



# Final Submissions for Ontario's Long-Term Care COVID-19 Commission

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If we do not learn from SARS and we do not make the government fix the problems that remain, we will pay a terrible price in the next pandemic.<sup>1</sup>

### Justice Campbell, The SARS Commission Report

- 1. The COVID-19 pandemic battered Ontario Long-Term Care Homes, killing thousands of residents and at least 11 workers, including one ONA member, Brian Beattie. As horrific as these numbers are, the true extent of the damage wrought by the pandemic on long-term care residents, their families and staff may never be known, and cannot be measured solely by lives lost. The real tragedy is that it did not have to be this way Registered Nurses ("RNs") and their union, the Ontario Nurses' Association (ONA), know that the carnage in long-term care could have been prevented.
- 2. The province's pandemic response has been defined by a series of systemic failures: a health system in transition, led by hospital leaders with little, if any, experience in long-term care, a public health system in disarray, uncoordinated and reactive inspection regimes and an obsolete and unprepared emergency response system. Long-Term Care Homes were starved of funds after decades of neglect and were utterly unprepared to face the storm barreling towards it.
- Critical lessons from the past were not learned. The humanitarian crisis that unfolded in long-term care could have been avoided had recommendations from the SARS Commission, the Gillese Inquiry and a host of other independent expert reports been implemented.
- 4. For over 20 years, staff, stakeholders, and a series of independent experts warned that the long-term care system was gravely underfunded and understaffed even as acuity amongst residents steadily rose and complex care patients were funneled out of hospitals and into Long-Term Care Homes.<sup>2</sup> Despite the rising complexity and acuity of residents, RN staffing remained minimal.
- 5. Many of these warnings occurred after other tragedies in which long-term care residents died. Reports and inquiries investigating deadly outbreaks, resident-on-resident murders, and the crimes committed by Elizabeth Wettlaufer warned of the need to make changes to the system in order to prevent such deaths in the future.<sup>3</sup>

<sup>&</sup>lt;sup>1</sup> Ontario. & Campbell, A.G. (2006). *Spring of Fear: The SARS Commission Final report.* Vol. 1. p.16. [SARS Report]

<sup>&</sup>lt;sup>2</sup> See, for example: Price Waterhouse Cooper: Report of a Study to Review Levels of Service and Responses to Need in a sample of Ontario Long-Term Care Facilities, 2001; Monique Smith: Commitment to Care: A Plan for Long-Term Care in Ontario, 2004; Shirlee Sharkey: People Caring for People: Impacting the Quality of Life and Care of Residents of LTC Homes, 2008; Gail Donner: An Action Plan to Address Abuse and Neglect in Long-Term Care Homes, 2012.

<sup>&</sup>lt;sup>3</sup> See, for example: Verdict of Coroner's Jury Regarding Influenza Deaths at Central Park Lodge, 1999; Report on the inquest into the deaths of Ezzeldine El Roubi and Pedro Lopez, 2005; Ministry of Health and Long-Term Care, *Report of the Expert Panel on the Legionnaire's Disease Outbreak in the City of Toronto September/October 2005*, December 2005; Geriatric and Long-Term Care Review Committee Recommendations, Report 2016-01; Ontario. & Gillese, E.E. (2019). *Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System.* 

- 6. Yet while politicians vowed "never again" after each tragedy, key recommendations that could have made long-term care safer for residents and staff lay dormant. Every few years, like clockwork, a new report was released, echoing the recommendations of the past. Each report was ignored. Like canaries in a coal mine, these previous tragedies were harbingers of what was to come.
- 7. Those familiar with the system, however, including RNs working in long-term care, and ONA, were acutely aware that conditions in Long-Term Care Homes meant that Ontario's residents were at risk.
- 8. It is a testament to the dedication of RNs and health care workers in Long-Term Care Homes that, despite all the cracks in the system, more lives were not lost. They did what they could with what they were given, sacrificing their health and in some cases their lives for their residents. It did not have to be this way.
- 9. In the months preceding the first outbreaks in long-term care, RNs, relying on their expertise and clinical experience, sounded the alarm, desperately concerned for the safety of their residents and for themselves. Many brought their concerns to Joint Health and Safety Committees ("JHSC"), asking about their Home's preparedness and supply of personal protective equipment ("PPE"). They made suggestions to management within the Home, and later, pled to implement basic infection protection and control ("IPAC") measures. Desperate for action, some RNs wrote to the owners of their Home. Calls to the Ministry of Long-Term Care ("MLTC") and the Ministry of Labour Training Skills and Development ("MOLSTD") were not fruitful. ONA members contacted politicians, including their MPPs, MPs, Premier Doug Ford and even Prime Minister Justin Trudeau. Some contacted the media, providing photos of staff wearing garbage bags in place of gowns.
- 10. RNs knew that not enough was being done to protect them and their residents, and did everything they could to bring attention to their plight to no avail. RNs looked to ONA to advocate for better protections in the long-term care sector.
- 11. ONA also sounded the alarm, in meetings with the Ministry of Health ("MOH") and the MLTC in January and February, demanding that the precautionary principle be applied. On February 14, 2020, ONA wrote to the MOLSTD, MOH and MLTC, alerting them to the large number of health care workers ill with COVID-19 in China, asking the MOLSTD to do proactive inspections, and for the application of the precautionary principle. ONA provided specific examples of issues with access to PPE. The government did not listen to ONA and in a decision that has reverberated ever since, downgraded their guidance from airborne to droplet protections in mid-March.
- 12. In the face of all these failures, RNs did what they always do: they provided skilled care for residents, working in conditions described as apocalyptic, catastrophic, and like a war-zone. Thousands became sick. And all the while they wondered: what will it take for change to come?
- 13. That time for change is now. In these submissions, ONA reviews some of the key evidence to support recommendations for change. In Part One, we provide an overview of the critical

role of RNs in long-term care, and review the staffing and funding problems permeating the sector. In Parts Two to Five, we examine the following issues that contributed to the crisis:

- i) Ontario's public health and emergency management system were not prepared for a pandemic;
- ii) An overview of the pandemic in Ontario demonstrating missed opportunities to contain the spread of the virus in the long-term care sector.
- iii) The dual failures by Long-Term Care Homes and government to implement comprehensive IPAC and occupational health and safety measures;
- iv) ONA's struggle to achieve timely enforcement of directives, legislative and collective agreement obligations.
- 14. In order to inform these submissions and ONA's recommendations, which are attached as Appendix A, ONA has collected evidence from its members who have a lived experience on the front lines of the pandemic. ONA also relies on its knowledge and expertise gained from being key participants in both the SARS Commission and long-term care reviews and inquiries of the past.
- 15. We conclude by exploring the impact that this pandemic has had on our members, who are grieving and traumatized by what they, their colleagues and their residents have endured. ONA's recommendations offer a path forward and are provided to assist the Commission in fulfilling its mandate.

## <u>PART ONE: TOO MANY REPORTS, TOO LITTLE ACTION — THE CRITICAL ROLE OF RNS IN LONG-TERM CARE AND THE WORSENING STAFFING AND FUNDING CRISIS</u>

Long-term care cannot become a better place to work, nor a better place to live, without increases to staffing levels.<sup>4</sup>

## **Staffing Advisory Group July 2020**

- 16. The staffing and funding crisis in long-term care is not news to the provincial government or to anyone familiar with the long-term care sector. Since 2001, the provincial government has been provided with multiple expert reports, inquests, and other reviews in long-term care that provide clear, strongly worded recommendations regarding an urgent need to increase staffing and funding in long-term care. These documents expressly reference the relationship between staffing and quality resident care. These recommendations had not been implemented prior to the start of the pandemic. We will never know how many lives may have been saved if the sector had been properly staffed to weather the coming storm.
- 17. While the pandemic did not cause the staffing crisis, it did shine a light on it by showing exactly how inadequate staffing levels were and the need to have the right number and skill mix of staff in the Home. Resident outcomes are directly tied to staffing levels and skill mix.
- 18. Dr. Sweetman, who sat on Staffing Advisory Group in 2020, identified to the Commission that the number and quality of nursing staff was an important factor in how Long-Term Care

<sup>&</sup>lt;sup>4</sup> Ministry of Long-Term Care, Long-Term Care Staffing Study, July 30 2020 p.28. [Staffing Study]

Homes performed during the pandemic.<sup>5</sup> He emphasized the importance of having experienced staff, including experienced RNs running the clinical side of the facility.<sup>6</sup>

## Important Role of RNs in Long-Term Care

- 19. As the Commission is aware, there are three categories of nurses in Ontario: RNs, RPNs and Nurse Practitioners ("NPs".) RNs and RPNs have different knowledge and skill sets largely arising from their differing educational preparation. RNs graduate with a baccalaureate degree (BScN or BN) which is eight semesters in length. They possess broad knowledge regarding clinical practice, nursing standards, critical thinking, resource management and leadership and are expected to incorporate critical inquiry, advocacy, evidence-based practices, research utilization and leadership into their practice in a manner beyond that expected of an RPN.<sup>7</sup>
- 20. In contrast, RPNs graduate from a two-year (four semester) diploma program. RPNs possess a more limited knowledge regarding clinical practice, nursing standards, critical thinking, resource management and leadership.
- 21. NPs are RNs who have additional education (masters degree) and clinical experience and an expanded scope of practice which provides them with the authority to diagnose, prescribe medication, perform procedures and order and interpret diagnostic tests.
- 22. There is a role for all three categories of nurses in long-term care. ONA recommends a staffing model that provides 20% RN care, 25% RPN care, 55% PSW care and 1 NP for every 120 residents.
- 23. The greater foundational knowledge of RNs means that they are able to practice autonomously regardless of the complexity of the client. RPNs, on the other hand, may only practice autonomously in a stable environment with clients of low, predictable, complexity. As patient complexity increases and the environment becomes less stable, RPNs must collaborate with RNs in providing care and may be unable to provide care as some patients are only suitable for RN care.<sup>8</sup>
- 24. While all nurses augment their knowledge and skills through ongoing learning and experience, an RPN cannot acquire the same foundational competencies as an RN simply through continuing education. The only way to acquire the same foundational knowledge and competencies is through the formal education and credentialing process of an RN.<sup>9</sup>
- 25. The College of Nurses ("CNO" has created a practice guideline, "RN and RPN Practice: The Client, the Nurse and the Environment," which sets out a "three factor framework" to provide direction in deciding which category of nurse is appropriate for a particular work assignment.

<sup>&</sup>lt;sup>5</sup> Long-Term Care COVID Commission, Transcript of Dr. Arthur Sweetman, September 10, 2020, pp. 10, 32.

<sup>&</sup>lt;sup>6</sup> *Ibid.*, pp. 33-34.

<sup>&</sup>lt;sup>7</sup> College of Nurses of Ontario "RN and RPN Practice: The Client, the Nurse and the Environment" at p.3. [CNO Practice Guideline]

<sup>&</sup>lt;sup>8</sup> *Ibid*.

<sup>&</sup>lt;sup>9</sup> *Ibid.,* p.7.

The three factors to be considered in making nursing assignments are: the client, the nurse and the environment. Decisions about whether to assign an RN or RPN to a particular patient are only to be made after considering each of the three factors <sup>10</sup> This guideline is applicable to all nursing assignments, including those in long-term care. The more complex the client, the greater the need for an RN to provide care or to be readily available for consultation.<sup>11</sup>

- 26. The long-term care practice environment is particularly unsupportive, with few consultation resources readily available. Medical directors and Nurse Practitioners are not in the Home on a daily basis and the Administrator does not typically have a clinical background. On evening and night shifts, the RN is in charge of the entire building, and in some cases, is the only regulated staff member present in the Home. This is further complicated by the increasingly acute resident population in long-term care, especially during the pandemic.
- 27. In the long-term care setting, if a resident's condition changes, for example after a fall, the RN will be required to conduct an assessment, regardless of whether that resident is otherwise assigned to her. It is not uncommon that several times a shift an RN will be called to consult with an RPN or a PSW.
- 28. This role is in addition to their other significant accountabilities. RNs are responsible for conducting assessments, including those completed upon admission, which are extremely time consuming and detailed. They update care plans, administer medications, provide wound care, follow up on physician orders. They also often take delivery of medications from the pharmacy and are assigned a multitude of other roles as needed. At the same time, they are usually supervising the Home, particularly on evening and night shifts when the Director of Nursing is not present in the Home. They provide leadership to the multidisciplinary team and supervision over the provision of care to residents by that team. It is a challenging role.
- 29. Cynthia Davis, President and CEO of Lakeridge Health, noted the importance of skill mix within long-term care in her interview with the Commission on January 20. She noted:
  - one of the things that I think we all struggle with is the skill mix within long-term care. So I know that we talk about the resident care hours and what that means, but the skill within these Homes is also really important and the ratio of professional staff to unregulated staff. And as we talked about the complexity of these residents changing over the years, what has not changed is actually an increase in professional staff. In most cases, there has actually been a decrease in that.<sup>12</sup>
- 30. The acuity of residents living in Long-Term Care Homes has risen to staggering levels. At least 81% of residents are cognitively impaired, with one-third of those displaying severe cognitive impairment.<sup>13</sup> Residents have multiple comorbid conditions, requiring multiple

<sup>&</sup>lt;sup>10</sup> *Ibid.*, p.11.

<sup>&</sup>lt;sup>11</sup> *Ibid.,* p.5.

<sup>&</sup>lt;sup>12</sup> Long-Term Care COVID Commission, Transcript of Dr. Kyle and Lakeridge Health, January 20, 2021, p. 128.

<sup>&</sup>lt;sup>13</sup> Staffing Study, *supra*, note 4 p.18

drug therapies. 14 Eighty-seven percent of residents entering the Home are scored as high or very high-need residents as of 2019.15 The Ontario Long-Term Care Association ("OLTCA") provided a snapshot of residents in their 2019 report, "This is Long-Term Care":

- 90% have some form of cognitive impairment:
- 86% of residents need extensive help with daily activities such as getting out of bed, eating, or toileting;
- 80% have neurological diseases:
- 76% have heart/circulation diseases:
- 64% have a diagnosis of dementia;
- 62% have musculoskeletal diseases such as arthritis and osteoporosis;
- 61% take 10 or more prescription medications;
- 45% exhibit aggressive behaviour;
- 40% need monitoring for an acute medical condition;
- 21% have experienced a stroke;
- 79.2 % have bladder incontinence;
- 58.9% have bowel incontinence. 16
- 31. Academic research has long documented a positive relationship between higher levels of RN staff with the quality of care and quality of life of residents. The relationship between staffing and quality care was examined in a 2020 paper, which concluded:

On the whole, higher nurse staffing improves both the process and outcome measures of nursing Home quality. The impact of registered nurses (RNs) is particularly positive, but total nursing staff including licensed vocational nurses or licensed practical nurses (LVNs/LPNs) and certified nursing assistants (CNAs) is also important. Higher RN staffing levels are associated with better resident care quality in terms of fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs) independence; less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rates. There is also a strong relationship between higher nurse staffing levels in nursing Homes and reduced emergency use and rehospitalizations. 17

- 32. A number of recent studies have been published examining the relationship between RN staffing levels and the outcome of COVID-19 outbreaks. The studies found:
  - Higher staffing and more total nursing hours were related to fewer COVID-19 outbreaks in long-term care facilities; 18

<sup>&</sup>lt;sup>14</sup> Ibid.

<sup>&</sup>lt;sup>15</sup> *Ibid.*, p.19.

<sup>&</sup>lt;sup>16</sup> Ontario Long-Term Care Association, "This is Long-Term Care 2019", p.3.

<sup>&</sup>lt;sup>17</sup> Harrington C., Dellefield, M.E., et al. (2020). "Appropriate Nurse Staffing Levels for U.S. Nursing Homes." Health Services Insights Volume 13: 1-142020 sagepub. DOI: 10.1177/1178632920934785

<sup>&</sup>lt;sup>18</sup> Gorges, R. J., & Konetzka, R. T. (2020). "Staffing levels and COVID-19 cases and outbreaks in U.S. nursing homes" Journal of the American Geriatrics Society (JAGS), 68(11), 2462-2466. doi:10.1111/jgs.16787

- Nursing homes with COVID-19 outbreaks were twice as likely to have low RN hours (less than 0.75 hours per resident per day);<sup>19</sup>
- California nursing homes with higher RN staffing levels had reduced COVID-19related deaths by approximately half and there was a correlation between high
  nursing turnover and higher COVID-19 case rates within nursing homes. The
  authors hypothesize that this is because RN staff have the knowledge, skills and
  judgment to provide training, supervision and infection control management within
  Homes to mitigate the spread of COVID-19;<sup>20</sup>
- Higher RN staffing in Connecticut nursing homes was associated with fewer confirmed COVID-19 cases. Among nursing homes with at least one COVID-19 case, every 20 minutes per resident day increase of RN staffing was related to a reduction of confirmed COVID-19 cases by 22%. Additionally, in nursing homes with at least one COVID-19 related death, each 20-minute increase in RN staffing was associated with a reduction in COVID-19 related deaths by 26%.<sup>21</sup>(Li et al., 2020).
- Nursing homes across 8 states with higher nurse staffing ratings were less likely to have greater than 30 COVID-19 cases and had fewer COVID-19 cases compared to nursing Homes with lower staffing ratings.<sup>22</sup>
- 33. These findings are remarkable, illustrating the value RNs bring to long-term care.
- 34. Residents who are ill with COVID-19 are not stable and their outcomes are not predictable. There are almost no supports in the Home, unless outside help is sent. The LMOH for Simcoe-Muskoka noted on January 26 regarding the outbreak at Roberta Place: "there is great concern that the acuity of the residents there has shifted dramatically" and "it is really no longer like a long-term care facility and it is more like an acute care and palliative care facility in terms of the needs of the residents that are present." The advanced clinical skills of RNs are desperately needed during COVID-19 outbreaks.
- 35. Unfortunately, despite the positive link between higher RN staffing levels and resident outcomes, Long-Term Care Homes do not employ sufficient RNs, in part because of the wage differential between RNs and RPNs. This emphasis on cost, instead of an appropriate skill mix based on the "three factor framework" was evident during the Gillese Inquiry when the OLTCA, which represents for-profit long-term care homes, advocated for the removal of

<sup>&</sup>lt;sup>19</sup> Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., & Bakerjian, D. (2020). "Nurse staffing and coronavirus infections in California nursing homes." Policy, Politics & Nursing Practice, 21(3), 174-186. doi:10.1177/1527154420938707

<sup>&</sup>lt;sup>20</sup> Spurlock, B., Stack, A., Harrington, C., Ross, L., Senathirajah, M., Yoon, F., Lewis, P., Benevent, R. (2020). Factors Driving COVID-19 Cases & Deaths in California Nursing Homes.

<sup>&</sup>lt;sup>21</sup> Li, Y., Temkin-Greener, H., Shan, G., & Cai, X. (2020). COVID-19 infections and deaths among connecticut nursing home residents: Facility correlates. Journal of the American Geriatrics Society (JAGS), 68(9), 1899-1906. doi:10.1111/jgs.16689

<sup>&</sup>lt;sup>22</sup> Figueroa, J. F., Wadhera, R. K., Papanicolas, I., Riley, K., Zheng, J., Orav, E. J., & Jha, A. K. (2020). Association of nursing home ratings on health inspections, quality of care, and nurse staffing with COVID-19 cases. JAMA: The Journal of the American Medical Association, 324(11), 1103-1105. doi:10.1001/jama.2020.14709

<sup>&</sup>lt;sup>23</sup> BarrieToday.com, "Roberta Place 'more like an acute care and palliative care facility' now says Gardner' January 26, 2021 <a href="https://www.barrietoday.com/coronavirus-covid-19-local-news/roberta-place-more-like-an-acute-care-and-palliative-care-facility-now-says-gardner-3296284">https://www.barrietoday.com/coronavirus-covid-19-local-news/roberta-place-more-like-an-acute-care-and-palliative-care-facility-now-says-gardner-3296284</a>

the minimum requirement to have one RN in the building at all times.<sup>24</sup> They wanted "flexibility" to use RPNs instead. AdvantAge, on the other hand, representing the municipal and not-for-profit sector, supported the requirement for at least one RN in the Home at all times.<sup>25</sup> They recognized the value of RNs in improving resident outcomes and quality care.

The Importance of Staffing during the Pandemic in Ontario

- 36. During the pandemic, the staffing crisis became even more dire. The single-facility rule decreased the number of baseline staff available to work in the Home. Years of relying on part-time labour meant that there were few full-time employees remaining. <sup>26</sup> Many other workers were off, either because they were required to isolate due to a high-risk exposure or because they themselves became ill.
- 37. Half of respondents to ONA's survey said that the staffing levels in their Homes decreased during the pandemic, with this being more pronounced in for-profit Homes. A third of respondents indicated that both RNs and RPNs were short-staffed often, which was defined in the survey as several times a week. That number increased to 45% in Homes with outbreaks of more than five resident cases of COVID-19.
- 38. The introduction of regulation 95/20 under the *Emergency Management Civil Protection Act A* relieved Long-Term Care Homes from the requirement to have at least one RN who is an employee of the Home and a member of the regular staff be present and on duty at all times. This applied to all Homes, whether or not they were in an active outbreak. 43% of respondents to the ONA Survey reported that their Homes did not always have a RN on duty in their Home during the pandemic. For-profit Homes were less likely to meet the standard, with only 50% of respondents from for-profit Homes answering that their Home always met the standard during the pandemic, versus 67.1% from not-for-profit Homes.
- 39. The government's decision that Homes did not need to have an RN on-site 24/7 during the pandemic was short-sighted and a response to lobbying by for-profit homes instead of a consideration of the level of care required by residents. It is when residents are most unstable, ill with a novel infectious disease, that they most need RN care.
- 40. Comments from ONA members vividly capture how challenging staffing was during the First Wave:
  - "Big impact- we had very few staff at start of outbreak, same staff circulated all units, exhaustion, many fell ill. It was one of the saddest darkest times I have ever experienced."
  - "We were short staffed almost every day before the outbreak When COVID hit we
    were down to a bare minimum or below, not only nursing staff but other
    departments to 3-4 staff was taking care of 72 residents, which was an impossible
    task."

