PECK: So we would go to whoever the Assistant Deputy Minister is who was responsible for that. At the time, it was

Brian Pollard we had the most connection with.

FCO's in a bit of weird position with funding. We're a provincial organization. We haven't been downloaded to the LHINs. So we're still housed and directly funded by the Ministry as one of their -- under their Programs Branch, so we still have a strong connection with them. So I would go to Brian and say, here are the concerns. Like, I was pretty much weekly talking about, really, visiting.

But he would have to go to the Minister, Minister's staff, talk to Public Health. So there was a lot of different moving pieces, talk to the sector because even now, I feel like, and what I've been hearing anecdotally is that home operators are still quite afraid of the risk of COVID. So we're in a second wave. Whether it's been publicly announced or not, we are.

And I've heard administrators say, you know, we're going to be more strict than what's in the guidelines because who do I want to get sued by? Do I want to get sued by a family who can't get in or sued by a family of someone who dies? So it's fear because they -- they want to eliminate the risk, but we can't.

We can only mitigate the risk because otherwise we're basically incarcerating people who have, you know, lived their lives contributing meaningfully to society, you know, helping to make Ontario what it is, and then when they're in their later years and really need our help and our care and our love, we're incarcerating them.

COMMISSIONER FRANK MARROCCO (CHAIR): There have been outbreaks in jails.

SAMANTHA PECK: Yeah, there have. Yeah, and that's --

COMMISSIONER FRANK MARROCCO (CHAIR): I don't know how much incarcerating them really helps.

SAMANTHA PECK: No, but people feel trapped that -- cognitively capable residents weren't even allowed to, like, go out to buy, you know, a pack of gum because they felt -- and that was part of the not being able to leave the home property, which is another issue, which you may hear from Ontario Association of Residents' Councils about that, and part of that is just congregate living. There are challenges around any setting of congregate living that have to do with staffing, that have to do with balancing rights and

risk management.

But families felt shut out, and they felt that that balance wasn't being struck. So the process, going back to the process, Brian Pollard, the other Ministry staff, sort of like the Assistant Deputy Ministers and so on, they heard and they understood, but they had to go through all the channels and work with Public Health and so on and managing risk and what people thought would keep residents safest, which wasn't always what was going to contribute best to their quality of life.

COMMISSIONER FRANK MARROCCO (CHAIR): And how would you hear about -- like, what was -- when things are changing or you think things have -- what's the source of your information about that? How would that happen?

SAMANTHA PECK: Most cases, I was getting a heads-up from the Ministry, from either ADM Brian Pollard or Mason Saunders at Minister Fullerton's office. So I would get a heads-up about something that was happening most of the time.

Sometimes I heard about it like everyone else did, but the government was -- the bureaucrats, so the staff were pretty good, to be

fair, to give them a lot of credit, at giving us a heads-up so that we could have advance viewing of what the policy or the decision was, because they rely on us to help families navigate and understand it and to help translate policy and decision-making for our constituents.

COMMISSIONER FRANK MARROCCO (CHAIR): On the other side of it, were the families providing you with information?

SAMANTHA PECK: Yes. Lots. Families will not hesitate to tell you what they think. So my entire team, we were on the phone and e-mail a lot, a really -- especially March, April, May, those early months.

Families would tell us what they thought should be different, what they were afraid of. Sometimes they just needed to talk. We'd all have calls with families where we'd say over the course of half an hour maybe five or six sentences because people just needed to be heard and to talk at us.

COMMISSIONER FRANK MARROCCO (CHAIR): Well --

SAMANTHA PECK: They would say -- just one comment I got a lot was, you're the only one

who's picking up your phone. I can't get ahold of my loved one's long-term care home. I can't get ahold of the LHIN. I can't get ahold of the Ministry. You're the only one who's answering the phone.

So we acted as a conduit for information to flow from grassroots level up to the Ministry because we were able to take all of the hundreds of calls we were getting, analyze, pull out key themes and recommendations, and flow that to government.

And then government could either bounce things off of us, say, this is what we're thinking. And we'd say, "yes," "no," "maybe," and then take those policies when finalized and disseminate them and then repeat the policy process.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. All right. Anything further?

SAMANTHA PECK: I think those are the main --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

SAMANTHA PECK: -- the main things. I'd say however you proceed with engaging families most directly affected by the pandemic, you're

going to hear a lot of heartbreak. You're going to hear a lot of anger. You're going to hear a lot of frustration that this is one more commission, one more inquiry, and we haven't even implemented everything from the previous ones, and we can't wait to make things better.