<sup>&</sup>lt;sup>24</sup> Closing Submissions of the OLTCA https://longtermcareinquiry.ca/en/closing-submissions/

<sup>&</sup>lt;sup>25</sup> Closing Submissions of AdvantAGE <a href="https://longtermcareinquiry.ca/en/closing-submissions/">https://longtermcareinquiry.ca/en/closing-submissions/</a>

<sup>&</sup>lt;sup>26</sup> According to the Staffing Study, only 40% of RNs in long-term care work full-time. Staffing Study, *supra*, note 4, p. 20.

- "One day no one worked on the 2<sup>nd</sup> floor. One from Responsive Unit came over to help us. Usually I have four staff on the 3<sup>rd</sup> floor but because of the one Home policy, I was alone. The building had just one PSW and me."
- "We have never been this short staffed. No RN on nights for months. Working short sometimes several staff each shift, including Registered staff and PSWs. Staff burning out, work load out of control day after day."
- "RNs and RPNs were unable to manage dangerously high workload and acuity. Patients were left with short PSW care, in addition to short nursing. Care was not completed for residents with tube feeds, IVs, and complex wounds. Management was unresponsive, and calls for help fell on deaf ears. Staff went without breaks and were too busy to eat. Management refused to step in or attempt to hire more nurses."
- "LTC Homes are grossly understaffed with RNs and PSWs, PSWs are so underpaid. The ratio of RNs and PSWs to number of residents are extremely inadequate and impacting very much quality of care residents are receiving. The workloads are overwhelming."
- "Not enough staffing to provide safe and competent care to residents. Extreme short staffing in RPNs has led to RNs completing double duty as RPN on unit and RN for building which creates unsafe work."
- 41. The Military Report<sup>27</sup> reflected the staffing crisis in its report dated May 20. The following are some of their comments:
  - "LTFC is severely understaffed during day due to resident comorbidities and needs (need more PSWs, RPN and RNs)" <sup>28</sup>(Eatonville);
  - "The staffing is such that it is impossible to provide care at a pace that is appropriate to each resident or allow them any kind of independence"<sup>29</sup>(Eatonville);
  - "No (civilian) RN in the building other than SNO during weekends. SNO and Executive Director (also an RN) only RNs on site on numerous occasions during the week. Significant resultant safety concerns regarding patient ratios (1 RN for up to 200 patients)"<sup>30</sup> (Hawthorne);
  - "The current staff to patient ratio at the facility do not allow for more care than the most basic daily requirements. Residents are changed and fed, however no ability to provide nail care, skin care, repositioning, nor adequate wound care"31 (Altamont);
  - "Night shift also understaffed and often requires significant movement of personnel within facility to stabilize number of personnel between wings" (Altamont).
- 42. ONA heard from many nurses who were required to work numerous double and consecutive shifts. In at least one case, we heard of one staff member who worked 20 days in a row.

<sup>&</sup>lt;sup>27</sup> Canadian Armed Forces, OP Laser JTFC Observations in LTCF in Ontario, May 20th, 2020. [Military Report]

<sup>&</sup>lt;sup>28</sup> *Ibid.*, p.A2/3.

<sup>&</sup>lt;sup>29</sup> *Ibid*.

<sup>30</sup> *Ibid.*, p.B2/3

<sup>31</sup> Ibid., p.D2/3.

<sup>&</sup>lt;sup>32</sup> *Ibid.*, p.D2/3.

- 43. Long-Term Care Homes attempted to respond to their staffing issues by using agencies to provide relief. Because agencies were exempt from the single-facility rule, agency staff were, in theory, available to help. Agency nurses are not as helpful as regular staff because they are unfamiliar with the Home, its residents and were given little training or orientation. Agency usage was not always predictable, with the military documenting that at Hawthorne Place, the "agency pulled back/rerouted RNs when they found out CAF members present resulting in regular degradation of patient ratios and instability of planning." The Military Report advised of "significant concerns about agency staff clinical skills" at Altamont Care Community, including inaccurate assessments and medication errors. They also reported concerns at Holland Christian Homes (Grace Manor):
  - 1. Concerns about agency staff:
  - Leaving food in a resident's mouth while they are sleeping;
  - 3. Aggressively repositioning a resident;
  - 4. Improper use of lifts; and
  - 5. Not assisting residents during meals (staff would rather write refused to eat, rather than helping them.<sup>35</sup>
- 44. Agency support is at best a stop-gap measure, necessary to get through the pandemic. What is truly needed is a comprehensive, appropriately funded provincial staffing strategy.

## ONA's Recommendation Regarding Staffing

- 45. The Long-Term Care Staffing Study, released July 20, 2020, confirmed what advocates had been saying for decades: staffing in the long-term care sector is in crisis and needs to be urgently addressed.<sup>36</sup> The Staffing Advisory Group urged the MLTC to move towards "a minimum daily average of four hours of direct care per resident" as quickly as possible.<sup>37</sup> The province has failed to come close to meeting that standard despite the fact that it was first recommended in the 2008 Sharkey Report.<sup>38</sup> The actual hours of direct care is estimated to be closer to 2.7 hours.<sup>39</sup>
- 46. In addition, the Staffing Advisory Group recommended that the requirement for at least one RN to be present and on duty at all times should be updated to consider Home size, because one RN is insufficient for meeting resident needs in larger Homes. 40 They also recognized that "sufficient levels of registered nursing staff are needed to provide greater clinical oversight and expertise to the care team as well as to enhance direct care." 41 The Advisory

<sup>&</sup>lt;sup>33</sup> Military report, *supra*, p.B3/3.

<sup>&</sup>lt;sup>34</sup> Military Report, *supra*, p.D1/3.

<sup>&</sup>lt;sup>35</sup> Military Report, *supra*, p.E1/1

<sup>&</sup>lt;sup>36</sup> Staffing Study, *supra*, note 4 p.26.

<sup>&</sup>lt;sup>37</sup> *Ibid.*, p.28.

<sup>38</sup> Sharkey, supra note 2.

<sup>&</sup>lt;sup>39</sup> Stall NM, Brown KA, Maltsev A, et al. COVID-19 and Ontario's long-term care homes. Science Briefs of the Ontario COVID- 19 Science Advisory Table. 2021;2(7). https://doi.org/10.47326/ocsat.2021.02.07.1.0 [Science Table Brief]
<sup>40</sup> Staffing Study, *supra*, note 4 p.29.

<sup>&</sup>lt;sup>41</sup> *Ibid.*, p.30.

Group further recommended expanding the use of NPs in long-term care to augment clinical leadership in Homes.<sup>42</sup>

- 47. This Commission recognized the critical importance of staffing, recommending in an interim recommendation that the Long-Term Care Staffing Study be implemented in a timely manner and that a minimum daily average of four hours of direct care per resident was required to meet residents' needs.
- 48. The provincial government's commitment to increasing staffing hours to the recommended 4.0 hours by 2025 is inadequate. The plan not only lacks details surrounding staffing skill mix, but four years is too long to wait. The need is urgent right now, as deadly outbreaks in the Second Wave continue to unfold in Long-Term Care Homes.
- 49. It is ONA's submission that given the acuity of the residents, a minimum of 4.1 hours of <u>actual hours worked</u> is required and that those hours should only include hours of front line, hands-on RN, RPN and PSW care. The staffing model should ensure a skill mix that is appropriate, which ONA submits would have 20% of the direct care provided by RNs, 25% by RPNs and 55% by PSWs and one Nurse Practitioner for every 120 residents.
- 50. If implemented, this recommendation- 20% of direct care provided by RNs, with a minimum 4.1 hours of actual hours worked-will have an immediate positive impact on the quality of care and quality of life for long-term care residents. Fixing the staffing crisis requires a serious investment to the funding of Long-Term Care Homes.

## **Funding**

- 51. The fact that municipal Homes fared better than for-profit Homes during the pandemic can largely be explained by the fact that they are better funded. While the base funding model is the same for both municipal/not-for-profit and for-profit Homes, municipal and not-for-profit Homes invest all of the funding in the "other-accommodation" envelope in staffing and may provide supplemental funding that is put towards resident care. For-profit Homes, on the other hand, regularly choose to use public funding, from the "other accommodation" envelope, as profit. This means that they spend even less money than the provided base funding on resident care.
- 52. ONA submits that the funding model needs to be fundamentally changed in the following ways:
  - The overall budget for long-term care must increase. This will permit Homes to increase staffing and to provide competitive salaries and benefits to attract RNs to work in the sector;
  - ii) The process for calculating the "level of care per diem" received by each Home must be changed;
  - iii) For-profit Homes must be eliminated in the long-term. Starting now, new bed licenses should not be awarded to for-profit Homes.

<sup>&</sup>lt;sup>42</sup> *Ibid.*, pp.36-37.

## Overall Budget Increase

- 53. It is universally accepted that the overall budget for long-term care must be increased. Justice Gillese found that funding increases had not kept pace with the demands on those working in long-term care, in part due to the increasing acuity of residents. She recommended that a staffing study be conducted and if it showed that additional staffing was required, that Long-Term Care Homes should "receive a higher level of funding overall, with the additional funds to be placed in the nursing and personal care envelope." 43
- 54. The budget increase must be enough to cover the additional staffing hours to get to 4.1 hours of actual care and must also be such that salaries and benefits in the for-profit Homes are improved so as to be comparable with wages and benefits in the hospital and municipal long-term care sector. The current disparity in compensation leads to difficulties in recruitment and retention and contributes to the perception that nursing in long-term care is less skilled than nursing in the hospital sector. It was undoubtedly a factor contributing to the extra challenges with staffing experienced by for-profit Homes during the pandemic. The Commission heard from staff that the decision as to which Home to work at during the pandemic was influenced by salary.
- 55. More full-time positions must also be created to attract staff to the sector. Full-time positions will reduce the number of RNs working multiple part-time jobs just to make a full-time wage. The Staffing Study noted the prevalence of part-time positions in the sector, recommending that the sector should look to maximize opportunities for full-time employment.<sup>44</sup>

### Calculating the Level of Care Per Diem Funding

- 56. The current method for calculating funding is problematic. At a high level, funding is determined by calculating the Case Mix Index ("CMI"), which is a value assigned to a Long-Term Care Home as a measure of the average care requirements of residents in the Home. The CMI is determined from information in the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), which is a standardized tool collecting administrative and clinical data reflecting residents' health at admission, quarterly or during a significant change. These assessments are completed by registered staff working in the Homes.
- 57. The CMI is used to determine the funding a Home is allocated as against all other Long-Term Care Homes. In other words, it determines how much of the overall funding "pie" a Home receives.
- 58. This system is inefficient and cumbersome and does not reflect the actual current needs of residents in the Home. There is a considerable lag between when the assessments are done and when funding is released: payments are usually based on data that is 12-18 months old. As Wendy Gilmour, a representative for Revera indicated, a Home may have to reduce their staffing in response to reduced funding based on outdated data yet still have a current need for more staff: "And basically what you're doing is adjusting for where you

<sup>&</sup>lt;sup>43</sup> Gillese, *supra* note 3 at p. 131.

<sup>44</sup> Staffing Study, supra note 4, p.34

were two years ago. It may not be where you are right now. So your Case Mix Index might have gone up, yet you're reducing staff because you don't have the funding." This unpredictability of funding also makes it more desirable to have part-time staff, as it provides the Home with flexibility when their funding is reduced. 46

59. Perhaps the worst part of the system is that RNs are required to spend a great deal of time "charting for dollars", performing RAI assessments, instead of providing hands-on care. While clinical charting will always be required, it should be focused on documenting resident care and outcomes, instead of focused on justifying funding. Dr. Sweetman indicated to the Commission that charting for clinical reasons and acuity measures should be separate and that Homes shouldn't be given incentives to make people look sicker by combining clinical charts with payment. <sup>47</sup> ONA agrees with his opinion.

Elimination of For-Profit Operators in Ontario's Long-Term Care System

- 60. For-profit long-term care in Ontario must be eliminated. The performance of for-profit Homes during the pandemic starkly illustrates that they are not up to the vital task of providing health care to fragile residents and that they do not provide a safe, quality environment.
- 61. The Long-Term Care Homes Act ("LTCHA") provides that a Long-Term Care Home "is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met." By any test, these objectives were not met during the pandemic by many for-profit long-term care licensees.
- 62. For years, research suggested that not all Long-Term Care Homes were created equal, that for-profit Homes tended "to deliver inferior care across a variety of outcome and process measures." Due to their very nature, which requires an accountability to shareholders, for-profit Homes do not use all public funds to support resident care, but instead take funds from the "other accommodation" envelope as profit. ONA is not aware of any research that concludes there is any particular benefit for residents to live in a for-profit Home.
- 63. Recent studies paint a damning portrait of the performance of for-profit Homes during the pandemic. Dr. Nathan Stall published a paper in July studying outbreaks during the First Wave. He concluded that while the risk of having an outbreak in a Long-Term Care Home was not directly related to the Home's for-profit status, there was evidence "that for-profit Long-Term Care Homes have larger COVID-19 outbreaks and more deaths of residents from COVID-19 than nonprofit and municipal Homes."
- 64. More startling are the recent findings published by Ontario's Science Table on January 20, 2021 which released a paper providing recommendations to the provincial government. The

<sup>&</sup>lt;sup>45</sup> Long-Term Care COVID Commission, Transcript of Revera, October 7, 2020, p. 24.

<sup>&</sup>lt;sup>46</sup> Ibid., p.23.

<sup>&</sup>lt;sup>47</sup> Sweetman, sura note 5, pp.57-58.

<sup>&</sup>lt;sup>48</sup> Nathan M. Stall, Aaron Jones, Kevin A. Brown, Paula A. Rochon, Andrew P. Costa "For-Profit Long-Term Care Homes and the Risk of COVID-19 outbreaks and resident deaths" CMAJ 2020. doi: 10.1503/cmaj.201197; early-released July 22, 2020 at p.1.

<sup>&</sup>lt;sup>49</sup> *Ibid.*, p.9.

Science Table concluded that for-profit Homes had outbreaks with "nearly twice as many residents infected" and "78% more resident deaths" compared to non-profit Homes:<sup>50</sup>

The most important risk factors for the size of a LTC Home COVID-19 outbreak and the number of resident deaths are for-profit status and crowding. For-profit Homes have a higher proportion of older design standards and chain ownership and crowded Homes have an increased number of residents per room and bathroom.<sup>51</sup>

- 65. What is truly alarming is that despite these findings, the provincial government has continued to provide new bed licenses to the for-profit sector. Of 3000 new beds announced in November, all of them were awarded to the for-profit sector, including a number of Homes that had troubling records during the First Wave of the pandemic. For example, Orchard Villa, which performed extremely poorly during the First Wave, with over 70 residents dying and 135 residents and 100 staff infected, was awarded 87 new beds in November 2020 by the MLTC. The Commission heard from Dr. Kyle and Lakeridge Health about how the Hospital had to become involved with Orchard Villa in April 2020 and the appalling conditions that were found when they first entered the Home.
- 66. As Hugh Armstrong stated to the Commission "while I don't think we can eliminate all the for-profits today or even the day after your final report comes out, we should be moving in that direction. And unfortunately in Ontario, we're moving in the opposite direction."<sup>52</sup>
- 67. In the past, it has been easy to blame problems in the for-profit sector as being specific to a particular Home. This year has shown that the problems are not with just one owner or one chain, but is endemic throughout the for-profit long-term care business. And that is fundamentally the problem: long-term care should not be a business, where a licensee has competing obligations to residents and to shareholders. If there is one lesson from this devastation, it is that for-profit Homes are simply not up to the task of reconciling these competing obligations.

### PART TWO: A PUBLIC HEALTH SYSTEM UNPREPARED FOR THE PANDEMIC

The public health system was broken, neglected, inadequate and dysfunctional. It was unprepared, fragmented, uncoordinated. It lacked adequate resources, was professionally impoverished and was generally incapable of fulfilling its mandate.

Ontario was not prepared for a public health crisis like SARS. It didn't even have a pandemic plan.

Justice Campbell, SARS Commission Report<sup>53</sup>

<sup>&</sup>lt;sup>50</sup> Science Table Brief, supra note 31, p.12.

<sup>&</sup>lt;sup>51</sup> Ibid., p.16.

<sup>&</sup>lt;sup>52</sup> Long-Term Care COVID Commission, Transcript of Dr. Pat Armstrong and Dr. Hugh Armstrong, November 17, 2020, pp. 25-26.

<sup>&</sup>lt;sup>53</sup> SARS Commission Report, *Supra* note 1 at pp. 17-18.

- 68. These words by Justice Campbell were as true in the months leading up to the COVID-19 pandemic as they were during SARS. Despite having 18 years to remedy the systemic defects identified by the SARS Commission, Ontario was grossly unprepared to prevent and contain the virus from taking hold in the province and in Long-Term Care Homes.
- 69. Ontario's overall health system was undergoing seismic changes in 2019 and early 2020. The creation of Ontario Health ("OH"), the approval of Ontario Health Teams ("OHT"), and the proposed reduction of public health units all introduced uncertainty into the health system without any real clarification as to how all the pieces were going to fit together. At the same time, the MLTC portfolio was removed from the jurisdiction of the MOH. Ontario's health system was fragmented and in a state of flux as the virus took hold in the province.

## State of Public Health, Emergency Management and Pandemic Preparedness

### Public Health Cutbacks

- 70. The state of Ontario's public health system and its general state of pandemic (un)preparedness demonstrates that the Ontario government did not make the investments necessary to robustly respond to a pandemic.
- 71. In 2019, after more than a decade of insufficient investment in public health, the Ontario government started rolling back the little investment that had been made. In the months prior to the pandemic, public health in Ontario was in a state of transition as the provincial government announced that it was slashing funding to public health by 27% (\$200 million) and reducing the number of public health units from 35 to 10. While these plans were not fully implemented before the pandemic broke, there was a great deal of uncertainty about the future of public health in the province.
- 72. As Dr. Allison McGeer stated to the Commission, "we took a system that is already in serious trouble, not able to do what public health systems should be able to do, and proposed to remove a third of its funding." She explained that this meant many working in public health were worried they were going to lose their jobs because of the proposed budget cuts. At Public Health Ontario ("PHO"), people were laid off in the fall of 2019 and a significant number of the organization's leaders left in the fall as PHO underwent a reorganization. Dr. McGeer also suggested that PHO was losing infection control expertise.
- 73. For reasons yet unknown, the provincial government did not consult with public health as expected in their pandemic response. In Dr. Shelley Deeks, PHO Chief Health Protection Officer's meeting with the Commission on January 8. She indicated that PHO had not been consulted on all versions of Directive 3, specifically stating that they had not reviewed the March 22 and March 30 versions of the Directive. 58 Dr. Deeks also noted that although PHO representatives sat on the Health Coordination Table, they were not always asked for input:

<sup>&</sup>lt;sup>54</sup> Long-Term Care COVID Commission, Transcript of Dr. Allison McGeer, September 3, 2020, p.45.

<sup>&</sup>lt;sup>55</sup> *Ibid.*, p.45.

<sup>&</sup>lt;sup>56</sup> Ibid., p.45; Long-Term Care COVID Commission, Transcript of Dr. Shelley Deeks, January 8, 2021, p. 35.

<sup>&</sup>lt;sup>57</sup> McGeer, *supra* note 46, p. 35.

<sup>&</sup>lt;sup>58</sup> Deeks, *supra* note 48, pp.32-33.

But the public health and lab-although public health measures or public health issues and lab science issues were frequently discussed, the public health experts who sat at the tables were not always asked for input, and that included public health experts from PHO as well as from the Office of the CMOH.<sup>59</sup>

- 74. PHO's recommendations regarding thresholds for a lockdown were also disregarded. This initiative was critical to the safety of Long-Term Care Homes, as the "biggest determinative of whether COVID enters the Home was rates of community COVID." Public Health's expertise on distributing vaccines was also disregarded. 61
- 75. The defunding of public health, coupled with the loss and devaluation of expertise, and the failure to recognize public health as a central player in the COVID-19 pandemic contributed to inability of the province to contain the virus.

PIDAC-IPC did not include any expertise on occupational health and safety

- 76. The Provincial Infectious Disease Advisory Committee on Infection Prevention and Control ("PIDAC") provides advice to PHO and to the government. During an outbreak, this scientific and technical advice is intended to be relied upon by the Chief Medical Officer of Health ("CMOH") in crafting directives to health care workers. A key finding of the SARS Commission was that occupational health and safety expertise must be included on decisions that have implications for workers.
- 77. As Justice Campbell identified, during SARS infection control and worker safety were treated as "two solitudes":

Infection control relies on its best current understanding of science as it evolves over time. It is unnecessary to point out again that infection control failed to protect nurses during SARS. Worker safety relies on the precautionary principle that reasonable action to reduce risk should not await scientific certainty.<sup>62</sup>

- 78. Shortly after SARS, the CMOH, Dr. Sheela Basrur, confirmed that in order to "ensure that the perspectives of occupational health and infection control receive consideration," an occupational health physician would be included on PIDAC and furthermore, that a physician delegate from the MOLSTD would also sit on the committee. <sup>63</sup> She noted that this would "highlight our commitment to ensuring that occupational health and safety expertise is brought to the table during all PIDAC deliberations now and in the future" <sup>64</sup>
- 79. Despite this commitment, by early 2020, PIDAC did not have any members with occupational health and safety expertise as sitting members. Once again, PHO and the government lacked advice incorporating worker safety into its recommendations. Their sole

<sup>60</sup> Long-Term Care COVID Commission, Transcript of MOH Capacity Planning and Analytics, September 15, 2020, p.24.

<sup>64</sup> *Idid*., p. 11 fn. 11.

<sup>&</sup>lt;sup>59</sup> *Ibid.*, pp. 35-36.

<sup>&</sup>lt;sup>61</sup> Long-Term Care COVID Commission, Transcript of Dr. Stall and Dr. McGeer, January 19, 2021.

<sup>&</sup>lt;sup>62</sup> SARS Report, *supra* note 1, p.10-11.

<sup>&</sup>lt;sup>63</sup> *Ibid.*, p.11.

focus was infection prevention and control, and its emphasis on scientific certainty, which had failed so badly to protect workers during the SARS outbreak.

### Outdated Pandemic Plan

- 80. Following SARS, Ontario created two plans: the Ontario Health Response Plan and the Ontario Health Plan for an Influenza Pandemic ("OHPIP"). Both were last updated in 2013. Aside from obvious flaws inherent in focusing solely on an influenza pandemic, the failure to update the plans as the health system evolved meant that it no longer provided a roadmap for government to follow in responding to a pandemic.
- 81. The creation of OH to oversee health care delivery across the province and the removal of long-term care from the portfolio of the MOH were not reflected in the province's emergency and pandemic planning. Justice Campbell had observed that "what we need is a system with clear lines of authority and accountability to prepare us better for the next infectious outbreak" Yet going into the pandemic, Ontario had an outdated plan that did not reflect the current organizational structure or state of oversight of the health system.
- 82. The Auditor General of Ontario ("AG") noted these failures in her report *COVID-19 Preparedness and Management Special Report*, observing that, unlike British Columbia's government, the Ontario government had not even bothered to update the plan in January or February 2020, after the first cases of COVID-19 were confirmed in Ontario.<sup>66</sup>
- 83. The AG also observed that the OHPIP did not adequately cover key topics that would become pivotal in the province's fight against COVID-19, including increasing laboratory testing capacity, speed and reliability; increasing contact-tracing capacity; increasing range and efficacy of screening for the virus; and balancing and dealing with competing priorities, such as preserving acute- and intensive-care capacity.<sup>67</sup>
- 84. Because of this failure to have current emergency response and pandemic plans in place, the government was not able to simply activate its existing emergency plans. Instead, the government hired an external consultant to create a new government structure, a process that took valuable time in March and April 2020 and which delayed a coordinated approach to the pandemic.<sup>68</sup>

### PPE Stockpile Destroyed

85. It is simply incomprehensible that the provincial government did not maintain — and in fact, destroyed — its stockpile of PPE.

<sup>&</sup>lt;sup>65</sup> *Ihid* n 19

<sup>&</sup>lt;sup>66</sup> Auditor General of Ontario, *COVID-19 Preparedness and Management Special Report: Chapter 2: Outbreak Planning and Decision Making,* November 25, 2020, pp. 69-71. [AG Special Report]

<sup>67</sup> *Ibid.*, p. 71.

<sup>68</sup> Ibid., COVID-19 Preparedness and Management Special Report: Reflections p.2

86. In 2006, the government created a stockpile of PPE to be used as an emergency supply to protect health care workers and their patients during an influenza pandemic.<sup>69</sup> The government was advised that if supplies were not obtained, "Ontario risks being unprepared for an influenza pandemic due to this unprecedented international demand and queueing for delivery." At the time it created the stockpile, Cabinet was warned by the Treasury Board that supplies could become scarce and create serious problems during a pandemic:

The key issue that all jurisdictions will face as they begin to prepare for an influenza pandemic is the lack of surge capacity for essential supplies and equipment to protect healthcare workers and their patients. This is a serious problem during a pandemic, but also well before one begins as countries initiate stockpiling campaigns and are forced to compete for scarce supplies. Further, many key items are produced in, or require components produced in, Asian countries which, according to experts, may be among the first hit by an influenza pandemic. International experts have already identified that essential supplies such as surgical masks are likely to be scare and highly sought-after during a pandemic.<sup>71</sup>

Scare supply was particularly a concern for Canada because it did not have domestic manufacturing capacity within the province.

87. Cabinet was also warned about the impact on health care workers and citizens if the province did not have a stockpile:

Without appropriate personal protective equipment, Ontario's health care workers may be placed unnecessarily at risk. Health care workers may refuse to work without adequate personal protective equipment. The level of care that can be provided to citizens during a pandemic could be compromised.<sup>72</sup>

- 88. The government was fully aware that having a stockpile of PPE was an essential component of preparing for a pandemic, and that failing to have that stockpile would place health care workers and their patients at risk. Yet not only did they not maintain a provincial stockpile, the Capacity and Analytics branch of MOH, which supports the MLTC, did not have information on PPE stocks for any sector.<sup>73</sup>
- 89. Having created the stockpile, which once included 55 million N95 respirators, the government apparently gave no consideration to managing and maintaining the stockpile, to ensure that supplies were used before they expired, and were replenished after use.
- 90. In 2017, the AG reported that 80% of the supply in the stockpile was expired and that the government was paying \$3 million a year to store expired product.<sup>74</sup> The Ministry of Health

<sup>&</sup>lt;sup>69</sup> Long-Term Care COVID Commission, Transcript of Justine Hartley and Jessica Bauman, January 7, 2021, pp.12-

<sup>&</sup>lt;sup>70</sup> *Ibid.*, p.15.

<sup>&</sup>lt;sup>71</sup> *Ibid.*, pp.19-20.

<sup>&</sup>lt;sup>72</sup> *Ibid.*, pp.31-32.

<sup>&</sup>lt;sup>73</sup> Capacity and Analytics, *supra* note 52 p. 26

<sup>&</sup>lt;sup>74</sup> Auditor General of Ontario, 2017 Annual Report, Volume 1, p. 258.

and Long-Term Care ("MOHLTC") advised the AG that their budget only allowed for storage and not maintenance of the items.

91. While the exact reasoning remains shrouded in mystery, the government chose to destroy the remaining supply, with no plan to immediately replace it. Destruction was occurring even as late as the final quarter of 2019. The province was left with practically no backup supply of PPE and the predictions of 2006 came to be: Ontario had to compete with other countries to obtain scarce, life-saving supplies of PPE at much higher prices while health care workers and citizens were placed at risk.

Who is Steering the Ship? Lack of Transparency in Ontario's Response to the Pandemic

- 92. The provincial response to the pandemic has been confusing, in part due to a lack of clarity about the roles and responsibilities of those leading the response. Indeed, it is not entirely clear who is leading and making key decisions affecting the lives of Ontarians.
- 93. The AG described in her Special Report the provincial response structure which consists of a Central Co-ordination Table, Command Tables and Sub-Tables, all of which appear to be advisory in nature only, with Cabinet and the Premier making final decision.<sup>75</sup>
- 94. The role of the CMOH in this structure is entirely unclear. Justice Campbell observed that the CMOH needs a "greater degree of actual and perceived independence from government." <sup>76</sup> He recommended:

The Chief Medical Officer of Health should have operational independence from government in respect of public health decisions during an infectious disease outbreak, such independence supported by a transparent system requiring that any Ministerial recommendations be in writing and publicly available.

The local Medical Officer of Health should have the independence, matching that of the Chief Medical Officer of Health, to speak out and to manage infectious outbreaks.<sup>77</sup>

- 95. This did not come to pass. The CMOH does not have operational independence from government in respect of public health decisions during the pandemic. The Commission heard that the MOH Emergency Operations Centre drafted the Directives to be issued by the CMOH and that the CMOH would merely review them.<sup>78</sup> Even more concerning, there is absolutely no transparency on advice and public health decisions made by the CMOH.
- 96. The AG noted this failure, finding that "the Chief Medical Officer of Health is not making his advice to the Ministry publicly available, which was recommended by the SARS Commission." 79

<sup>78</sup> Long-Term Care COVID Commission, Transcript of CMOH/HPPA Briefing, September 17, 2020, p.75.

<sup>&</sup>lt;sup>75</sup> AG Special Report, *supra* note 58, chapter 1 p.26.

<sup>&</sup>lt;sup>76</sup> SARS Report, *supra*, note 1 Volume 4, p.196.

<sup>&</sup>lt;sup>77</sup> *Ibid.*, p. 199.

<sup>&</sup>lt;sup>79</sup> AG Special Report, *supra*, note 58, chapter 2 p. 4.

97. She also found that the CMOH was not fully exercising his powers under the *Health Protection and Promotion Act* ("HPPA") to respond to the COVID-19 crisis:

While the Chief Medical Officer of Health has the power to independently issue directives, he informed us he would not do so without consulting others, including the Deputy Minister of Health and the Health Command Table. The Chief Medical Officer of Health did issue five directives to health-care providers and health-care entities, such as requiring the use of personal protective equipment and precautions to be taken by hospitals. But he did not issue directives to local Medical Officers of health to ensure public heath units responded consistently to the COVID-19 pandemic, nor did he issue directives on their behalf.<sup>80</sup>

- 98. The AG concluded that the CMOH "neither played a leadership role nor fully exercised his powers under the HPPA to ensure timely and consistent responses by local public health units and health-care providers."<sup>81</sup>
- 99. Similarly, Local Medical Officers of Health ("LMOH") did not consistently exercise their powers under the HPPA. This led to an inconsistent approach towards public health inspections and the making of orders under the HPPA. For example, Dr. Kyle, the LMOH for Durham, issued two orders in April 2020 under s.29.2 of the Act, to take over management of Orchard Villa and a retirement home. Other LMOH did not make such orders and chose to do things on a voluntary basis. These varying approaches led to a patchwork response to a provincial problem.
- 100. Taken together, the deteriorating state of public health and the failure to prepare adequately for a pandemic by having an updated pandemic plan and a stockpile of PPE, and the failure of the CMOH to play a transparent leadership role, had a devastating impact on the province's ability to prevent the virus from taking hold and spreading to catastrophic levels in Ontario. ONA submits that the recommendations from the SARS Commission to invest in public health and pandemic preparedness must be implemented so that lives are never again lost in vain due to a virulent infectious disease outbreak.

## <u>PART THREE: THE TERRIBLE PRICE — AN OVERVIEW OF COVID-19 PANDEMIC IN ONTARIO'S LONG-TERM CARE SYSTEM</u>

101. The devastating impact COVID-19 has had on Ontario's long-term care sector hardly needs repeating: 14,465<sup>82</sup> residents and 5,919 staff infected, with 3,516 residents and 11 staff dead. Harrowing stories of frail, elderly seniors confined to their rooms, alone, with no contact with their families and friends. Staff run off their feet, desperately trying to provide care and comfort. Dead bodies unattended. Garbage and uneaten food piling up in hallways. Infestations of cockroaches. Nurses having to perform the duties of physicians, pharmacists,

<sup>80</sup> Ibid.

<sup>81</sup> *Ibid.*, p. 13.

<sup>&</sup>lt;sup>82</sup> These numbers are from Provincial data published at <a href="https://www.ontario.ca/page/how-ontario-is-responding-covid-19#section-0">https://www.ontario.ca/page/how-ontario-is-responding-covid-19#section-0</a>, accessed on January 31, 2021. The published data is from April 24, 2020 to the present. These numbers do not capture the number of cases and deaths in LTC from the early outbreaks which started around March 20, 2020.

even funeral directors. Staff and residents sweltering in the summer heat in Homes without air-conditioning, an annual discomfort made that much worse under layers of PPE. Residents, families, and staff grief-stricken, terrified and unable to process the trauma.

- 102. What follows is an overview of how the COVID-19 pandemic has unfolded in Ontario's long-term care system. ONA and many others attempted to warn and call for action early on. We highlight the early warning signs that neither the government nor the Homes seemed to heed. As the pandemic progressed, the government moved from virtually ignoring long-term care to implementing a delayed response which can only be described as chaotic.
- 103. After outlining the warning signs, calls for action, and failed government response, we turn to examine what happened in the Homes themselves. Finally, we outline the issues happening right now in the Second Wave. Despite having months to prepare, the tragedy of the Spring is happening all over again. By mid-January, the number of cases of COVID-19 in long-term care surpassed the number of cases from the First Wave. The numbers are still mounting, and the curve has not yet begun to flatten. To compound matters, Ontario is far behind other jurisdictions in vaccinating long-term care residents and staff.<sup>83</sup>

Government Inaction Turns to Chaos: Too Little Too Late

In my opinion as a nurse, it is not a secret that COVID is all over the world. Eventually we will experience a pandemic. As a nurse, the first defense is precautionary measures... Don't wait until everyone is sick. You can't just relax; we had to act as quickly as possible.

## **Anonymous ONA Member**

I worked through SARS in ICU. I will never forget it, but it seems that the government report, which I read the whole report, nothing was learned. It's stunning.

### **Anonymous ONA Member**

- 104. In December 2019, an outbreak of a then-unknown virus began in Wuhan in China's Hubei province. By January 7, 2020, the cause of the outbreak would be identified as a new coronavirus, which would come to be known as SARS-CoV-2, and the illness it caused as COVID-19. China reported the first death from the virus, a 61-year-old man from Wuhan, on January 11, 2020. By January 20, the virus was found outside of China, with the WHO first confirming cases in Thailand, Japan and South Korea. The following day, the United States confirmed its first case in Washington State.
- 105. Ontario saw its first case of COVID-19 a few days later, on January 25: a patient who was treated at Sunnybrook Hospital after returning from a trip to Wuhan. On January 30, the WHO declared the outbreak a global public health emergency, with more than 9000 cases world-wide. By February 9, the death toll in mainland China alone surpassed the total number of fatalities from the SARS outbreak in 2003.<sup>84</sup> By March 11, the global public health emergency was declared a pandemic.

83 Stall and McGeer, *supra* note 53

<sup>&</sup>lt;sup>84</sup> Muccari, Robin et.al. "Coronavirus timeline: Tracking the critical moments of COVID-19" ABC News, https://www.nbcnews.com/health/health-news/coronavirus-timeline-tracking-critical-moments-covid-19-n1154341

- 106. One of the first warnings that COVID-19 could be devasting in congregate settings was the fate of the Diamond Princess cruise ship. The first passenger tested positive on February 1. On February 4, the cruise ship, with approximately 3,700 passengers and crew, was quarantined in Yokohama, Japan. 712 people tested positive for COVID-19, and of these, 37 required intensive care and nine succumbed to the virus.<sup>85</sup>
- 107. Ontario had the opportunity to learn lessons from outbreaks in long-term care facilities in the United States and British Columbia. The first known outbreak of COVID-19 in a long-term care setting in North America occurred on February 29, at the Life Care Centre Long-Term Care Home in Kirkland, Washington. At the time it was first reported, 27 of 108 residents and 25 of 180 staff had tested positive. The numbers would continue to rise to a total of 129 cases: 81 residents, 34 staff and 14 visitors, with at least 37 deaths. When authorities inspected the facility in mid-March, they found a series of failures had contributed to the outbreak, including the failure to have an infection control surveillance program, failure to have a contingency plan to deal with the impact an outbreak might have on their ability to provide quality care, and the failure to promptly intervene and notify public health. The Life Care Centre was fined \$600,000 for its failures. Within a few short weeks, it would become apparent that Long-Term Care Homes in Ontario were repeating the same mistakes.
- 108. COVID-19 first hit long-term care in Canada a week after the Life Care Center outbreak. On March 7, Dr. Bonnie Henry announced two cases in the Lynn Valley Care Centre in Vancouver. By the time the outbreak ended, there was 79 cases and 20 deaths, making it BC's worst outbreak in the First Wave.
- 109. Despite the warning signs from the west coast, priority in early days for Ontario was hospitals, not long-term care. Ontario established a COVID-19 Command Table on February 28. The Command Table is chaired by Helen Angus, Deputy Minister of Health; Dr. David Williams, Chief Medical Officer of Health for Ontario ("CMOH"); and Matthew Anderson, President and CEO of OH. The Deputy Minister of Long-Term Care was at the Table, but representatives from the long-term care sector were not included.<sup>87</sup> A table for long-term care was not created by OH until March 17, including representatives from the sector for the first time. This table was moved under the Provincial Command Table on April 6<sup>th</sup>.<sup>88</sup>
- 110. To the extent long-term care was considered in February and March, it was to open up capacity in long-term care for a potential Hospital surge. <sup>89</sup> Between March 22 and April 3, a total of 97 temporary emergency licenses were issued in 69 Homes to move people out of Hospitals and into Long-Term Care Homes. <sup>90</sup> On March 24, a memo was sent to all Long-Term Care Homes from the Assistant Deputy Minister which directed Homes to implement

<sup>&</sup>lt;sup>85</sup> Moriarty, Leah F et. al. Public Health Responses to COVID-19 Outbreaks on Cruise-ShipsWorldwide, February-March 2020, *Morbidy and Mortality Weekly Report*, Centers for Disease Control and Prevention

<sup>&</sup>lt;sup>86</sup> Department of Health and Human Services Centers for Medicare & Medicaid Services OMB No. 0938-0391, March 16, 2020 https://www.documentcloud.org/documents/6824371-CMS-Survey-of-Life-Center-of-Kirkland.html

<sup>&</sup>lt;sup>87</sup> Long-Term Care COVID-19 Commission, Transcript of Ontario Hospital Association, October 5, 2020, at p. 18

<sup>&</sup>lt;sup>88</sup> Long-Term Care COVID-19 Commission, Transcript of Government of Ontario, Ontario Health, and LHINs, September 30, 2020, at p. 40-42

<sup>&</sup>lt;sup>89</sup> *Ibid.* p. 37

<sup>&</sup>lt;sup>90</sup> Long-Term Care COVID-19 Commission, Transcript of Government of Ontario MLTC Capital Development and Licensing, September 18, 2020, at p. 24-25 and 41-47.

- more "nimble placement requirements" to free up space for an anticipated COVID surge. This happened despite the fact that twelve Homes were already in outbreak by March 22.
- 111. ONA followed the international developments closely, and we attempted to engage with government as early as January to express our concerns about the need for preparation in the health care sector. ONA lost members to SARS during the outbreak in Toronto in 2003. We knew health care workers are vulnerable, and particularly our members in long-term care, a system so badly under-resourced and neglected.
- 112. ONA raised its concerns multiple times to Government:
  - On January 28, 2020, ONA attended a meeting with Christine Elliot and Helen Angus, at which we asked about the precautionary principle, supply of PPE, and pay for self-isolation for hospitals and long-term care.
  - On February 14, ONA wrote to the Ministers for Health and Long-Term Care about PPE and preparedness in all health care sectors. In our letter we asked for proactive MOLSTD inspections in all health care facilities to assess their state of readiness.
  - On February 19, we attended a meeting with Minister Fullerton and key MLTC staff. While the purpose of the meeting was the Long-Term Care Staffing Study Advisory Group, ONA used the opportunity to raise our concerns about the impact COVID-19 and particularly the impact the number of part-time staff in long-term care could have on COVID preparedness.
  - Throughout March, we continued to try to raise our concerns. For example, on March 16, ONA raised with the MOH and the CMOH its concern that health care workers were not being required to isolate after overseas travel, and on March 18, ONA raised concerns at the Labour Table regarding lack of PPE supply in long-term care, workers working at more than one facility, and the lack of direction to long-term care.<sup>91</sup>
- 113. Many others familiar with long-term care in Ontario were also trying to ring alarm bells about the long-term care sector. The rising voices mounted as the virus spread in Ontario and began to hit long-term care:
  - Infection Control Practitioners at Mount Sinai Hospital began their preparations for potential outbreaks in in the hospital in December 2019, and turned their attention to Mount Sinai's Long-Term Care Homes after the February outbreak at the Life Care Centre in Washington.<sup>92</sup>
  - In January, the OLTCA was talking to global partners about COVID-19 and first wrote to government in late January.<sup>93</sup> By March, they were advocating for an emergency order, and seeking assistance in preparing for outbreaks.

<sup>&</sup>lt;sup>91</sup> A copy of ONA's letter of February 14, 2020 and a timeline of our interactions with government are provided with our submissions.

<sup>&</sup>lt;sup>92</sup> Long-Term Care COVID-19 Commission, Transcript of Dr. Jennie Johnstone and Dr. Dylan Kain, January 8, 2021 at p. 12, 26-30

<sup>93</sup> Long-Term Care COVID-19 Commission, Transcript of OLTCA, September 30, 2020 at p. 27-29

- By around March 9, AdvantAge Ontario anticipated problems in long-term care, and started implementing protocols, including searching for PPE to support universal masking.<sup>94</sup>
- In early March, the Advocacy Centre for the Elderly was speaking to the media about the vulnerability of long-term care. 95
- The Canadian Institute for Health Information ("CIHI") looked at literature from China on comorbid conditions, and mapped it against data for long-term care. Based on their analysis, they described long-term care as "basically dry tinder in a forest fire." This was obvious to them on March 17, and they tried to get that message to the Ontario government.<sup>96</sup>
- Dr. Vera Etches, the LMOH for Ottawa Public Health, wrote to the CMOH on March 18 advocating for universal masking of all health care workers in all settings.<sup>97</sup>
- The Ontario Hospital Association ("OHA") had a meeting with the Deputy Minister of Long-Term Care on March 21 to try to bring to their attention to the fact that IPAC capabilities in Hospitals could be mobilized to support long-term care. 98
- 114. The Ontario government ignored all of these warning signs and failed to treat the long-term care sector as a central pillar of its response to COVID-19.
- 115. Among the early outbreaks in Ontario was Hillsdale Terrace, where the first resident to test positive began showing symptoms on March 19, followed by the devasting outbreak at the Pinecrest Long Term Care Home in Bobcaygeon, announced on March 20, and the outbreak at the Seven Oaks Long Term Care Home in Toronto, announced that same day. Over the course of the following weeks, many more would join these ranks. By March 22, twelve Homes were in outbreak. Two weeks later, by April 5, there were 100 Homes in Outbreak, and by the end of the following week, 127 Homes. 99 Throughout April, the number of outbreaks, cases and deaths spiraled upwards. It took months to bring the outbreaks from the First Wave under control.
- 116. The government appears to have forgotten long-term care. By mid-March, the sector had received only a handful of memos with instructions to screen visitors and "strongly encouraging" Homes to only allow essential visitors. There was no policy at the MLTC to proactively inspect Homes with respect to IPAC preparedness. <sup>100</sup> Proactive inspections and assistance with IPAC preparedness were key recommendations from the SARS Commission and would have likely made a significant difference. There were exceptions. The LMOH for Kingston Public Health sent inspectors into Long-Term Care Homes to ensure that all had testing plans, adequate PPE, and appropriate outbreak management

<sup>&</sup>lt;sup>94</sup> Long-Term Care COVID-19 Commission, Transcript of AdvantAge Ontario, September 29, 2020, at p. 30

<sup>&</sup>lt;sup>95</sup> Long-Term Care COVID-19 Commission, Transcript of ACE, September 23, 2020 at p. 47.

<sup>&</sup>lt;sup>96</sup> Long-Term Care COVID-19 Commission, Transcript of Canadian Institute for Health Information, September 24, 2020 at p. 25-26.

<sup>&</sup>lt;sup>97</sup> Long-Term Care COVID-19 Commission, Transcript of Dr. Vera October 2, 2020, p. 9.

<sup>&</sup>lt;sup>98</sup> OHA *Supra* note 79, p. 20.

<sup>&</sup>lt;sup>99</sup> OH *Supra* note 80 p. 44.