There have to be small things that we can do now to improve the quality of the experience for residents, families, and staff because we can't wait.

COMMISSIONER FRANK MARROCCO (CHAIR): Can we ask this before -- we can end the session around now, I guess, but if there's a way that occurs to you that we might get input directly from the -- obviously, we can't meet with every single family that has experienced this.

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): If you could think about a way in which we could either meet with a representative group or they could give a statement of some kind or something could be drawn up so that we would be able to get that kind of feedback and communicate that to Ms. Drummond, our executive director, that would be a help to us, actually, because we're struggling a

bit with how do we access all of the families who give people a voice --

SAMANTHA PECK: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- but at the same time, we recognize we can't meet with everybody. So that would be a help to us.

SAMANTHA PECK: Yeah, and also recognizing that you have a very short turnaround time to deliver your report and complete your mandate.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, we recognize that too.

SAMANTHA PECK: Yes, I'm sure you're very aware of the pressures. I mean, there's a few ways to do it.

If you wanted to go for breadth, written submissions are an option, and that would mean anyone who's affected, who's been affected may be invited to do a written submission. So there's that option.

What you could also look at is if you want depth, so doing focus groups of, you know, selected -- of families from homes, from specific homes. So you could do a few of those. For that channel, you likely want to go through the

administrator or someone else at the home, but we could also echo that message, that if you've been affected, here's how to go through it.

But I think it depends on what types of information you want, if you're going for breadth or depth or a combination of both.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we're trying to get a -- see if we can -- apart from what we -- information we received from you, we're trying to get a sense of if we can get something back from the people who were affected.

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): We might pick up something that we didn't get.

SAMANTHA PECK: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): And at the same time, the people know that we're interested in what they have to say --

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- as opposed to you telling them you went and spoke to us. So we're trying to figure out some form of engagement, and if you could give some thought to that.

We certainly have no problem receiving written statements, but if you wanted to talk to Ms. Drummond about that, see if you could come up -- we would be relying more on you than us trying to impose a system on you as to how we would get that feedback, because we're not familiar with your clients, I guess, or your -- the people you represent, really, the interest you represent.

SAMANTHA PECK: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): If you could think about that, that would be a help to us.

SAMANTHA PECK: Yeah, absolutely. I mean, my first response is focus groups that are well-facilitated and run, because then you get a lot of information in a smaller time frame.

But my team and I will definitely put our heads together. We've got some very skilled and capable people to give it a think.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Any -- well, I want to thank you. Sam, it looks like you had the burden of being the spokesperson for the most part, and I want to thank you very much for a very thorough presentation and thoughtful, and it gives us something to think

about.

SAMANTHA PECK: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): And Cathleen and Tiffany, thank you both for coming, and you may hear from us again.

SAMANTHA PECK: Well, my virtual door is open for how I can help. I want to make long-term care better. I think it can be. I don't think it's an unsolvable problem or a broken system. I just think that it needs attention, it needs time, it needs money. But it's doable because --

COMMISSIONER FRANK MARROCCO (CHAIR): We're in a position where we can't -- normally, in a commission, you do an investigation, you have public hearings --

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- write a report, and so on. The only problem is, you could tell from perhaps the Wettlaufer Inquiry, that takes a long, long time.

SAMANTHA PECK: It does.

COMMISSIONER FRANK MARROCCO (CHAIR): And from our perspective, we're in the middle of it.

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): It's not over and we're looking back. We're living through it. Kind of turns our procedure upside-down and makes us think that maybe we should try to get some interim recommendations to the government first and then see later on whether we need to go further and actually have public hearings or not.

It's hard to anticipate the end of the process if you haven't gone through it yet.

SAMANTHA PECK: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Anyway, that's kind of what -- that's what we're thinking about.

SAMANTHA PECK: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): And once again, thank you. Thank you very much.

SAMANTHA PECK: You are very welcome. It's been a pleasure. I could talk for hours about long-term care, but I hope what I've said so far is helpful.

COMMISSIONER FRANK MARROCCO (CHAIR): It was, indeed. Thank you.

COMMISSIONER JACK KITTS: Thank you.

SAMANTHA PECK: All right. Thank you, everyone. Take care. Best of luck with your work.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you. Thank you.

-- Adjourned at 2:58 p.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, Chartered Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination 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 22nd day of September, 2020.

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