<sup>&</sup>lt;sup>100</sup> Long-Term Care COVID-19 Commission, Transcript of Government of Ontario MLTC Long-Term Care Inspections, September 15, 2020, at para. 78-80.

plans. The inspections appeared to have worked: there were no deaths from COVID-19 in the Kingston region during the First Wave.<sup>101</sup>

- 117. Ontario lagged behind other Provinces, British Columbia in particular, when it came to issuing directions to long-term care. Ontario was 14 days behind BC on universal masking, 20 days behind BC in issuing a single-site directive, 28 days behind BC in setting the threshold for outbreak at a single case, and 40 days behind BC in creating IPAC teams that could be deployed to assist long-term care. 102 BC's directions also went further than Ontario's. For example, at the time BC issued its single-site directive, it also took measures to promote full-time work and standardized wages. 103
- 118. Initially, PHO's guidance on precautions, released in February 2020, recommended a precautionary approach "...using a precautionary approach that combines airborne precautions and droplet/contact precautions should be observed until the epidemiology of the novel agent is established." <sup>104</sup>
- 119. Application of the precautionary principle means using the highest level of precautions, in this case airborne precautions and N95 respirators, until there is scientific certainty about transmission. After learning that the CMOH was planning to downgrade to droplet and contact precautions, ONA and other unions representing health care workers fought back, insisting that the precautionary principle needed to be applied to COVID-19.
- 120. The government ignored the unions and on March 11, introduced Directive 1 downgrading to droplet and contact precautions, only requiring airborne precautions for aerosol-generating medical procedures ("AGMPs"). After the release of Directive 1, meetings at the Labour Table between unions, the MOLSTD and the MOH, were discontinued.
- 121. After the release of Directive 1, ONA immediately started hearing from members in all sectors that employers had started to deny access to N95s. In fact, many employers were removing N95s from their normal, accessible locations and locking them away.
- 122. A few weeks later, on March 30, Directive 5 was issued<sup>105</sup>, directed towards hospital workers. Directive 5 introduced the concept of the Point of Care Risk Assessment "PCRA" and ostensibly put the decision to use N95s in the hands of health care workers:

If a worker determines, based on the PCRA, and based on their professional and clinical judgement, that health and safety measures may be required in the delivery of care to the patient, then the public hospital must provide that worker with access

Liu, Michael *et.al.* "COVID-19 in long-term homes in Ontario and British Columbia", Canadian Medical Association Journal, Vol. 192 Issue 47, Nov 23, 2020 at p. E1543 https://www.cmaj.ca/content/cmaj/192/47/E1540.full.pdf; see also Mazur, Alexandra "Kingston's long-term care COVID-19 inspection initiative a 'big win': public health" Global News, April 23, 2020 https://globalnews.ca/news/6859843/kingstons-long-term-care-covid-19-inspections/
 Lui, *ibid*, see also Long-Term Care COVID-19 Commission Transcript of CUPE, October 8, 2020 at p. 66.
 Lui, *ibid*, at p. E1542

 <sup>104</sup> Public Health Ontario, PIDAC "Best Practices for Prevention, Surveillance, and Infection Control Management of Novel Respiratory Infections in all Health Care Settings", first revision dated February 2020.
 105 Directive 1, March 12, 2020

to the appropriate health and safety control measures, including an N95 respirator. The public hospital will not unreasonably deny access to the appropriate PPE.<sup>106</sup>

- 123. As we discuss below, the wording of Directive 5 has caused difficulty for nurses throughout the pandemic. But even the far-from-perfect directive initially excluded nurses in long-term care. It would be another 11 days before Directive 5 was amended on April 10 to extend the PCRA and the ability to determine appropriate PPE to nurse in long-term care. 107
- 124. The first CMOH directive specific to Long-Term Care Homes, Directive 3, was not issued until March 22 and was very brief. Residents were not permitted to leave the Home for short-stay absences. Employers were required "wherever possible" to work with employees to limit the number of different work locations that employees work at, to minimize the risk to patients and exposure to COVID-19.
- 125. On March 30, the CMOH issued a revised version of Directive 3 which contained new requirements around screening, isolating and cohorting. The MOH also finally issued "COVID-19 Guidance for Long-Term Care Homes," for the first time giving comprehensive guidance to the sector. It came a full month after the first North American outbreak in long-term care, and eleven days after the first COVID-19 outbreak in Ontario. As a representative from the sector told the Commission, "It was only when the hospitals were clearly very stabilized and it was clear that Ontario wasn't going to have the hospital surge, that's when we were able to get our support." AdvantAge Ontario told the Commission that even in April, Homes could only access the provincial PPE supply if they were in outbreak.
- 126. On April 10, Good Friday, the OHA wrote to the Premier insisting on immediate action in LTC to prevent unnecessary loss of life. The OHA recommended that hospital workforces be mobilized to assist struggling Homes. 110 The following week, OH was directed to work with local hospitals to engage the hospital sector to support Homes on outbreak. 111
- 127. Finally, on April 15, the Government issued the "COVID-19 Action Plan: Long-Term Care Homes." The Action Plan set out a plan to support testing, screening and surveillance for residents and staff, manage outbreaks and spread of the disease, and grow the health care workforce. The government did not legally restrict health care workers in the long-term care sector to one workplace until April 22, and the rules excluded agency workers and other employees redeployed to long-term care from hospitals.
- 128. The Action Plan came too late. Half of the residents who would lose their lives to COVID-19 in the First Wave died before April 15. An Ontario study examining the impact of the one Home policy using anonymized mobile device location found that in the seven weeks before the pandemic, 42.7% of Homes had a connection with at least one other Home, compared to 12.7% in the seven-week period after the restriction. 112

<sup>&</sup>lt;sup>106</sup> Directive 5, March 30, 2020

<sup>&</sup>lt;sup>107</sup> Directive 5, April 10, 2020

<sup>108</sup> OLTCA supra note 85, at p. 45

<sup>&</sup>lt;sup>109</sup> AdvantAge *supra* note 86 16 at p. 30.

<sup>&</sup>lt;sup>110</sup> OHA *supra* note 79 at p. 21

<sup>111</sup> OH supra note 800 at p. 45

<sup>&</sup>lt;sup>112</sup> Science Briefs supra note 31 at p. 18

- 129. Ontario did not begin proactive testing of residents until April 22. 113 The results proved to be devasting. ONA members reported huge numbers of positive test results in many Homes. In their words:
  - When tested, there were more than 70 residents who were positive for COVID-19.
     That means staff were working with COVID-19 positive residents without PPE or even masks.
  - First tested en masse on April 20. Christine [Mandegarian-the first health care worker to die from COVID-19 in LTC] died on April 14. It was then that attitude changed.
  - On April 26, the staff and the residents were tested with the result being that 24 of my remaining 28 residents were COVID-positive and so was I.
- 130. After months of ignoring long-term care, when the government finally began to respond to the growing crisis, the response was unorganized and chaotic. Staff in the Homes, public health, and even enforcement officers had difficulty keeping up with the flurry of CMOH Directives, MOH and MLTC Guidelines, and PHO guidance, which was often contradictory. Different agencies interpreted these documents differently, further compounding the confusion. To make things worse, the government frequently issued new directions on Friday evenings, leaving weekend staff scrambling to understand and comply. Representatives from Revera described how "EMS came in and did the training of our staff on PPE at the announcement of our outbreak. The next day, the Public Health unit came in and contradicted everything that we were told. The next day, same health unit, different person, contradicted that."
- 131. On April 28, the Canadian Armed Forces ("CAF") received a request for assistance to provide humanitarian relief to five Ontario Long-Term Care Homes: Holland Christian-Grace Manor, Orchard Villa, Altamont, Eatonville Care Centre, and Hawthorne Place Care Centre. An additional two Homes, Downsview Long Term Care and Woodbridge Vista Care Centre, were added. CAF provided support until July 3. An initial report of findings on May 2 sent shock waves through the province: reports of inadequate IPAC measures, quality of care issues, inadequate medical supplies, grossly inadequate staffing, disturbing reports of Homes infested with cockroaches, trays with rotten food in the hallways, Homes with no civilian RN on shift.
- 132. It is unfortunate that it took a report from the CAF to focus attention on the gravity of the situation in long-term care when ONA's members and other front line health care workers had been sounding the alarm to anyone who would listen for months. The failure to listen to the voices of RNs and their clinical expertise led to delays in implementing measures that could have contained the spread of COVID-19 and saved many lives.
- 133. Faster government action and mandatory direction to long-term care may have saved many lives. Research by the Canadian Institute of Health Information shows that countries that

<sup>113</sup> Liu, s*upra* note 23

<sup>&</sup>lt;sup>114</sup> Long-Term Care COVID-19 Commission Transcript of Sienna Senior Living on October 9 at p. 14, *supra* note 16 at p. 92, *supra* note 17 at p. 60-61

<sup>&</sup>lt;sup>115</sup> Revera *supra* note 37 p. 51

issued specific, mandatory prevention measures such as broad long-term care testing and training, isolation wards, surge staffing, specialized teams, and PPE requirements <u>at the</u> same time as their stay-at-Home orders fared much better during the First Wave. 116

### The Saddest, Darkest Time: Homes Fail to Act

We didn't have the damn tools, they wouldn't give them to us, everything was reactive. Those who went through the First Wave said they will never do it again. Not because of the virus but because of how they were made to feel and the lack of resources and the lack of control over those resources.

### **Anonymous ONA Member**

The first day, I remember it vividly. We got a phone call that we have COVID in the building. I went in early and it was a war zone. Everyone was on high alert. I was trying to direct people because there were so many people that didn't want to come in. We were left with so few people in the building. We had the Chaplain providing care and recreation staff were acting as PSWs. Managers had to give meds because we had no schedule. It was wild, chaotic, unplanned and unorganized.

## **Anonymous ONA Member**

- 134. In this section, we outline key observations around failures of individual homes: a lack of preparedness, failure to implement key IPAC measures such as screening and testing, isolation and cohorting, a failure to develop staffing plans, and regressive practices around denying access to PPE. These issues still plague RNs today.
- 135. ONA members report that in the weeks leading up to the outbreaks in the First Wave, their Homes were not prepared. Generally, Long-Term Care Homes were slow to implement screening measures, visitor policies, and social distancing was not practiced. ONA members reported management held staff meetings, often in crowded rooms, and residents were still using common lounges and eating in common dining halls. PPE, which is normally available to staff at nursing stations or in open storage rooms, was being locked up. Nurses who tried to be proactive and wear masks were told they were wasting PPE or scaring residents, and in some cases were forbidden outright to use PPE.
- 136. In September 2020, ONA conducted a survey of our members who work in long-term care. 117 Nurses who responded to the survey provide a rich source of information on their experience during the pandemic. They provide compelling observations on what went right, what went wrong, what lessons we should learn. They gave us a picture of the dangerous and frightening work on the front lines. The depth, scope, and quality of the response of these RNs gives us a strong and candid insight into what actually happened. We have also

<sup>&</sup>lt;sup>116</sup> Canadian Institute for Health Information. *Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare With Other Countries?*. Ottawa, ON: CIHI; 2020, at p. 5.

<sup>&</sup>lt;sup>117</sup> This survey is similar to the one ONA developed during SARS which was provided to the SARS Commission to assist in its investigation. Justice Campbell found this information valuable, incorporating testimonials of RNs into the report. We have provided a copy of the COVID-19 survey to the Commission and hope it will be of similar value to you.

conducted one-on-one interviews with nearly 200 ONA members who worked in long-term care through the pandemic.

- 137. The evidence we have collected from our members shows that many, perhaps most, Long-Term Care Homes failed to prepare for potential COVID-19 outbreaks. Homes either failed to, or were slow to:
  - Conduct audits of their PPE supplies<sup>118</sup>
  - Begin screening of staff and visitors entering Long-Term Care Homes
  - Conduct preparatory education of staff on outbreak management, PPE use and other IPAC measures
  - Develop contingency staffing plans
  - Implement universal masking
  - Implement testing and screening programs for residents
- 138. In the Homes with early outbreaks, a common story is that the first positive resident was not suspected to have COVID-19 and was not tested at the onset of symptoms. Instead, they were not tested until the resident was admitted to hospital, orafter the resident's death. Many ONA members have told us in interviews that they repeatedly advocated for swabbing, but they were ignored. The Commission has heard that unlike in hospitals, there is not a system or culture of proactive surveillance and testing in long-term care. 120
- 139. The Homes were slow to implement procedures to isolate residents. Common lounges and dining halls remained in use, and residents were free to wander. Most Homes only have a single infirmary with the capacity of one bed to isolate residents. Once this infirmary bed was used, there is no space to isolate any additional symptomatic residents. If a symptomatic resident had roommates, they would inevitably be exposed.
- 140. Many RNs report attempting to implement isolation measures, only to be overruled by managers. One RN reported that she recommended to her Home's Director of Care ("DOC") that residents be isolated to their rooms after several residents in the Home tested positive. When the DOC proceeded to instruct an RPN that one of the wings of the Home did not have to be isolated, the RN sought advice from Public Health, who directed the DOC that if all residents were not placed in isolation, Public Health would issue an order.<sup>121</sup>
- 141. In many Homes, leadership i the Home were either unable or unwilling to implement IPAC measures such as cohorting residents. Some asserted curtains between ward room beds would be enough to stop the spread. RNs found themselves stymied by their employers when they tried to protect their residents and implement infection control measures. 122

<sup>&</sup>lt;sup>118</sup> See OH *supra* note 10

<sup>&</sup>lt;sup>119</sup> This was the case in several homes, including Stoneridge Manor, Anson Place and Altamonte

<sup>&</sup>lt;sup>120</sup> Johnstone and Kain, supra note 84 at p. 19

<sup>&</sup>lt;sup>121</sup> Affidavit of Tiffany Van Rompaey, ONA materials for Participating Homes Arbitration in front of Arbitrator John Stout, provided to the Commission, October 2020

<sup>&</sup>lt;sup>122</sup> *Ibid.* see also Long-Term Care COVID-19 Commission Transcript of Registered Practical Nurses Association of Ontario, September 25, 2020 at p. 65-66.

- 142. Homes lacked adequate supply of PPE, and what supply they did have was often locked away. RNs and other staff were required to reuse or extend the use of PPE meant for single use which was contrary to infection control standards. Use of N95 respirators was often forbidden, or staff required management's permission to use them.
- 143. Older, more crowded Homes where multiple-bed "ward rooms" are prevalent tended to experience the most severe outbreaks. As one RN described to the Commission, many of these rooms are so crowded that "residents can reach out from their beds and hold hands." Homes with older designs are more prevalent in the for-profit sector.
- 144. Most COVID-19 positive residents were not admitted to Hospital. Admission rates from long-term care to hospitals actually reached their lowest point in April when the overall incident rate of COVID-19 was highest. This is contrasted with admission rates greater than 30% in subsequent months. 124 We heard from interviews with ONA members that transfers to hospitals were discouraged, with one Home even instructing a NP to call families and actively discourage them to transfer their ailing family members regardless of the NP's actual assessment.
- 145. RNs and front-line staff were often the only people entering the Homes. At some Homes, managers did not attend their own facility during the outbreak. Other ONA members report that managers spent their days behind closed doors in meetings, never interacting with staff or residents, and doing nothing to help, even when staffing was so low that the front-line staff could barely keep residents fed, hydrated and changed.
- 146. Medical directors, pharmacists and funeral Home staff generally did not enter the Homes. 125 This increased the workload on RNs, who had to spend additional time communicating over the phone or with iPads with doctors and pharmacists to get physician orders and prescriptions. Registered staff were required to prepare dead bodies and remove them from the Home, which presented a high-risk situation and was particularly traumatic.
- 147. Some ONA members reported that after testing positive for COVID-19 themselves, they were pressured to return to work before it was safe for them to do so. 15% of ONA survey respondents report that they were required to return to work while still showing symptoms of COVID-19; 22% report that they were required to return to work before two weeks had elapsed since their first positive test, and 41% report that they were required to return to work before receiving two negative tests. 126
- 148. ONA and its members desperately tried to address the issues in their Homes. In our survey, 49% of all respondents said they raised concerns with their managers or with the JHSC. The number rises to 55% in Homes with outbreaks, and to 62% in Homes with uncontrolled outbreaks. <sup>127</sup> Often their concerns were ignored or met with resistance. ONA was required to intervene and threaten legal proceedings in order for the Home to act.

<sup>&</sup>lt;sup>123</sup> Long-Term Care COVID-19 Commission panel meeting with staff, Thursday Jan 22, 2021

<sup>&</sup>lt;sup>124</sup> Science Brief supra. Note 31 at p. 9

<sup>&</sup>lt;sup>125</sup> Where physicians continued to attend, made a difference in outcomes. See OHA *supra* note 79 at p. 79.

<sup>&</sup>lt;sup>126</sup> Survey Results, *supra* note 109 at p. 19

<sup>&</sup>lt;sup>127</sup> *Ibid.* at p. 23

- 149. As RNs recognized they were not safe at work, they escalated concerns to the MOLSTD to no avail. The MOLSTD reported a 200% increase in complaints since the start of the pandemic, including 351 complaints and 13 work refusals in the long-term care sector. 128 From mid-March to mid-April, it was ONA's experience that few, if any, complaints resulted in orders. MOLSTD inspectors conducted investigations by phone and took the Home's assertions of facts as truth. Often the person raising the complaint was not even interviewed.
- 150. As we outline in Part Five, ONA took extraordinary measures to seek enforcement of CMOH Directives and occupational health and safety standards, including seeking an injunction at several Homes. In the resulting decision, Justice Morgan ordered the four respondent Homes to respect a nurse's PCRA, provide N95 respirators, and to comply with cohorting and other IPAC measures required under the Directives. Justice Morgan recognized that the access to PPE was a public safety issue:

One need only read the affidavits of the individual nurses in this Application record to understand that they spend their working days, in particular during the current emergency situation, sacrificing their personal interests to those of the people under their care. And given the nature of the pandemic, they do this not only for the immediate benefit of their patients but for the benefit of society at large. To suggest that their quest for the masks, protective gear, and cohorting that they view as crucial to the lives and health of themselves and their patients represents a narrow, private interest seems to sorely miss the mark. 129

- 151. Some Homes managed to control outbreaks and avoid the devastation. Of the Homes that experienced an outbreak during the First Wave, more than half managed to limit the outbreak to 5 or fewer residents infected. <sup>130</sup> The data from ONA's survey shows that these Homes were more likely to:
  - Have adequate supplies of PPE
  - Place fewer restrictions on PPE access
  - Maintain better staffing levels
  - Promptly isolate symptomatic residents
  - Cohort positive residents and staff<sup>131</sup>

### Iron Ring Was Never Built

I feel that the government and my employer let my sector down. They failed to protect us, we should not have had to fight and continue to fight for PPE. SARS taught to us highest level of protection until evidence shows that it is not needed. Long-term care was not provided with the basics and even today N95 are in limited supply. Government is making decisions without frontline workers at the table. The Second Wave is coming and they are still not prepared.

<sup>&</sup>lt;sup>128</sup> Long-Term Care COVID-19 Commission, Transcript of Ministry of Labour, Training, Skills and Development, October 20, 2002, at p. 26

<sup>129</sup> Ontario Nurses' Association v. Eatonville/Henley Place, 2020 ONSC 2467 at para. 93.

<sup>&</sup>lt;sup>130</sup> Provincial data, *Supra* note 74 and ONA Survery *supra* note 109.

<sup>&</sup>lt;sup>131</sup> ONA Survey, *ibid.* 

- 152. The Second Wave of COVID-19 in long-term care is proving to be even more deadly than the first. Despite the promise of an "iron ring," on January 11, the Second Wave surpassed the peak of the First Wave. The Second Wave may not have yet reached its peak, and with the new, more virulent mutation detected in at least three Homes, it is difficult to predict how devastating the Second Wave may prove to be.
- 153. Many of the mistakes of the First Wave are being repeated. In ONA's interviews with members, and through the panel meetings the Commission is conducting with staff, the same story is being told: Homes are unprepared, staffing levels are decimated, test results are too slow, Homes are still failing to isolate and cohort, and failing to provide ready access to N95 respirators and other PPE, and government guidance and directives are still unclear and inconsistent.
- 154. An Ontario Health Coalition survey of staff in Homes on outbreak released on December 18 showed:
  - Over 64% of respondents said they did not have adequate staffing levels;
  - 25% said they lacked access to adequate PPE;
  - Over 14% said COVID-positive residents were not separated from negative residents;
  - 25% said they did not have enough staff to stop residents from wandering from safe areas to COVID-19 hot areas;
  - Over 14% said asymptomatic COVID-positive staff were required to work.<sup>132</sup>
- 155. The approval of the Pfizer and Moderna vaccines by Health Canada in December of 2020 brought a welcome ray of light when a PSW from long-term care received the first vaccine on December 14<sup>th</sup>. Since that promising start, the vaccine roll out in long-term care has been plagued by issues. Ontario is lagging behind Alberta, British Columbia and Quebec in vaccinating residents.<sup>133</sup> This despite the fact that Ontario had enough doses at the end of 2020 to vaccinate all long-term care and retirement Home residents.<sup>134</sup> As Doctors Stall and McGeer explained on January 19<sup>th</sup> to the Commission, the problems appear to be due to poor planning, prioritization and coordination, rather than supply.<sup>135</sup> Preparatory work in the Homes, such as providing the information necessary for residents and substitute decision makers to give informed consent to vaccination, was delayed.<sup>136</sup> Modelling presented by Dr. Stall based on infection rates in January showed that vaccinating all residents by January 21 would have prevented around 3,700 cases, and around 750 deaths, whereas the Province's current plan will only prevent around 2,000 cases and 400 deaths.<sup>137</sup>

<sup>&</sup>lt;sup>132</sup> Ontario Health Coalition https://www.ontariohealthcoalition.ca/index.php/report-covid-19-second-wave-survey-of-staff-in-long-term-care-Homes-with-large-outbreaks/

<sup>133</sup> Stall and McGeer, supra note 55 a p. 7-8

<sup>&</sup>lt;sup>134</sup> *Ibid.* at p. 17

<sup>&</sup>lt;sup>135</sup> *Ibid.* at p. 13

<sup>&</sup>lt;sup>136</sup> *Ibid.* at p. 20-28

<sup>&</sup>lt;sup>137</sup> *Ibid.* at p. 40-41

## PART FOUR: THE TWO SOLITUDES — INFECTION CONTROL AND HEALTH AND SAFETY

There were during SARS two solitudes: infection control and worker safety. Infection control relies on its best current understanding of science as it evolves over time. It is unnecessary to point out again that infection control failed to protect nurses during SARS. Worker safety relies on the precautionary principle that reasonable action to reduce risk should not await scientific certainty. 138

### **Justice Campbell, SARS Commission Report**

156. A key lesson not learned from the SARS report was the need to bridge the gap between IPAC and worker safety: Justice Campbell's "two solitudes." Throughout the COVID-19 pandemic, the same mistakes have been repeated. The reality is, preventing worker infection is one of the best ways to protect residents, and vice versa.

## The Precautionary Principle

- 157. The precautionary principle simply means that reasonable steps to reduce risk should not await scientific certainty. It is a concept that is well known in the realm of occupational health and safety. Despite Justice Campbell's extensive discussion of the precautionary principle and recommendations in the SARS report, this Commission was told in a briefing on the CMOH and the *HPPA* that the precautionary principle is not well-known in the health sector.<sup>139</sup> The lessons of SARS were not learned.
- 158. The failure to apply the precautionary principle can be seen at all levels of the response to COVID-19, from preparation, through the hierarchy of controls, and down to the contentious issue of worker PPE.
- 159. One of the most intensely debated applications of the precautionary principle is with respect to the level of precautions health care workers should apply: droplet precautions versus airborne precautions. The scientific community increasingly recognizes airborne spread of SARS-CoV-2, yet at the level of IPAC policy and practice in Ontario, we see a steadfast conservatism clinging to outdated orthodoxy about droplet versus airborne spread. In a recent piece in the Journal Clinical Infectious Diseases, the authors wrote:

Perhaps the biggest surprise about the issue of airborne spread of SARS CoV-2 is that it has been surprising to so many people. From the beginning of the epidemic, the ability of the virus to spread from person to person has been regularly downplayed by public health officials despite clear evidence of exceptional transmissibility, from the initial explosive spread in Wuhan to its rapid dissemination across China and to the rest of the world. A key lesson learned from this pandemic is that the distinction between "droplet" and "aerosol" spread is a

<sup>&</sup>lt;sup>138</sup> SARS Commission *supra* note 1 Volume 2 at p. 10

<sup>139</sup> CMOH/HPPA supra note 70 at at p. 46

false dichotomy that is inconsistent with contemporary knowledge about respiratory aerosols.<sup>140</sup>

- 160. Some jurisdictions, like China, learned the lessons from SARS. Initially China followed recommendations from the World Health Organization advising that COVID-19 was spread via droplets and contact and therefore surgical masks were sufficient. After observing a spike in health care worker infections, the National Health Commission of China acted on a precautionary basis, issuing a directive requiring all health care workers in contact with suspect or confirmed COVID-19 cases to wear airborne precautions, including N95s.
- 161. As we discuss in more detail below, an airborne virus has the potential to become particularly deadly in the type of environment found in many Ontario long-term care homes: congregate care settings in crowded buildings built to outdated-design standards and lacking modern ventilation systems. This is something engineers and aerosol scientists have increasingly warned government about.<sup>141</sup>
- 162. Infectious disease outbreaks are not new in long-term care. Homes deal with outbreaks all of the time. Some Homes coped with COVID-19 outbreaks well, and were able to limit the spread of infection showing that outbreaks did not have to spread like wild-fire. Leadership in the homes made a significant difference as to whether or not the Homes were able to contain a COVID-19 outbreak. The Homes that did well had leaders who ensured that the home was adequately prepared, and took an active role guiding their staff to ensure IPAC and health and safety measures were properly implemented. The Homes that did not contain their outbreaks did not.

### **Preparation**

They were not prepared. I asked to see their pandemic plan in January of this year and they did not have one.

### Anonymous ONA Member

We are currently in outbreak... A lot of confusion about what to do and how to do it... We could have been so much more prepared if she had listened to me... I like to be proactive. I still see people donning PPE wrong.

## **Anonymous ONA Member**

- 163. LTC Homes are required to have an IPAC program under subsection 86(1) of the *LTCHA*. Section 229 of O. Reg. 79/10 prescribes the requirements of the program, which include:
  - Annual evaluation of the program (subsection 229(2)(d);

<sup>&</sup>lt;sup>140</sup> Fang, Ferric C. *et. al.* "COVID-19—Lessons Learned and Questions Remaining", *Clinical Infectious Diseases*, Received 3 October 2020; editorial decision 21 October 2020; published online 26 October 2020, <a href="https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1654/5940148">https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1654/5940148</a> at P. 1-3.

<sup>&</sup>lt;sup>141</sup> Open letter to Christine Elliot, Dr. David Williams and Dr. Brian Schwartz dated November 24, 2020. A copy was provided to the Commission as an enclosure to ONA's letter of December 22, 2020.

- Designating a staff person who has education and experience in IPAC to coordinate the program (subsection 229(3));
- An outbreak management system and a written plan for responding to infectious disease outbreaks (Subsection 229(8)(a)&(b).

The regulation does not prescribe training for staff on IPAC or require a PPE stockpile.

- 164. ONA's survey data suggests that there is a correlation between preparatory measures and how Homes fared in a COVID-19 outbreak. Homes that took preparatory steps such as educating staff on IPAC measures and fit-testing staff for N95s in January-March of 2020 tended to experience smaller outbreaks. 142
- 165. More concerning, ONA's survey data suggests a significant number of Homes did not have IPAC programs prior to the pandemic, or if they did, staff were not aware of them. 18% of respondents said either their Home had no IPAC program, or they didn't know if their Home had an IPAC program. Homes that managed to contain their outbreak were 8% more likely to have an IPAC program than Homes that experienced an uncontained outbreak.
- 166. Dr. Shelley Deeks, advised the Commission that although PHO provides IPAC courses and resources, Long-Term Care Homes were not required to access them. Ms. Deeks noted that PHO conducted IPAC assessments in Long-Term Care Homes and that they found that the Homes and MTLC inspectors did not demonstrate the capacity to assess IPAC practices against existing guidance, nor did individuals within the Homes have the knowledge to conduct such an assessment. Market PHO provides IPAC practices against existing guidance, nor did individuals within the Homes have the knowledge to conduct such an assessment.
- 167. It is impossible to know whether Homes were in compliance with the requirements of section 229 at the start of the pandemic, because of a policy change at the MLTC in 2018 which largely discontinued comprehensive Resident Quality Inspections ("RQI"). Under the new policy, complaint or critical incident inspections were considered sufficient to meet the requirement that every Home be inspected annually. <sup>147</sup> Only approximately half of all Homes received an RQI in 2018, and only nine in 2019. <sup>148</sup> Residents and families are rarely going to complain about infection control meaning these issues are not often inspected. <sup>149</sup>
- 168. As previously discussed, only limited guidance or direction was issued to Homes by the government in the months leading up to the pandemic. There was no requirement that Homes conduct preparatory risk assessments, or develop contingency plans. The MLTC did not engage in proactive inspections to assess the state of readiness in the Home, and the MOLSTD's proactive inspections were limited. To the extent that any Homes were prepared, they prepared on their own initiative.

<sup>&</sup>lt;sup>142</sup> ONA Survey, supra note 109

<sup>&</sup>lt;sup>143</sup> ONA Survey, supra note 109 at p. 20

<sup>&</sup>lt;sup>144</sup> *Ibid.* at p. 21

<sup>&</sup>lt;sup>145</sup> Deeks, supra note 48 at p.22

<sup>&</sup>lt;sup>146</sup> *Ibid.* p. 27-28.

<sup>&</sup>lt;sup>147</sup> MLTC Inspections, supra note 92, P. 1-3.

<sup>&</sup>lt;sup>148</sup> Pedersen, Katie *et. al.* "Ontario scaled back comprehensive annual inspections of nursing homes to only a handful last year" CBC April 15, 2020 <a href="https://www.cbc.ca/news/canada/seniors-homes-inspections-1.5532585">https://www.cbc.ca/news/canada/seniors-homes-inspections-1.5532585</a>

<sup>&</sup>lt;sup>149</sup> ACE s*upra* note 87 at p. 18

#### **Hierarchy of Controls**

Started screening the staff later. It was delayed. Also, no screening or COVID testing of residents. So we didn't know who was positive and who is negative...

#### **Anonymous ONA Member**

We didn't have normal housekeeping staff. We had friends and cousins doing housekeeping. They were cleaning garbage and messes just trying to Clorox everything. The Home would tell them, thanks for coming, now go figure it out.

#### Anonymous ONA Member

- 169. The concept of the hierarchy of controls arises from occupational health and safety literature. There are five levels of control, with the highest levels being the most effective:
  - 1) Elimination-physically remove the hazard
  - Substitution-replace the hazard
  - 3) Engineering controls-isolate people from the hazard
  - 4) Administrative controls-change the way people work
  - 5) PPE-protect the worker with personal protective equipment
- 170. While PPE is the last control, for health care workers, it is critically important. The nature of their work requires them to come within 2 meters of "the hazard"—suspected or confirmed COVID-19 positive residents requiring care.
- 171. Elimination and substitution tend to be the most difficult to implement. When the hazard is a virus, elimination includes vigorous measures to test and screen staff and visitors to reduce the chances that the virus enters the workplace. Eleven months into the pandemic, testing remains an issue in long-term care. Swabs from staff and residents are not prioritized for testing. Delays in receiving test results has been an issue throughout the pandemic, with no real improvement seen in the Second Wave. It often take 5-7 days for test results to be received. While long-term care operates 24 hours a day, 7 days a week, 365 days a year, labs do not. ONA members have reported in interviews that some of the current outbreaks started over the Christmas and New Year's holidays, and that test results were delayed due to lab closures on statutory holidays.

#### **Engineering Controls**

I was the person who made sure that residents were put in isolation. When we don't have isolation rooms, I put them down in a lounge that can be used as an isolation room. I get the PSW to move the chairs out of the room, I get the appropriate PPE in there for the staff

<sup>&</sup>lt;sup>150</sup> National Institute for Health and Safety, https://www.cdc.gov/niosh/topics/hierarchy/default.html

<sup>&</sup>lt;sup>151</sup> Etches, *supra* note 89 at p. 19

<sup>&</sup>lt;sup>152</sup> Long-Term Care COVID-19 Commission Transcript of Ontario Long-Term Care Clinicians, September 30, 2020 at p. 64, Long Term Care COVID-19 Commission Transcript of Dr. Kyle, October 2, 2020, p. 19-20, OHA *supra* note 79 at p. 80 and 95, Revera *supra* note 37 at p. 76, AdvantAGE *supra* note 86 at P. 16-21 Sienna, *supra* note 106 p. 25

and garbage buckets. When I do the transfer I put a mask on the patient, transfer the bed down the hall to the new isolation room. After I do the transfer I tell management what I did, and they respond, "okay." I am knowledgeable about infection control practices and I know you cannot have anyone with a respiratory infection in a four-bed ward.

#### **Anonymous ONA Member**

No proper isolation technique in place. Home is one open level... My resident died end of March from COVID... Patient was not isolated at all. She was in four-bedroom ward where everyone was exposed. Every single resident in that room came down with COVID and two out of four died.

#### **Anonymous ONA Member**

Isolation came really late. The initial resident we had an infirmary that was usually used for palliative residents. Once others got sick, there wasn't a place for them.

- 172. Design standards of long-term care facilities in Ontario are classified based on the structural requirements of the time. Older design standards, known as C and D, are associated with smaller room sizes, shared bathroom facilities and smaller rooms. In particular, C and D Homes contain ward rooms with as many as four beds and a shared washroom. Approximately 60% of all residents in long-term care are housed in shared rooms, and a quarter of all licensed beds in Ontario are in quadruple-bedded rooms. A recent study found that residents in crowded Homes were more than twice as likely to become infected with and die from COVID-19 compared to residents in less-crowded Homes. <sup>153</sup> Older Homes are much more likely to be privately owned.
- 173. Homes built to pre-1999 design standards are more likely to have additional design flaws that made it difficult for staff to isolate infected residents:
  - Simple design issues like the absence of doors that could be closed between wings or units made it difficult to contain residents prone to wander.<sup>154</sup>
  - The square footage per resident is vastly improved in newer design standards, from 350 square feet per resident in the pre-1980 standards, to 600 square feet in the current standards. <sup>155</sup>
  - Most Homes typically have at best one infirmary with one bed that can be used to isolate a resident with a potential communicable disease. While all hospitals have negative pressure rooms, they are unheard of in LTC Homes.
  - Newer Homes tend to be set up in 32 bed units, with separate dining halls for the unit. When staffing levels are adequate, staff can be assigned to a single unit. In

<sup>&</sup>lt;sup>153</sup> Brown, "Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada", *JAMA Intern Med. doi:10.1001/jamainternmed.2020.6466 Published online November 9, 2020 p.* E3-E7

<sup>&</sup>lt;sup>154</sup> Affidavits of ONA members, supra note 113.

<sup>155</sup> Sienna, supra note 106 at p. 24

- the event of an outbreak, this model makes it easier to contain the outbreak and not have infection spread to the broader resident population. 156
- Older Homes often have large wings with up to 100 residents, and common dining facilities. Residents have to use common elevators to move around the building.
- 174. Aerosol scientists and engineers have increasingly called for ventilation standards to be incorporated into COVID-19 prevention measures. 157 It is doubtful that many Long-Term Care Homes, particularly older Homes, meet ventilation recommendations for fresh air exchange. To date, little guidance or support has been provided to Homes regarding ventilation.

#### Administrative Controls

Employer was not listening to registered staff. I remember people having symptoms, and I was saying this person should be isolated to prevent them from coming and going as they want. But he was still allowed to go around and two weeks later he had a crazy high fever and tested positive, that is when they isolated. We were also saying too many residents with too much proximity, they shouldn't be there. The Home didn't try to start sending residents to the Hospital until around May.

#### **Anonymous ONA Member**

I believe the layout had a huge impact in stopping the spread of COVID-19. Any residents testing positive were moved to the back of a Home which is typically used for rentals for family gatherings or outpatient physio. Having a separate entrance to this area for the employees working with the positive patients and being in private rooms completely separate from other residents I believe stopped the spread.

- 175. The first administrative control that PHO recommends in its "Infection prevention and control for Long-Term Care Homes" guide is ensuring that there is a clear expectation on staff to not come to work ill with symptoms that are of an infectious origin. 158 ONA's survey reveals that during the First Wave, this advice not heeded with many respondents indicating that they were required to attend work while still symptomatic, before two weeks had elapsed since a positive test, or before two negative test results. 159
- 176. Sick pay for workers has been widely touted by politicians, physicians and academics as an important administrative control to encourage workers to stay Home when sick. In 2019, amendments to the Employment Standards Act removed mandatory sick days for employees, and to date nothing has been implemented to reinstate sick pay.

<sup>&</sup>lt;sup>156</sup> *Ibid.* p. 24

<sup>&</sup>lt;sup>157</sup> Open Letter, *supra* note 104

<sup>158</sup> Ontario Agency for Health Protection and Promotion (Public Health Ontario), Infection prevention and control for Long-Term Care Homes: summary of key principles and best practices. Toronto, ON: Queen's Printer for Ontario; 2020, at p. 37

<sup>&</sup>lt;sup>159</sup> ONA Survey, *supra* note 109 at p. 19

- 177. Isolating patients in single-patient rooms is always indicated for patients placed on airborne precautions, and is preferred for patients who require contact or droplet precautions. 160 During the pandemic, Homes put forth an unusual definition of "isolating" residents, arguing that "isolating" meant keeping residents in their rooms, even where the resident who is suspected or confirmed to have COVID-19 has one or more roommates, rather than moving residents so that the suspected or confirmed positive case is separated from others. With the growing evidence of the significance of airborne transmission, curtains or even temporary partial walls between beds are hardly inadequate protection in shared rooms.
- 178. Cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with others. Cohorting is implemented when infection control practices (screening, testing, isolating) have failed to control an outbreak.<sup>161</sup>
- 179. Directive 3, issued under s. 77.7 of the *HPPA*, requires Long-Term Care Homes to have a plan for, and to use to the extent possible, staff and resident cohorting. For residents, this may include alternative accommodation within the Home, cohorting residents by COVID-19 status, utilizing respite and palliative care beds and rooms, and utilizing other rooms. For staff, this may include designating staff to work only with specific cohorts of residents based on the residents' COVID-19 status. The direction to cohort was added to Directive 3 in a March 30, 2020 revision and has remained in all subsequent versions of the Directive.
- 180. As we discuss in Part 5, the failure of many Homes to cohort residents and staff in the First Wave was the subject both of ONA's application for an injunction in *Eatonville*, and of the participating Homes' arbitration in front of Arbitrator John Stout. ONA's struggles with enforcement are continuing into the Second Wave, with some homes still failing to isolate and cohort residents immediately.
- 181. Our interviews with members working in Homes experiencing Second Wave outbreaks reveal that the failure to isolate and cohort remains an ongoing issue. This has also been reflected by staff participating in the confidential panels with the Commission who have described Homes that are unprepared, overwhelmed and unable to cope with the outbreak. Despite months of preparation, the mistakes of the First Wave are playing out all over again.

#### Personal Protective Equipment

We were not given the keys to access anything and management was not in the building. I went digging through everything for PPE, including the designated housekeeping closet. In the past, the emergency backup supply mandated by MLTC for this type of situation was that it used to be kept in the back of the housekeeping closet. No clue where it was moved to until around three-quarters of the way through the Outbreak.

<sup>&</sup>lt;sup>160</sup> Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) Centers for Disease Control and Prevention, <a href="https://www.cdc.gov/infectioncontrol/guidelines/isolation/prevention.html">https://www.cdc.gov/infectioncontrol/guidelines/isolation/prevention.html</a>
<sup>161</sup> *Ibid*.

When we were declared COVID outbreak I refused work as I was denied any mask even if I supplied my own. I was told I would be escorted off the property if I wore a mask at work. I was only permitted to use surgical mask for people in isolation. I had many conversations with management about how the residents were being put at risk. Denied use of any PPE until government implemented. N95 denied use and all locked in undisclosed location.

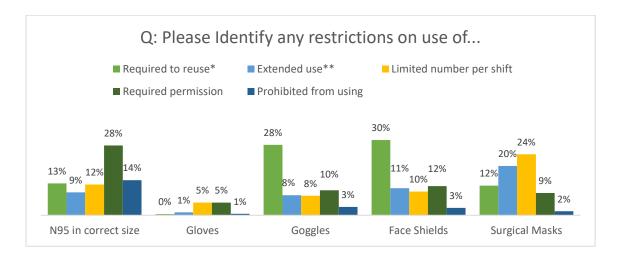
- 182. Controlling the hazard at the level of the worker through proper use of PPE is the <u>last</u> line of defense under the hierarchy of controls, however, for health-care workers it is a critical control because close contact cannot be avoided in providing care. Appropriate PPE has been one of the most contentious and problematic issues for workers in long-term care during the pandemic.
- 183. Whether or not a Home had appropriate PPE supply was a question of the Home's leadership: some maintained stock, some did not. 162 While some private chains boasted of maintaining a week's supply in their facilities, 163 this proved to be grossly inadequate in the face of a global pandemic which taxed global supply chains and which will continue for some time.
- 184. PPE shortages during the First Wave were a serious issue. Neither individual Homes nor the province had adequate supplies. As discussed above, Ontario went into the pandemic with virtually no stockpile of vital PPE. ONA's survey data shows that Homes that experienced outbreaks during the First Wave experienced alarming shortages of PPE:
  - 17.5% report no supply of gloves for a brief time or longer:
  - 35.6% report no supply of gowns for a brief time or longer
  - 35.3% report no supply of goggles for a brief time or longer
  - 39.3% report no supply of face shields for a brief time or longer
  - 28.9% report no supply of surgical masks for a brief time or longer
  - 49% report no supply of N95s for a brief period of time or longer<sup>164</sup>
- 185. During the second wave, the provincial government has repeatedly stated there is no longer an issue with PPE supply. Despite this, some of ONA's members have reported that their Homes do not have a sufficient supply, and the union has had to press Homes to make additional efforts to acquire PPE from either the government or other sources.
- 186. Access to PPE needs to be understood as a separate issue from supply. Many Homes restricted access to PPE, such as locking up the supply. Nurses have described complicated procedures to access PPE such as having to call an after-hours manager to gain access to a code, which unlocked a locked box, which contained a key to a locked room of PPE supplies. 165 Some of the limitations on PPE supply reported in the ONA survey include:

<sup>&</sup>lt;sup>162</sup> OH *supra* note 80 p. 35

<sup>&</sup>lt;sup>163</sup> Sienna *supra* note 106

<sup>&</sup>lt;sup>164</sup> ONA Survey Report *supra* note 109 p. 28. A "brief time" was defined in the survey as 1-2 days without supply. Even a day without critical PPE is a serious concern in the midst of an outbreak.

<sup>&</sup>lt;sup>165</sup> Eatonville affidavits, *supra* note 113



- 187. In their meeting with the Commission on October 20, representatives of the MOLSTD made a point of stating that Ontario was the only jurisdiction at the beginning of the pandemic to require N95s. What the MOLSTD representatives failed to clarify for the Commission is that PHO downgraded its recommendation to droplet precautions in its March 10 technical brief. This was the day before the WHO declared COVID-19 a pandemic, and a week before Ontario declared a state of emergency. On the basis of the technical brief, most health care employers began denying employees access to N95s, and MOLSTD inspectors refused to consider whether the technical brief met the requirements under *OHSA* to take every precaution reasonable in the circumstances.
- 188. As we outlined previously, access to N95s has been a struggle for nurses and other healthcare workers throughout the pandemic. While Directive 5 ostensibly put the decision to use an N95 in the hands of RNs by giving them the ability to determine their PPE needs through the PCRA, many employers latched on to the word "reasonable" and denied N95s to nurses, substituting the employer's determination of reasonable for the nurses'. Even after the word "reasonable" was removed, employers still tried to control when a N95 could be used. As we discuss in the next section, this was the subject of ONA's enforcement remains an ongoing issue. Even where nurses are not denied N95s outright, they are pressured by managers telling them that N95s are not needed in Long-Term Care Homes despite the prevalence of respiratory generating behaviours, conditions, and symptoms and cognitive conditions that prevent residents from adhering to infection control practices.
- 189. While health care workers continue to struggle for N95s, the evidence that SARS-CoV-2 is airborne has continued to mount. In recent weeks, several European countries recently made filtering facepiece respirators, which are equivalent to N95s, mandatory for the general public. A manuscript recently accepted to the journal *Open Forum Infectious Diseases* reports for the first time SARS-CoV-2 nosocomial infection of healthcare workers, despite proper use of droplet precautions including surgical masks and physical distancing, strongly suggesting aerosol transmission.<sup>166</sup>

<sup>&</sup>lt;sup>166</sup> Goldberd, Lotem *et. al. SARS-CoV-2 infection among healthcare workers despite the use of surgical masks and physical distancing - the role of airborne transmission*, Open Forum Infectious Diseases, ofab036, <a href="https://doi.org/10.1093/ofid/ofab036">https://doi.org/10.1093/ofid/ofab036</a>, January 27, 2021

- 190. Anecdotally, ONA members in the Homes where the new, more virulent strain of COVID-19 has been found are reporting that the only workers who have not contracted COVID-19 are those who are insisting on wearing an N95 based on their PCRA.
- 191. There is no more time to delay in requiring mandatory use of N95s. The health and lives of workers and residents are at stake.

#### Leadership

Leadership has been isolating themselves in their offices. They explained that this was to limit their exposure to COVID-19; however, it made front line staff feel as if members of management were hiding in their offices while front line staff continued to work and risk their health. It has created a "them and us" environment between front line and management staff with the RNs being the go-between.

- 192. In addition to the serious staffing crisis and issues with PPE, ONA members have consistently pointed to a lack of leadership as a factor in the extent of the outbreaks. The leadership failures fall in to two main categories: (1) failure to proactively prepare, educate and communicate, and (2) failure to implement IPAC and health and safety measures.
- 193. Nurses have told us that their attempts to prompt managers to prepare and implement IPAC measures were often rebuffed. Our members have recounted many stories of their efforts to get the leaders in their Homes to act: they suggested screening visitors weeks before Directive 3 was first issued, they recommended adding extra handwashing stations, they read the literature on masking and asked if they could wear masks, they discussed preparing party rooms and activities rooms as extra isolation spaces. Too many times, RNs were ignored. In some cases, they were told they were over-reacting or fear-mongering.
- 194. Many Homes continue to lack infection control expertise. In the 1999 Central Park Lodge coroner's inquest into an influenza A outbreak that killed 18 residents, the jury recommended that Long-Term Care Homes should have an infection control practitioner on staff. Those Homes that did have IPAC leads rarely had someone with the proper qualifications or someone who was given the authority to make decisions on infection prevention and control.
- 195. An IPAC specialist is a designation recognized by the Canadian Nursing Association. The designation requires a Certification of Infection Control, which requires coursework, on-the-ground training, and a certification exam. <sup>168</sup> An IPAC specialist is not merely someone who has taken a few webinar courses. <sup>169</sup> Despite this, ONA members report that many Homes are creating new IPAC lead roles and assigning them to RPNs rather than to RNs with the appropriate science-based education and designation.

<sup>&</sup>lt;sup>167</sup> Central Park Lodge, supra note 2

<sup>&</sup>lt;sup>168</sup> Johnstone and Kain *supra* note 89 p. 44.

<sup>&</sup>lt;sup>169</sup> Deeks *supra* note 48p. 29

- 196. A survey conducted by the Registered Nurses' Association of Ontario in December 2020 revealed only 15% of Homes have a staff member fully dedicated to IPAC. 30% indicated their IPAC lead has no formal training.<sup>170</sup>
- 197. In order to have a meaningful IPAC program, every Home needs to have a dedicated IPAC lead with the proper education. As Dr. Vera Etches told the Commission, IPAC "really requires ongoing oversight and reinforcement. That means leadership and IPAC supervision really needs to be there seven days a week if not 24/7."<sup>171</sup>

#### PART FIVE: DESPERATE MEASURES—ONA'S QUEST FOR ENFORCEMENT

- 198. ONA continues to fight throughout the pandemic to find a way to ensure that collective agreement obligations, the *Occupational Health and Safety Act* ("OHSA") government directives and orders are enforced. Without an effective and efficient enforcement mechanism, protections offered by the directives are meaningless and ONA's members and the residents they care for are at heightened risk.
- 199. We first began to hear from our members in late March that Long-Term Care Homes were failing to isolate and cohort residents. Positive and negative residents were being "isolated" in the same room, with only flimsy curtains drawn around the bed. PPE was of poor quality, inaccessible, or simply non-existent.
- 200. Initially, members called either the MLTC to report the failure to isolate as abuse or neglect, or the MOLSTD to report that their employer was not taking "every precaution reasonable in the circumstances for the protection of a worker" contrary to section 25(2)(h) of the Occupational Health and Safety Act ("OHSA")
- 201. Calls to the MLTC were not responded to with any sense of urgency. One member reported that she was told by an inspector that her employer was "doing their best" and no findings of non-compliance were made.
- 202. The MLTC is also limited in what it can do because they can only make orders related to compliance of the Act. On December 24, 2020, ONA's Chief Executive Officer, Beverly Mathers, made a series of emergency calls and emails to the MOH, the MLTC and OH regarding Banwell Gardens, a home in outbreak in Windsor. She was asking for immediate assistance to be sent to the Home because there was only 1 RN and 1 PSW working with 132 residents. Over a month later, on January 29th, Ms. Mathers received a phone call from a MLTC inspector. The inspector asked why Ms. Mathers had not called the MOL "action line." Ms. Mathers replied that because there was 1 RN in the building, the Home was technically in compliance with the Act. The inspector agreed and said that she would not be able to make a finding of non-compliance against the Home, despite it being so short-staffed. The only way around it would be to cite the Home for resident abuse or neglect.

<sup>&</sup>lt;sup>170</sup> https://www.newswire.ca/news-releases/nurses-urge-dedicated-funding-for-infection-prevention-and-control-to-combat-wave-of-covid-19-outbreaks-in-long-term-care-Homes-843211526.html

<sup>&</sup>lt;sup>171</sup> Etches, *supra* note 89 p. 13.

- 203. Calls to the MOLSTD were equally ineffective with few orders being written in March and April. An anonymous ONA member described her experience on the survey: "It is totally (sic) incompetence. Everybody I spoke at the Ministry of Health and Ministry of Labour sided with the Employer. Nobody was listening to the worker's voice. Why isn't anybody listening?"
- 204. Several flaws with the MOLSTD's process became obvious very quickly. First, all inspections in long-term care were conducted by phone between March 16 and April 28. Phone inspections were futile. As just one example, at Anson Place, inspectors conducted at least two phone inspections, repeated assurances made by management that they were compliant, and issued no orders. Following a mediation on April 23, 2020 between SEIU, ONA and the MOLSTD at the Ontario Labour Relations Board, inspectors began to conduct in-person inspections. On the first visit, the inspectors observed a number of violations of the Act and issued orders.
- 205. Even the MOLSTD agreed that in-person inspections were more effective:

Even though we were engaging the worker side of the joint health and safety committee during these virtual visits, we felt that being there in person, starting from entering at the front door and walking through the screening process and so on, and being able to see visibly and ask questions of various workplace parties, not just those that are engaged in the phone conversation, were a lot more effective at identifying hazards or contraventions in the workplace, deficiencies, that we may not be able to see or hear about over a virtual or telephone call.<sup>172</sup>

- 206. Despite this, ONA recently learned that on January 25, a MOLSTD inspector attended at Extendicare Kapuskasing, but would not enter the building. Instead, the inspector asked the Director of Nursing to take pictures, which the inspector reviewed while sitting in the parking lot. The Home was in the midst of a serious outbreak. How can hazards and breaches of the Act be identified from still photos, which could be staged and not reflect what is actually happening in the Home? This is just a different form of remote inspection. The fact that it is still occurring eleven months after the start of the pandemic is difficult to fathom.
- 207. Second, inspectors took the position that employers had taken every precaution reasonable in the circumstances if they were compliant with CMOH directives. Since many of the measures recommended in the directives were not mandatory in late March and early April, few, if any, orders were written. Section 77.7 of the HPPA, the section under which the Directives were issued, provides that if there is a conflict between the section and the OHSA, that OHSA prevails. Inspectors treated it as if it were the other way around. Directives were treated as a health and safety ceiling instead of a floor.
- 208. Third, ONA heard from multiple inspectors that they were required to consult with a committee before they could issue any orders. Shortly thereafter, The Toronto Star published an article in which sources confirmed that an internal committee, the COVID-19 Advisory Committee, was vetting reports and orders before they were issued.<sup>173</sup>

<sup>173</sup> The Toronto Star "Many Ontario workers are trying to refuse work due to COVID-19 fears-but the government isn't letting them." April 27 2020.

<sup>&</sup>lt;sup>172</sup> MOLTDS *supra* note 121 pp.61-62.

- 209. Fourth, MOLSTD inspections are not always timely, particularly those involving a critical injury. The MOLSTD was notified after Brian Beattie an RN employed at Kensington Village, died in May, and has not yet completed its investigation. How can the workplace be made safer for those workers left behind if it takes more than 9 months to receive a final report?
- 210. Receiving no meaningful assistance with enforcement from the MLTC or the MOLSTD, ONA turned to public health, sending a letter to the LMOH for the Haldimand Norfolk Health Unit on April 9. ONA advised the medical officer of health that Anson Place, which was in a serious outbreak, was violating Directive 3 by not cohorting and isolating residents. A few hours later, ONA received a brief email response, stating that the public health unit was working closely with the leadership team of Anson Place. A letter from the Executive Director of Anson Place was enclosed, assuring ONA that the safety of residents and employees was the Home's highest priority while confirming that they had not cohorted residents.
- 211. ONA's only other recourse was to file grievances under the collective agreement. Over 200 of them were filed in April, alleging that Long-Term Care Homes had not taken every reasonable precaution to protect RNs and their residents. On April 9, ONA proposed the an expedited arbitration process starting April 15, but its offer was turned down. Labour arbitration can be a slow process, and in the absence of an agreement to expedite a hearing, it can take months and even years for a grievance to be heard and a decision to be rendered. ONA's members and their residents could not wait weeks, let alone months or years.
- 212. ONA decided to take the extraordinary step of seeking an injunction from the Superior Court of Justice ordering Long-Term Care Homes to comply with Directives 3 and 5 including resident isolation and cohorting, and to provide nurses with access to N95 respirators and other PPE. ONA filed its application April 16 and a hearing was held April 22.
- 213. Justice Morgan released his decision the following day, finding that "Where the lives of nurses and patients are placed at risk, the balance of convenience favours those measures that give primacy to the health and safety of medical personnel and those that they treat" He ordered the Respondents to provide nurses with access to fitted N95 respirators and other PPE when assessed by a nurse at point of care to be appropriate and required, in accordance with Directive 5. He also ordered them to implement other controls, including cohorting and isolating residents and staff.
- 214. After this decision was released, ONA and the MOLSTD reached an agreement about how inspectors were to address health and safety complaints regarding PPE. The agreement, which was reached in settlement of an OHSA appeal in the hospital sector, was equally applicable in long-term care and confirmed that at a minimum, the MOLSTD would take the position that taking every precaution reasonable in the circumstances meant that nurses were required to be provided with access to fitted N95 respirators and other appropriate PPE when assessed by a nurse following a point of care risk assessment.
- 215. Shortly after the release of Justice Morgan's decision, the Long-Term Care Homes agreed to an expedited arbitration process before Arbitrator John Stout. Arbitrator Stout issued a

<sup>&</sup>lt;sup>174</sup> Eatonville/Henley Place, supra note 122 at para. 94.

decision in early May in which he incorporated Justice Morgan's decision, setting out comprehensive infection control and health and safety measures.<sup>175</sup>

- 216. This was not the end. Since May, ONA's members have continued to repeatedly raise concerns about their employer's failure to comply with the directives. They have been discouraged from requesting N95 respirators and in some cases have been outright denied access to them. Homes continue to fail to isolate and cohort residents and staff.
- 217. The importance of Directive 5 and access to N95s and other PPE cannot be overstated. Evidence continues to grow that the virus transmits through aerosols which can be generated not only through medical procedures but through talking, coughing and sneezing, and other aerosol-generating behaviours. In October, ONA and the other unions negotiated changes to Directive 5 that were intended to make access to N95s easier. The government steadfastly refused to acknowledge in writing that the virus was airborne or even that the sciences was uncertain. Without that explicit acknowledgement, health care workers are being misled about what level of protection they require.
- 218. In November, PHAC recognized the possibility of airborne transmission:

SARS-CoV-2, the virus that causes COVID-19, spreads from an infected person to others through respiratory droplets and aerosols created when an infected person coughs, sneezes, sings, shouts, or talks. The droplets vary in size from large droplets that fall to the ground rapidly (within seconds or minutes) near the infected person, to smaller droplets, sometimes called aerosols, which linger in the air under some circumstances.<sup>176</sup>

- 219. On November 26, ONA wrote to Dr. Williams, urging him to revise Directive 5 to reflect this growing evidence. To date, ONA has not received a response. It is for this reason that ONA wrote to this Commission on December 22, asking that they consider making an interim recommendation to require, at a minimum, that all health care workers use NIOSH approved fit-tested N95 respirators (or equivalent or greater protection) when providing care or when within six feet of suspected, presumed or confirmed COVID-19 residents. On January 25, 2021, ONA issued an open letter to Premier Ford asking that he mandate airborne level of precautions for health care workers.<sup>177</sup>
- 220. Throughout this period, ONA's members continued to report difficulties in accessing N95s in accordance with Directive 5. Management in Long-Term Care Homes and public health inspectors continue to advise workers that N95s are not required. A recent email sent by the Executive Director of Blackadar Continuing Care to ONA's bargaining unit president while they were in outbreak is indicative of the messaging that is being provided to health care workers that they do not need to wear an N95:

I have told you repeatedly that the choice of wearing an N95 is your choice to make and neither your or anyone has been denied. And YES, both PH and HHSC IPAC

<sup>&</sup>lt;sup>175</sup> Ontario Nurses' Association v. Participating Nursing Homes, 2020 CANLII 36663.

<sup>&</sup>lt;sup>176</sup> https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/main-modes-transmission.html

https://www.ona.org/news-posts/open-letter-airborne/

were in the home repeatedly stating that a face shield/surgical mask would suffice. If you have an issue or disagree, feel free to call them and clarify. We have only our resident staff safety in mind including our own.

This response from Vicki at ONA is a blatant lie and I take offense with their constant skewing of facts to suit their objective. They really need to concentrate on real issues not the narratives and misinformation they spew.

- 221. ONA has written at least 30 letters to Long-Term Care Homes, demanding compliance with Arbitrator Stout's decision and the directives. In several cases, ONA has had to return to Arbitrator Stout to address breaches of his decision. As recently as January 12, ONA received an enforcement order from Arbitrator Stout involving Blackadar Continuing Care Centre, which contained orders ensuring ready access to N95s, making best efforts to acquire additional supply of N95 respirators, health and safety training, and compliance with Directives 3 and 5 regarding outbreak management and testing of residents and staff.<sup>178</sup>
- 222. This is an unwieldy process at a time when every single passing day counts. It is for this reason that ONA recommends that a process under the *HPPA* must be established to ensure timely enforcement of public health orders and directives. Disputes must be resolved quickly given that the directives address matters critical to life and death.

#### **Enhanced Whistleblower Protections**

The RNs at the Home are afraid to speak up in an official capacity for fear of reprisal and do not wish to be identified. Even before the current pandemic and the outbreak at the Home, my members were reluctant to come forward with concerns or to attach their names to complaints given fears of reprisal and impact on their employment, so I have been their voice and attempted to advocate on their behalf.

#### **Anonymous ONA Member**

- 223. ONA members voiced concerns throughout the pandemic that they were afraid to report violations of directives out of fear of losing their job.
- 224. Ontario's patient ombudsperson reported that her office had received reports from long-term care staff who raised similar concerns:

Patient Ombudsman received a number of complaints from staff working in Long-Term Care Homes expressing serious concerns about infection prevention and control, staffing and their ability to provide basic care to residents. Patient Ombudsman classified 20 such complaints from Long-Term Care Home staff as whistleblowers; however, we received a larger number of anonymous complaints, many of which appear to be from unidentified staff members raising serious concerns. The majority of these staff complainants feared negative impacts to their job or standing at work. Many did not want to be identified to the health sector

<sup>&</sup>lt;sup>178</sup> Ontario Nurses' Association v. Blackadar Continuing Care Centre, 2021 CanIII 3440 (ON LA)

- organization who employed them. Many of the whistleblower and anonymous staff complaints we received were of a very serious nature. 179
- 225. Strong whistleblowing protections are essential so that risks to staff and residents are reported and acted upon. Whistleblowing provisions under *OHSA* and the *LTCHA* provide only limited protection. Under section 50 of the *OHSA*, a worker is protected if he/she has acted in compliance with the Act, has sought enforcement of the Act or has given evidence in a proceeding in respect of the enforcement of the Act or in an inquest.
- 226. This provision has been interpreted very narrowly by the Ontario Labour Relations Board, requiring a worker to have framed their concern as a workplace health and safety issue to the employer. Typically, they must have engaged in a work refusal, initiated an inspection or identified a situation as a health and safety hazard. The health and safety hazard must be identified as such, as opposed to merely being a complaint that could be characterized as raising a health and safety issue. For example, in *Cambridge Pallet Ltd. V. Kechnie*, the Board dismissed the worker's s. 50(1) application because the worker failed to articulate his complaint as a workplace health and safety concern to his employer before his termination occurred. The Board stated that "[n]oting that a machine requires a certain repair is not the same as characterizing the machine as hazardous to operate without that repair."
- 227. Under the *LTCHA*, the protections are even more limited in scope. Section 26 only prohibits retaliation against any person because of information disclosed to an inspector or the Director or because of evidence has been given in a proceeding, or in an inquest.
- 228. ONA recommends that the whistleblower protections under the *OHSA* and *LTCHA* be amended to broaden the scope of protected activities and to ensure that RNs are also protected from potential regulatory consequences from the College of Nurses of Ontario.
- 229. ONA also recommends that Justice Campbell's recommendations on whistleblowing protections be implemented. He proposed that whistleblower protection must be embedded in the *HPPA* and must:
  - a. Apply to every health care worker in Ontario and to everyone in Ontario who employs or engages the services of a health care worker;
  - b. Enable disclosure to a medical officer of health (including the CMOH);
  - c. Include disclosure to the medical officer of health (including the CMOH) of confidential personal health information;
  - d. Apply to the risk of spread of an infectious disease and to failures to conform to the *HPPA* and directives or orders made under the Act;
  - e. Prohibit any form of reprisal, retaliation or adverse employment consequences direct or indirect;
  - f. Require only good faith on the part of the employee; and

<sup>&</sup>lt;sup>179</sup> Patient Ombudsman, *Special Report: Honouring the Voices and Experiences of Long-Term Care Residents, Caregivers and Staff during the First Wave of COVID-19 in Ontario*, October 2020 online (PDF): <a href="https://www.patientombudsman.ca/Portals/0/documents/covid-19-report-en.pdf">https://www.patientombudsman.ca/Portals/0/documents/covid-19-report-en.pdf</a>.

<sup>&</sup>lt;sup>180</sup> Kechnie v. Cambridge Pallet Ltd. 2006 CanLII 17247 (ON LRB)

<sup>&</sup>lt;sup>181</sup> *Ibid.*, at para. 20.

- g. Not only punish the violating employer but also provide a remedy for the employee. 182
- 230. To this, ONA would also add that such protections must also prohibit any adverse consequences from regulatory bodies, such as the CNO. It is of little protection to keep your job if you lose your license to practice, either temporarily or permanently. RNs who disclose information to protect the public's health need assurance that they are protected against both employer and regulatory consequences.

#### PART SIX: THE AFTERMATH-LASTING IMPACT ON LONG-TERM CARE NURSES

The experience hurt some of us very badly, don't like to talk about it. I remember one woman, almost there 20 years, she was curled up in a ball, crying. I thought at that moment I just want to walk out of here, but I got down on my knees beside her with no PPE, because that is what we do.

#### **Anonymous ONA Member**

War zone... it was hell on the night shifts where I was alone and 5 or 6 actively dying people, had 70 others who were sick... so much more to do but just can't.

#### **Anonymous ONA Member**

Impact of the COVID is permanent on all of us I am still fighting the feeling of desperation, loss and death. Yes I think there is also depression and constant doubt and questioning if we could do better next time?

#### Anonymous ONA Member

I was redeployed to a Home from a Hospital. The experience made me very sad and worried me very much. It was honestly devastating to see the conditions that people were living in and working in. I had never worked in long-term care before. Seeing the problems of staffing that there was no one to cover, it felt hopeless. I was exhausted and not able to maintain relationships with family and friends while working there. I was too tired to talk to my mother on the phone at the end of the day. The one positive was the staff already there were exceptional. They still found ways to laugh and smile during a shift. They were really committed to residents. Generosity and resilience of the staff who worked there was really outstanding. Really good people.

#### **Anonymous ONA Member**

231. ONA's members have shared their experience on the front-lines of the pandemic, whether through completing ONA's survey, speaking directly with the Commission, or with the media. Their stories are heartbreaking, providing a glimpse of the devastating personal impact the pandemic has had and bring into focus what numbers alone cannot: chaos, grief, fear, and loneliness. Most people cannot imagine what it must be like going in to work in the middle of an outbreak, not knowing how many deaths you may face in the course of your workday,

<sup>&</sup>lt;sup>182</sup> SARS Report, SARS and Public Health Legislation. Second Interim Report, Volume 5, p. 297.

- and perhaps in the back of your mind knowing that one of your colleagues is currently lying in an ICU bed, fighting for their life against the very virus raging in your workplace.
- 232. ONA's survey reveals concerning data about the economic, professional and psychological effects the pandemic has had on nurses in the long-term care sector.<sup>183</sup>
- 233. Significant numbers of nurses reported losing hours or income as a result of having to quarantine or isolate as a result of a COVID-19 exposure. In Homes with an outbreak, 27% of respondents report loss of hours or income, and in Homes with an outbreak of six or more residents, the percentage rises to 33%. A nurse must test positive for the virus in order to qualify for sick benefits, if full-time, or WSIB coverage; 184 nurses isolating because of an exposure do not get paid.
- 234. The number of survey respondents who report symptoms consistent with PTSD<sup>185</sup> is startling: 51% of respondents in Homes that experienced an outbreak, and 61% in Homes that experienced an outbreak of 6 more residents. Even more shocking perhaps, 42% of respondents said their employer was not offering counselling and support, with the percentage increasing to 46% among respondents who worked at for-profit Homes.<sup>186</sup>
- 235. Two questions from ONA's survey in particular should raise alarms. We asked respondents whether COVID-19 and the response had changed their attitude towards (1) the nursing profession, and (2) towards long-term care. 47% responded yes to the first question, and 45% to the latter. While these questions were neutral, suggesting neither a positive nor negative change in attitude, the narrative responses reveal that the experience of working through the pandemic has left many nurses questioning their careers. These are just a few examples of the hundreds of responses to these two questions:
  - Covid as well as other things that have gone on in the nursing over the last years has stopped me from having any interest in the field of work.
  - I can no longer provide the care that our seniors very much deserve. This is not why I went into this profession.
  - I am undecided about continuing with my nursing profession at this time.
  - Proud to be a nurse but at other times want to leave to decrease risk.
  - Its not worth it.
  - Would like a safer profession where I could still make the same amount of money, ie. a factory.
  - Think about other professions and why work shift work hours and put life at risk for others when they don't care about me.
  - This pandemic has proven to me how essential nurses and care providers really are, but also emphasized the personal risk that nurses put themselves at to Care

<sup>184</sup> ONA was unsuccessful in arguing for isolation pay in an arbitration proceeding with the participating Homes. *Participating Nursing Homes v Ontario Nurses' Association*, 2020 CanLII 36663 (ON LA)

<sup>&</sup>lt;sup>183</sup> Similar findings were reported in the article *Sacrificed: Ontario Healthcare Workers in the Time of COVID-19*, Brophy, James T. *et. al.* New Solutions: a Journal of Environmental and Occupational Health Policy 0() 1-15.

<sup>&</sup>lt;sup>185</sup> Depression, anxiety, sleeplessness, fear, and nightmares were listed as examples of PTSD symptoms in the survey question.

<sup>&</sup>lt;sup>186</sup> Survey *supra* note 109.

for their patients. It sometimes makes me question if the potential sacrifice and risks of nursing are worth it.

236. The Commission and the government should be concerned about whether those who have stayed out of a sense of loyalty to their residents will stay when the pandemic ends. Morale in long-term care is extremely low, and staff are burned out. Urgent action is needed to make nursing a safe and fulfilling profession.

#### CONCLUSION

- 237. The time for change in Ontario's long-term care system is now. The Homes in which we house and care for our frailest, most vulnerable citizens have been neglected far too long. Residents, families and staff have waited long enough. They have suffered too much.
- 238. The humanitarian crisis that has unfolded before our eyes over the past nine and half months need not have happened. The COVID-19 pandemic hit a system whose foundations were so cracked, it likely could not have withstood a windstorm. What came was a tornado. Action on the recommendations of previous Commissions, Inquiries, and other expert reports may have prevented the crisis. It certainly would have mitigated the impact of the pandemic in long-term care.
- 239. Attached you will find ONA's final recommendations, which complement the short-term recommendations we provided in October. Our recommendations are focused around the key themes we have discussed in these submissions.
- 240. ONA is encouraged by the Commission's interim recommendations. We eagerly await your final report and recommendations, and are willing to provide any additional information or assistance that you require. We can only hope that your recommendations will lead to action and change so that this time, we can all truly say "never again".



# Final Recommendations for Ontario's Long-Term Care COVID-19 Commission

(Appendix A)

February 3, 2021

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#### **Long-Term Care Homes**

#### Fundamental Principles

1. The *Canada Health Act* must be amended to include an addendum incorporating long-term care. National standards should be developed, adherence to which is mandatory by publicly funded long-term care homes.

Rationale: A coordinated approach with federal standards and leadership is required to address the disparities of elder care across Canada. Federal intervention, through the development of enforceable standards, will ensure that seniors receive the care they need and deserve.

2. The Ministry of Health and Ministry of Long-Term Care should be merged back into one Ministry.

Rationale: Historically, the Ministry of Long-Term Care and the Ministry of Health were under one portfolio. Long-term care cannot be divorced from health: it is an integrated part of the entire health system. The removal of long-term care from the MOHLTC resulted in a lack of long-term care representation on various command tables.

3. To ensure that all public funding to long-term care homes is provided directly to resident care, the Ministry of Long-Term Care must develop a plan to ensure that all "for profit" long-term care homes are eliminated and replaced by a "not-forprofit" home within the next five years.

In the alternative, newly funded long-term care beds should only be provided to "not for profit" homes.

Rationale: Academic research indicates that for-profit homes tend to deliver inferior care. They did particularly poorly during the pandemic, experiencing worse outbreaks compared to municipal and not-for-profit homes. It was reported that for-profit homes continued to pay shareholders even while the facilities were experiencing a staffing crisis and residents were dying. There is no space for for-profit ownership in post-COVID-19 Ontario.

4. In the interim, funds in the Other Accommodation envelope should not be used as profit. Homes who meet key benchmarks on quality and outcome of care, including meeting staffing requirements in the LTCHA, should be entitled to a bonus, which can then be used for profit or, in the municipal and not-for-profit sectors, as a reinvestment back into the home.

Rationale: As an alternative to eliminating for-profit homes, there must be stricter regulations on how homes are able to obtain and distribute profits. Currently, for-profit long-term care homes profit by using funding out of the "other accommodation" envelope. Those funds should be used to enhance resident care and services. Homes that do not provide care that meets key benchmarks on quality and outcome of care should not be entitled to profit. It is time to re-think the way the system works.

#### Funding

5. Funding should be on a flat per-diem basis, instead of being based on the RAI assessment.

Rationale: A flat per-diem funding model provides predictable income to Long-Term Care Homes, which assists in determining consistent staffing levels. As it stands now, funding bears no real relationship to the acuity of residents in the home as it is based on data that is often 12-18 months out of date. Furthermore, because the current system allocates funding between homes based on resident acuity, the model does not incentivize improving resident outcomes.

6. Funding provided for infection prevention and control (including PPE) must be legislatively required to be used only for that purpose. It should be provided to the homes in a separate envelope.

Rationale: Infection control costs are spread across different funding envelopes including the "other accommodation" envelope. IPAC funding must be consolidated in a separate envelope and be used only for that purpose or be returned to the Ministry. Twenty percent of ONA's members who responded to the survey indicated that they had been advised that the cost of PPE was an issue for their home. Action must be taken to eliminate the ability for for-profit homes to take money for profits while the homes they operate have insufficient supplies of PPE.

#### Physical Structure of Homes

7. Licensees must upgrade C & D category homes within 2 years to meet current design standards. Those who have not done so will not have their licenses renewed.

Rationale: Category C and "Upgraded D" homes were at greater risk of outbreak during the pandemic. The ability to put in place IPAC measures, such as isolating and cohorting residents and social distancing was compromised by the physical infrastructure of those homes, which include ward rooms, shared bathrooms, and crowded public spaces. Research by Nathan Stall et al has associated worse outbreaks to for-profit chain ownership and old building design standards. Simulations suggested that converting all 4-bed rooms to 2-bed rooms would have averted 988 (18.9%) infections of COVID-19 and 271 (18.7%) deaths.

#### https://www.medrxiv.org/content/10.1101/2020.06.23.20137729v1

8. The MLTC must fund HVAC assessments in every LTC home. Licensees must upgrade their HVAC system pursuant to the assessment and must ensure that every home has central air conditioning.

Rationale: This recommendation is consistent with Public Health Agency of Canada's guidance on indoor ventilation. An increasing body of research is showing that COVID-19 can be spread over distances greater than two meters, and aerosolizing behaviours such as coughing, sneezing, talking can emit particulars large enough to carry the virus. Engineering controls to address ventilation are important tools in preventing infection.

9. New builds must have a minimum of at least one negative pressure room per 32 residents to serve as an infirmary or isolation room.

Rationale: Long-Term Care Homes experience infectious disease outbreaks on a fairly regular basis and require access to dedicated space in which to isolate residents. Many Homes do not have a dedicated isolation room. During the pandemic, homes had to be creative in creating space for isolation but for many, it was a difficult challenge. In at least one home, an RN was forced to isolate residents in a shared lounge space because there were no private rooms available.

#### Home Management: Director of Nursing and Administrator

10. All Homes should have both a Director of Nursing and an Administrator who works regularly in those positions on-site at the home, 35 hours a week, regardless of the size of the Home.

Rationale: Currently, a full-time Director of Nursing ("DON") position is only required in homes with 65 or more beds, pursuant to Regulation 79/10, s. 213. A full-time administrator is only required in homes with 97 or more beds, pursuant to Regulation 79/10, s.212.

It is imperative that there be full-time leadership in Long-Term Care Homes.

11. The qualifications for the Director of Nursing should be enhanced to include a requirement for more clinical experience as a RN in a long-term care setting.

Rationale: Currently, section 213(4) of Reg. 79/10 requires that everyone hired as a DON has at least 1 year experience working as an RN in long-term care and at least 3 years experience working in a managerial or supervisory capacity in a health care setting.

Long-Term Care is a unique practice environment. Dr. Sweetman emphasized the importance of experienced leadership in a home. ONA recommends that the DON must have at least 3 years experience working as a RN in Long-Term Care and 5 years experience working in a managerial or supervisory capacity in a health care setting.

12. There should be no exclusions to the requirement to have a Director of Nursing onsite in the home during a pandemic.

Rationale: During a Pandemic, Homes need to have a DON regularly on-site who can provide leadership, clinical guidance and support. Strong leadership is essential. Section 213(6) of Reg. 79/10 eliminates the requirement for a DON to be on-site during a pandemic. This regulation must be revoked. It is critical to have the DON on-site during a pandemic.

13. Enhanced qualifications for the Administrator to require that the Administrator be a regulated health professional and that the supervisory/managerial experience must be in a health care setting.

Rationale: The legislated minimum qualifications of an administrator are insufficient. They are not required to be a regulated health professional and also are not required to have managerial experience in a health care setting. ONA survey respondents reported that administrators were directing health care workers in the provision of care. Given the important role of an administrator, the qualifications for administrators must be enhanced.

14. The MLTC should develop, in consultation with key stakeholders, a list of accountabilities for the Director of Nursing and Administrator roles. Compliance with these accountabilities should be subject to inspection by the MLTC.

Rationale: In furtherance of the Commission's second interim recommendations on leadership, there continues to be a significant legislative gap in the *Long-Term Care Homes Act* regarding the accountability and responsibilities of management of ong-term care homes in Ontario. Throughout the Pandemic, Registered Nurses reported managers being unavailable, unsupportive and lacking leadership in decision-making. Accountabilities must be clear and enforceable by Ministry of Long-Term Care ("MLTC") inspectors.

15. During any outbreak, the Director of Nursing and Administrator must alternate the times of day they are in the long-term care home to provide leadership and direction at times other than Monday to Friday during the daytime.

Rationale: During the First Wave, our members in long-term care report that in many cases supervisors were inaccessible to staff during the peaks of a Home's outbreak. It is always essential that management be available during an emergency, such as the current pandemic, as staff require their support to do their work.

#### Multi-disciplinary Team

16. A multi-disciplinary approach to resident care must be strengthened in long-term care homes, with recognition that the Registered Nurse is a skilled health professional leading and guiding the day-to-day care for residents in the home. Their clinical skills are all the more valuable during a COVID-19 outbreak, when residents' health is unstable, unpredictable and acute.

Rationale: A multi-disciplinary approach to resident care ensures that all aspects of a resident's care needs are met. RNs are highly skilled professionals who have greater foundational knowledge than RPNs and PSWs and can practice autonomously. Research has shown that higher RN staffing levels are linked to better resident outcomes. Studies conducted in homes with COVID-19 outbreaks suggested that higher RN staffing levels were linked to fewer and less deadly outbreaks. The role of an RN in the multi-disciplinary team is critical.

#### Medical Director

17. The role of the medical director needs to be clarified so that it is clear that they are expected to attend the Home in person during an outbreak and ensure quality care of residents as part of a multi-disciplinary team.

Rationale: Section 214 of *O Reg 79/10: General* under the *Long-Term Care Homes Act* must be expanded and clarified to ensure Medical Directors physically attend the workplace to fulfill their responsibilities and duties.

#### Nurse Practitioner

18. There should be at least (1) NP who is an employee of the home for every 120 residents given the present acuity of Ontario residents. This should be a legislated, enforceable minimum, which would require a change to Section 8 of the *Long-Term Care Homes Act* (LTCHA) and any applicable regulations.

Rationale: Nurse Practitioners are Registered Nurses who have additional nursing education and experience and an expanded scope of practice. Research has demonstrated that the presence of a Nurse Practitioner in a long-term care home increases the quality of care provided to residents.

The Long-Term Care Staffing Study recommended that homes expand the use of Nurse Practitioners so as to support clinical leadership in the home, particularly since Medical Directors are not present on a daily basis in the home.

#### IPAC Lead

19. Every home must have a Registered Nurse who is an Infection Control Practitioner who is trained and certified in IPAC Canada-endorsed courses. This education should include IPAC Canada's:

Novice Infection Prevention and Control course; and Basic Infection Prevention and Control Program at Centennial College in Toronto or Queen's University in Kingston

Ideally, the Infection Control Practitioner will be or will agree to be, certified in Infection Control (CIC).

Rationale: The First Wave demonstrated the critical need to have infection control expertise in Long-Term Care Homes. Many Homes did not have a dedicated infection control registered nurse to proactively implement policies and procedures to protect residents and staff.

An RN who is certified in an Infection Prevention and Control Canada-endorsed course will have the knowledge to identify when and how homes implement cohorting and isolation protocols. They will be able to teach appropriate donning and doffing of personal protective equipment ("PPE") and ensure that the Home is compliant with fit-testing requirements.

20. The Infection Control Practitioner will have the authority to make effective decisions about infection prevention and control in the workplace.

Rationale: The extent of the outbreaks at particular homes demonstrate that supervisors lacked the knowledge and expertise in IPAC to sufficiently protect staff and residents. As such, those who have special training to prevent spread of infection need to have the authority to act quickly.

21. Immediately, cease requiring registered nurses to perform the role of funeral directors and coroner during an outbreak. Funeral directors and the coroner can safely attend in long-term care homes wearing personal protective equipment for airborne protection.

Rationale: RNs were given the responsibility to complete death pronouncement processes for deceased residents. The death pronouncement process was previously completed by coroners or funeral directors that would enter the Long-Term Care Home. Upon a resident's death, RNs were required prepare the body, place the body in a bag and taking the body out to the front of the building to be picked up by the funeral home. This responsibility caused a substantial increase in workload for our members and was a significant traumatic experience.

#### **Staffing**

#### Basic Staffing Requirements

22. The Ministry of Long-Term Care should immediately increase the funding per home to ensure there is 4.1 hours of direct care (worked hours) provided by registered nurses, registered practical nurses, and personal support workers. Of those hours, 20% should be registered nurses, 25% registered practical nurses, and 55% personal support workers. The total number of hours and distribution between different health care workers should be enshrined in the *Long-Term Care Homes Act* so that it is enforceable through the inspection process.

Rationale: The MLTC must immediately increase the funding to long-term care homes to reflect the urgent care needs of the increasingly aging and high acuity population. The Ontario Long-Term Care Staffing Study Report issued on July 30, 2019 recommended that Long-Term Care Homes should be funded and staffed to ensure that each resident receives a minimum of four hours of direct resident care per day. ONA believes that 4.1 hours of direct care must relate only to the care provided from RNs, RPNs, and PSWs.

23. Section 8(3) of the LTCHA should be amended to increase the minimum number of RNs who are employees of the licensee and members of the regular nursing staff of the home required to be on duty and present in the home at all times. The minimum number should depend on the size of the Home and should also be tied to the number of RNs required to meet 4.1 hours of direct care (worked hours).

Rationale: The Staffing Study released in July 2020 recommended that the requirement for at least one RN to be present and on duty at all times should be updated to consider home size. ONA agrees. The ability for RNs to provide quality resident care is affected by the number of residents in the home.

24. The Ministry of Long-Term Care must provide immediate funding to long-term care homes which the homes will be required to use to create more full-time positions with benefits to attract and retain staff.

Rationale: Full-time is defined as a regular work schedule of a minimum of 75 hours on a biweekly period. According to the Ontario Long-Term Care Staffing Study, only 40% of RN positions in long-term care are full-time. It was recognized in the Gillese Inquiry that one of the factors which contributed to the staffing crisis is a lack of full-time positions with benefits. Full-time positions are highly sought after in this sector as they provide stability and consistency in hours of work .

25. In addition, licensees or homes must maintain a roster of part time and casual employees who are members of the regular nursing staff and can cover shifts in the case of an unexpected absence.

Rationale: Justice Gillese recommended that Homes should reduce their use of agency staff. In order to facilitate that, she recommended that Homes should maintain a roster of part-time and casual employees to be called upon instead of using agency staff, who are unfamiliar with both the home and the residents. Section 74(1) of the LTCA already recognizes the importance of having a strong compliment of staff that can provide continuity of care to residents rather than resorting to agency staff.

During the pandemic, Long-Term Care Homes in outbreak were often required to use agency staff because of the extreme staffing crisis. The Commission heard evidence that some agencies exploited the staffing crisis by raising prices to over 50% of their natural costs. By having a roster of part-time and casual employees available to help with staffing shortages, the need to rely on agency staff will be minimized.

26. Immediately require every licensee to ensure that long-term care homes are staffed in accordance with the requirements established in the Long-Term Care Homes Act, its regulations and all obligations under collective agreements. In future, long-term care homes should never be exempted from meeting minimum legislated staffing levels, as the failure to staff appropriately puts residents and staff at serious risk.

Rationale: On March 20, 2020 the Ontario Government passed amendments to *Ontario Regulation 79/10* under the *Long-Term Care Homes Act*, relieving Homes of the requirement to meet the legislated standard of having at least one registered nurse in the building 24 hours per day, 7 days per week. The Ontario government states that the legislative changes are needed in order to provide flexibility to long-term care ("LTC") homes who might not meet the legislated minimum standard. These amendments undermine the required skill mix necessary in a LTC home environment and puts residents at serious health risk. This must be implemented immediately.

27. During any outbreak, long-term care homes must upstaff registered nurses, registered practical nurses and personal support workers beyond minimum standards. The Ministry of Long-Term Care must provide funding so that this can be implemented immediately.

Rationale: The workload of staff increased exponentially during this pandemic. RNs were required to assess their assigned residents multiple times throughout the day, contact residents' families, complete IPAC audits, donning and doffing PPE between residents and fulfill responsibilities of coroners and funeral directors in the Home. During outbreak, resident acuity levels increased adding to an already unmanageable workload. During an outbreak, Long-Term Care Homes must anticipate that staff may become sick, or otherwise be unable to attend work, and use staff that are available to up-staff.

28. Part-time employees who choose to work at a single long-term care home during the Pandemic or serious infectious disease outbreaks should be provided with full-time hours. Licensees/operators must not offer hours to agency or full-time employees at overtime until all part-time employees have been offered available hours.

Rationale: ONA's survey indicates that hundreds of members have suffered serious financial harm due to being restricted to one workplace. ONA continues to hear stories that Long-Term Care Homes are not offering full-time or over-time hours to part-time RNs even when hours are available and instead utilize agency staff. The prevalence of precarious work in the LTC sector continues to cause serious recruitment and retention issue that needs to be immediately addressed.

#### Recruitment and Retention

29. A key recruitment and retention measure is parity with hospitals and municipal homes in salary, benefits, pension, and working conditions. The MLTC therefore

must base staff funding to long term care homes on remuneration rates that are the same as to similar roles in these other MOH and MLTC funded health care workplaces. It must ensure that any homes in receipt of such funds are using the funding for staffing and not the remuneration of administrators, managers, or for profit.

Rationale: The Long-Term Care Staffing Study Advisory Group acknowledged that lack of wage and benefit parity contributes to the labour challenges in the long-term care sector. They recommended that "compensation parity should be strongly considered across settings and occupations to reduce compensation-related labour shortages."

30. The Ministry of Long-Term Care must provide a temporary wage increase for registered nurses and registered practical nurses so that they are receiving the same pay as nurses in the hospital and municipal sector. This temporary wage increase is to last until the pandemic is over and should end at the same time as the increase to personal support workers' wages. This would be followed by a permanent wage increase after the pandemic.

Rationale: As recognized in the Gillese Inquiry, wages in the for-profit long-term care sector continue to be a barrier for staff retention. The wages do not adequately compensate our members for the current working conditions within the for-profit sector. Temporarily increasing the wages will assist some Homes in retaining staff to satisfy an urgent need in the Second Wave.

31. The MLTC must direct homes to address staffing shortages with funding from the Other Accommodation ("OA") envelope funding. Licensees, Administrators, and DONs should be educated to ensure they are aware that OA funding can be used for increased staffing.

Rationale: The current funding model allows for-profit homes to continue to pay dividends to shareholders even when staffing levels are inadequate to meet resident care needs. In addition to being morally unjustifiable, this does not maximize the economic or social return on public spending. Regulations must ensure that homes must financially invest in care first, before profit. Education is required: evidence from before Justice Gillese indicated that administrators and DONs did not fully understand how funds in the "other accommodation" envelope could be used.

#### Agency Use

32. Agency use should be minimized in long term care homes and regular staffing should be increased. Agency should only be a measure of last resort and not a substitute for inadequate staffing.

The MOH and MLTC must provide oversight of all agencies who provide staff to the health or long-term care sector. The Ministries should maintain a list of agencies that are approved for sending staff to LTC homes. Part of the approval criteria must include a requirement for substantive IPAC training (not online learning) to agency staff.

Rationale: Justice Gillese recommended that agency use needed to be minimized in long-term care. ONA believes that ultimately, agency use should be eliminated but until that is possible, there must be oversight over agencies and the staff who are sent to work with residents. With

respect to the pandemic, it is crucial that agency staff (in addition to regular staff) receive substantive IPAC training.

33. Agency workers should be limited to working in one health care facility while provisions of Bill 195 remain in place and/or the WHO declares an end to the COVID-19 pandemic (whichever is later).

Rationale: Agency workers are as likely to spread the virus as long-term care staff. To protect against the spread from facility to facility, they must be treated in the same manner. During an outbreak, agency nurses will be restricted to working in only one health care setting (eg one long-term care home.)

#### **Transparency**

34. All long-term care facilities must be required to provide full disclosure of their yearend financial statements. Those statements should be made available to the public for review.

Rationale: Long-term care facilities currently do not publicly disclose their financial statements. Increased transparency is necessary to keep Long-Term Care Homes accountable to residents, their families and staff. Decisions on how homes choose to spend their funding may impact the choices made by prospective residents in identifying homes in which to reside.

35. To ensure increased transparency on staffing, every licensee should post the staffing plan in the Home and through other means easily accessible to the public, such as the MOH/MLTC website profiling individual long term care homes: <a href="http://www.health.gov.on.ca/en/public/programs/ltc/home-finder.aspx">http://www.health.gov.on.ca/en/public/programs/ltc/home-finder.aspx</a> or the Health Quality Ontario website measuring system performance in long-term care. <a href="https://www.hqontario.ca/System-Performance/Long-Term-Care-Home-Performance">https://www.hqontario.ca/System-Performance/Long-Term-Care-Home-Performance</a>.

The staffing plan (above) must include proactive plans to address staffing shortages and crises.

Rationale: There is a direct link between staffing levels and quality of care in long-term care. Public transparency on staffing plans keeps homes accountable for meeting those plans.

36. The Licensee/Home must advise the MLTC, applicable unions, and resident and family councils when they don't meet the minimum legislative staffing requirements, including the requirement under section 8(3) of the Act to have a Registered Nurse in the Home at all times.

Rationale: There is no requirement now for Long-Term Care Homes to report that they have not met the minimum legislative staffing requirements, including the requirement to have an RN in the Home at all times. The MLTC only becomes aware of these breaches if someone happens to call in a complaint. Violations of this provision are serious and should be reportable. Failure to meet these minimums are signs that a Home is having difficulties and that resident care is endangered.

#### Communication in Long-Term Care Homes during an Outbreak or Pandemic

37. Every Long-Term Care Home must create a pandemic plan, which is to be reviewed and updated annually. Training must be provided on the pandemic plan annually and it must be reviewed at the beginning of and regularly throughout, any outbreak. It is to be provided to the Joint Health and Safety Committee and unions.

Rationale: Some Long-Term Care Homes did not have pandemic plans or, if they did, they were outdated. It is essential that Homes have updated pandemic plans, that staff are aware of the plans and that it be regularly reviewed by the Joint Health and Safety Committee ("JHSC") and unions. There is no reason that a more transparent approach to pandemic plans should not be adopted, given the overall impact of infectious diseases on residents and staff.

38. Administrators/Director of Nursing/Assistant Director of Nursing should be communicating with families and Substitute Decision makers.

Rationale: In addition to providing direct care, RNs were required to speak with residents' families. Our member's report that this was difficult work and they often lacked the information many family members were seeking. Although communicating to families is critical work, registered nurses efforts need to be directed towards front line resident care during an outbreak.

39. Licensees are required to immediately notify all employees when a resident or employee tests positive for COVID-19.

Rationale: Our members who have worked and continue to work in Long-Term Care Homes in outbreak are not provided the basic information required to take infection prevention and control measures. In some homes during the height of the outbreak, staff were not told which residents had been confirmed positive for COVID. In addition, some Homes were demanding that staff come to work while infected with COVID. Our members were not given the necessary information to protect themselves, which contributed to the spread of infection to health care workers in the long-term care sector.

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

Rationale: As above, all IPAC measures require staff to know who is positive with COVID.

41. Daily huddles on every shift should be held to discuss new or updated policies, procedures and measures. Huddles should also include new and emerging treatment and care protocols particularly for emerging diseases e.g. COVID-how to provide supportive care. Information should be documented in a binder or on an electronic platform so that it can be shared with staff working on the evening and night shifts.

Rationale: The ONA survey confirmed that there was a significant lack of communication from the Government and employers about changes to procedures and protocols. Their ability to exercise clinical judgement is affected when they do not have the latest information about applicable policies.

42. The care plans of all residents need to be updated immediately, to reflect the resident's wishes regarding enhanced care and alternative care settings.

Rationale: We heard from our members that in many cases residents' advanced medical care directives and DNRs may not be relevant in the context of the pandemic.

43. Following an outbreak, management in long-term care homes must conduct a review with registered nurses and other health care professionals and incorporate the clinical experience of nurses to identify what worked (best practices) and what didn't work, as well as changing or evolving information about a novel pathogen, to identify improvements in process.

This should be shared with internally with the Joint Health and Safety Committee, and externally with the MLTC, the CMOH, the long-term care community (perhaps through the OLTCA and AdvantAGE), and other relevant stakeholder to aid in developing provincial guidelines and standards for provision of care that are based on the clinical experience of registered nurses.

Rationale: Identifying and sharing best practices learned from infectious disease outbreaks can prevent illness and death in the future. Sharing lessons learned amongst Long-Term Care Homes makes the entire sector safer.

## Government Accountabilities Preparing and Responding to a Public Health Emergency/Pandemic

#### **Guiding Principle**

44. The precautionary principle must be adopted as a guiding principle in Ontario's public health, infection prevention and control and occupational health and safety systems. It must be enshrined in the Occupational Health and Safety Act, the Health Protection and Promotion Act, the Public Hospitals Act, the Long- Term Care Homes Act and other relevant legislation. It must inform every response to the pandemic.

Rationale: The SARS Commission identified the precautionary principle as the cornerstone to occupational health and safety. The principle incorporates a cautious and proactive approach to worker safety, recognizing that is "better to be safe than sorry." The COVID-19 pandemic has exposed the reality that the health care sector has not yet embraced the precautionary principle. Unless it is mandatory, employers and the government cannot be trusted to take a precautionary approach.

45. The precautionary principle must guide the development, implementation and monitoring of measures, procedures, guidelines, processes and systems to ensure worker health and safety.

Rationale: The SARS Commission established the precautionary principle as a fundamental aspect of worker health and safety. The precautionary principle is a health and safety obligation requiring Government and Employers to take proactive and substantive action to protect health and safety to workers. The precautionary principle has not been appropriately implemented in this pandemic and it requires Employers to immediately implement the maximum level of protection

through PPE (ie.fit-tested NIOSH approved N95 respirators or equivalent or better protection) and training.

46. Training must be provided to all regulated health professionals on the precautionary principle and its applicability in the health context.

Rationale: Health professionals, including infectious disease experts, do not seem to have an understanding of the precautionary principle. The Commission heard from counsel for the Ministry of Health, who indicated that the precautionary principle is not well-known in health care. This is concerning, given that this was a fundamental recommendation of the SARS Commission. This lack of knowledge must be remedied so that the failure to apply a precautionary approach never happens again. Education and training will ensure that decision-makers and those advising them understand the importance of taking a precautionary approach when faced with a novel deadly virus.

#### Ongoing Preparation for Public Health Emergency and Pandemic

#### Public Health

47. The CMOH should be accountable for provincial pandemic preparedness which should include all sectors of the health care system including long-term care. The CMOH must publicly report, on an annual basis, to the Legislature, on the state of Ontario's public health emergency preparedness, and make recommendations to address any shortcomings. This report should reflect the concerns and perspectives of health worker unions and safety experts.

Rationale: There has been a lack of clarify as to who is accountable for pandemic preparedness. That accountability should lie with the CMOH, who the SARS Commission envisioned as being like a public guardian of health. Public reporting will also assist in accountability. We should never again be taken unaware by the state of the province's pandemic preparedness.

48. The CMOH should have operational independence from government in respect of public health decisions during an infectious disease outbreak. The CMOH requires the independent duty and authority to communicate directly and warn the public and the Legislative Assembly whenever they deem it necessary on public health risks including those related to the long-term care sector, acting as an independent public guardian on the crisis in long-term care.

Rationale: The 2020 Auditor General's Special Report suggests that the current Chief Medical Officer of Health ("CMOH") is not leading the pandemic response. Currently, there are reporting lines from the CMOH to the deputy Minister of Health. Without operational independence, workers in the health care sector, and the public at large, should be concerned that political influence is a factor in decision-making at a higher level. Justice Campbell believed that operational independence is necessary to ensure that the CMOH will give impartial, unbiased reporting, leadership and direction to the public on matters of provincial concern.

49. Public Health should work with long-term care homes to conduct robust testing and contact tracing and report the results in a timely manner.

Rationale: Robust testing and contract testing is essential to contain the spread of disease. Testing in long-term care homes was often not timely, with health care workers having to wait a long time to learn whether they, and their residents, were COVID positive.

50. Annually and at the outset of a pandemic, public health units must deploy inspectors into long-term care homes to ensure that they are prepared to respond to an outbreak. Inspectors must be encouraged to write any orders required to ensure the health and safety of residents and workers in the Home. All orders must be publicly available on the public health website.

Rationale: Experience shows that public health can and should have a role in IPAC preparedness in long-term care. For example, Kingston public health took a proactive approach, inspecting homes prior to any outbreaks. This was very effective and is a best-practice that should be emulated.

51. The long-term care homes management of infection control, infectious disease outbreaks, or other public health risks should be subject to more proactive investigation and intervention by public health authorities. The HPPA should be made explicit that the CMOH and Local MOH have a duty and power to monitor, advise, investigate, require investigation by a nursing home or an independent investigation, intervene where necessary, and issue orders which should be publicly posted.

Rationale: There appeared to be some uncertainty over the power of local medical officers of health and public health inspectors to issues orders affecting long-term care homes, particularly during the first few months of the pandemic. Clarity around their powers and accountabilities is needed. In addition, there is disparity amongst the units as to transparency. Some units will post public health orders in their entirety while others do not seem to post them at all. ONA recommends that all orders be posted, in a similar manner to those of the MLTC inspectors.

52. The CMOH should create and maintain a provincial stockpile of PPE and will provide an annual report on the status of the stockpile, including numbers of PPE in stock and expiration dates. The stockpile must be maintained at a level that ensures all health care workers can be protected at an airborne level for a minimum of three months. Decisions as to what level of stockpiled PPE is sufficient should be made in consultation with unions and occupational health and safety experts who are members of a permanent preparedness advisory panel.

The appropriateness of the level and the stockpile itself should be independently audited by the Auditor General of Ontario. That audit should also include auditing the maintenance and purchasing policies surrounding the PPE stockpile.

Rationale: Ontario's attempt to stockpile PPE was an unmitigated disaster. No one appeared to have ownership over the stockpile and there was no plan in place to replenish, distribute and manage the stockpile. It is imperative that a provincial stockpile be maintained with at least a three month supply of all PPE. Annual public reports will ensure transparency and accountability, and keep the issue of the PPE stockpile in the public eye.

53. The Province should establish and maintain a domestic PPE manufacturing capability.

Rationale: International geo-political forces should not dictate Ontario's supply chain of PPE. Now that we have created a domestic PPE manufacturing capacity, we must continue to support it so that we are never again held hostage to foreign manufacturing capacity.

54. In addition, individual long-term care homes must have and maintain their own stockpile of PPE, sufficient to provide protection for all staff for a minimum of three months. The stockpiles and maintenance policies of individual homes should be audited as part of annual inspections by the MLTC.

Rationale: Long-Term Care Homes did not have sufficient supplies to protect staff and residents. A supply of three days, or even a week, is grossly inadequate. Health care workers must never be put at risk again because their employers did not have the PPE required to protect them.

55. In preparation for the possibility of a future infectious disease outbreak, the Ministries of Labour, Health and Long-Term Care must jointly establish teams of trained and equipped infection control experts, occupational physicians, occupational hygienists and labour inspectors who can be rapidly deployed to sites of workplace outbreaks.

Rationale: This was yet another recommendation not implemented from the SARS Commission. The provincial inspection system is fragmented and reactive. The ability to rapidly attend sites with outbreaks, and provide assistance and to take a coordinated approach, while still considering the unique needs of workers, residents and the public, is essential.

56. Ontario should recommend the establishment of a worker safety research agency as an integral part of the Public Health Agency of Canada with legislated authority for decision-making on matters pertaining to worker safety, including the preparation of guidelines, directives, policies and strategies. It would be modeled on NIOSH, an essential part of the U.S. CDC, and would be focused on worker safety and health research and on empowering employers and workers to create safe and healthy workplaces. Like NIOSH, its staff would represent all fields relevant to worker safety, including epidemiology, nursing, medicine, occupational hygiene, economics and various branches of engineering.

Rationale: The SARS Commission recommended that Ontario's Agency for Health Protection and Promotion "should have a well-resourced, integrated section that is focused on worker safety research and investigation, and on integrating worker safety and infection control." To date, no organization in Ontario certifies N95 respirators. Ontario's only option is to go to NIOSH in the United States for approval which can lead to delays during a global pandemic.

57. In any future epidemic or pandemic, when determining the precautions for health care workers, a multi-disciplinary advisory panel must be consulted. The panel must include a broad community of experts including infection control, health and safety, engineering, nursing and geriatrics, and should include representatives from the Ministry of Labour, and union representatives. All decision-making on precautions must be guided by clinical experience on the ground and be guided by the precautionary principle where science is uncertain or evolving.

Rationale: A multi-disciplinary approach ensures that advice provided to the government is inclusive of multiple perspectives. Relying solely on hospital IPAC experts is limiting, placing blinders on the government. The SARS Commission emphasized the need to incorporate health

and safety expertise with infection prevention and control. The COVID-19 pandemic has shown that other disciplines, such as engineering, geriatrics and nursing, have valuable perspectives that should be incorporated. Above all, adherence to the precautionary principle must be mandatory.

#### **Directives**

58. Ensure that directives, orders, guidelines and supporting interpretive documents do not conflict and are consistent with one another.

Rationale: The documents were confusing and at times misleading, causing difficulty for staff, employers, public health and enforcement officers. For example, guidelines connected to Directive Five suggested that health care workers may only consider a limited set of factors during a point of care risk assessment when determining whether what level of PPE is required.

59. All directives (past and present) should be available on the Government website.

Rationale: The Government's current practice is to delete the previous versions of the Chief Medical Officer's directives from the Government website. For those who do not have a copy of the previous directive it would be simply impossible to determine the changes that were made from the previous version.

60. Directives should clearly indicate that they represent minimum standards and requirements.

Rationale: Employers treat the Chief Medical Officer's directives as the ceiling of infection prevention and control standards. As such, in many Long-Term Care Homes, Employers have failed to take the necessary, proactive action required to prevent or minimize the extent of outbreaks.

#### Enforcement and Whistleblower Protection

61. A system and process is required to ensure timely enforcement of the Directives. As part of that process, the Health Protection and Promotion Act must be amended to provide health care workers whistleblower protection from reprisals in the employment context and from regulatory consequences. In the interim, a whistleblower line should be established so that staff can report their concerns.

Rationale: Under the *Health Protection and Promotion Act* ("HPPA") there is no effective way to either challenge the content of CMOH Directives or enforce directives. Violations of Directives are critical matters of life and death. There needs to be a mechanism for timely enforcement. A whistleblower line and protection are measures that will assist in timely enforcement.

62. The enforcement process to be established under the *Health Protection and Promotion Act* must ensure an expedited process by an independent adjudicator who can resolve disputes quickly (within a few days) given that Directives address matters critical to life and death.

Rationale: Without the ability to address concerns quickly, public health directives are meaningless and health care workers, long-term care residents and the general public remain at risk.

- 63. Whistleblower protection must be strengthened in the *Occupational Health and Safety Act*. Strengthened protection must include:
  - a. language to protect workers' identity so that they can make a confidential complaint regarding their employer's health and safety practices;
  - b. language that protects workers in speaking out regarding public health concerns as opposed to just health and safety concerns;
  - c. language broadening the scope of protected activities beyond the three that are currently identified in section 50 of OHSA (acting in compliance with the Act, seeking enforcement of the Act and providing evidence in a proceeding under the Act).
  - d. language clarifying that a worker is not required to formally frame their concern as a workplace health and safety issue to the employer in order to enjoy whistleblower protection.
  - e. language that broadens the definition of "reprisal" to include adverse effects on employment or working conditions or threats.
- 64. Whistleblower protection must be strengthened under the *Long-Term Care Homes Act*, including adding language:
  - a. to protect workers' identity so that they can make a confidential complaint regarding their employer's health and safety practices;
  - b. to broaden the scope of protected activities to include acting in compliance with the Act or seeking enforcement of the Act and reporting health and safety concerns internally to their Employer.
  - c. to minimize risk to residents from disease and/or staffing shortages.
- 65. Whistleblower protection must be included in the *Health Protection and Promotion Act*. The protection must:
  - a. Apply to every health care worker in Ontario and to everyone in Ontario who employs or engages the services of a health care worker;
  - b. enable disclosure to a medical officer of health (including the Chief Medical Officer of Health):
  - c. include disclosure to the medical officer of health (including the Chief Medical Officer of Health) of confidential personal health information;
  - d. apply to the risk of spread of an infectious disease and to failures to conform to the Health Protection and Promotion Act and directives or orders made under the Act;
  - e. Prohibit any form of reprisal, retaliation or adverse employment or regulatory body consequences direct or indirect
  - f. Requires only good faith on the part of the employee; and
  - g. Not only punish the violating employer but also provides a remedy for the employee.

Rationale: Whistleblower protection is an essential tool to ensuring that the government hears about risks to public health from health care workers in a timely manner. The current protections

in the OHSA and LTCHA are limited in scope and need to be expanded to truly provide meaningful protection to health care workers. In addition, Justice Campbell's recommendation to add broad whistleblower protection to the *Health Protection and Promotion Act* must be implemented.

#### Infection Prevention and Control/Health and Safety

#### Preventative Measures to Keep COVID-19 Out of Long-Term Care Homes

- 66. All staff, including the Administrator, Director of Nursing and all other management, must receive comprehensive training on the following:
  - a. Infection control and prevention. This training must be in-person and include training, testing and drilling workers on donning and doffing personal protective equipment. A document review, or e-learning is insufficient.
  - b. This training should be performed annually and anytime there is a change to infection control direction and policies and at the beginning of any outbreak.
  - c. Training in the disease process especially new or novel diseases and infections causing the outbreak (e.g. spread, course of the disease, treatment of the illness, etc)
  - d. To ensure management and staff can regularly attend training, licensees must pay for the costs of the training, cover staff salaries during the training, and backfill shifts as necessary.

Rationale: ONA's survey of members employed in long-term care revealed that many nurses had not received ongoing training on IPAC measures prior to the COVID-19 pandemic. Some had never received this training. Our survey and interviews have also revealed that many nurses are not receiving comprehensive hands on training that meets their needs. Many nurses have also stated they did not receive any training in the disease process of COVID-19. Proper training must be in-person and hands on. Reviewing documents, e-learning, or having nurses watch videos on youtube is, not sufficient training. In order for IPAC to become part of a way of life in long-term care, IPAC training and education needs to be meaningful, and needs to be regularly updated and reinforced.

#### 67. Directives must mandate that:

a. Admissions and readmissions must be tested within 48 hours prior to admission/readmission. Residents who leave the building and/or grounds (e.g. home visit) must be isolated for 14 days upon return.

Rationale: In order to keep COVID-19 out of the home, there needs to be measures to ensure that admissions, readmissions and residents who leave the grounds are not infected when they return.

b. In hot zones, admissions must cease. Residents must not be permitted to leave the grounds.

Rationale: Where there is a high rate of community spread, chances of an outbreak increase. Ceasing admissions and off site visits for residents helps prevent the virus from entering the home.

c. Staff and residents should be tested every two weeks in a manner that is least intrusive (eg sputum testing instead of NP testing.) Results must be received within 48 hours, therefore homes must either receive priority testing or new fast testing.

Rationale: Delays in testing results allowed devasting spread during the First Wave. Because of the possibility of asymptomatic spread, there must be ongoing testing with fast results.

d. Agency staff, staff obtained through the government HHR Matching tool, students, private family caregivers/sitters/companions/essential caregivers and family visitors must be tested and they must demonstrate proof of a negative test before they enter the home.

Rationale: These are necessary measures to help prevent the virus from entering the home.

e. Regulated health professionals and other health care employees diagnosed with COVID-19 will not return to work until they have received two negative tests, or until 14 days have elapsed after symptom onset, if they are symptom free.

Rationale: Lack of clarity in the public health guidance on return to work led to many employers requiring nurses to return to work when they may have still be infectious. In ONA's survey of long-term care members, 17.53% of nurses who tested positive for COVID say they were required to RTW while still exhibiting symptoms. 36.99% say they were required to return to work before receiving 2 negative tests, and 22.73% say they were required to return to work before 2 weeks had elapsed since their first positive test.

f. Every home must identify and prepare rooms that are available to be used for isolation. We recommend at least one room per 32 residents.

Rationale: The inability to isolate symptomatic or COVID-19 positive residents was a significant source of spread in the First Wave. "Isolating" residents who have roommates in their rooms is not sufficient, all Homes must have enough space to properly isolate symptomatic or COVID-19 positive residents.

g. Residents should not be placed in a room with more than one other resident. This includes not only new admissions and readmissions, but also those who are currently occupying ward rooms. Ward rooms should be converted to semi-private rooms as soon as possible, through attrition.

Rationale: Multi-resident rooms, particularly ward rooms, were a major contributor to the spread in the First Wave. Once one resident in a ward room became ill, it was only a matter of time before their roommates were as well. Drawing a curtain around beds that were less than 2 feet apart from one another did not provide any protection.

h. Every Long-Term Care home will implement enhanced and terminal cleaning during the period of the pandemic.

Rationale: It goes without saying that cleaning is essential to containing the spread of infection. It was clear from the military report that several of the homes with severe outbreaks were badly lacking in essential cleaning.

68. The Ministry of Long-Term Care must provide funding to ensure that employees who quarantine or isolate due to an exposure are paid for their time off and that part-time and casual employees receive paid sick leave.

Rationale: Employees who are required to quarantine or isolate after an exposure generally do not qualify for sick pay. Additionally, most part time employees in long-term care do not have paid sick days. Employees are being placed at financial risk when they are unable to work due to an exposure.

#### Measures to Respond to COVID-19 in Long-Term Care Homes

69. Isolating and cohorting residents and cohorting staff must be mandatory.

Rationale: Directive #3 states that "Long-term care homes must have a plan for and use, to the extent possible, staff and resident cohorting as part of their approach to preparedness as well as to prevent the spread of COVID-19 once identified in the home". This is insufficient. Cohorting is an essential tool in containing the spread of the virus and must be mandatory.

70. Amend Directive 5 to be truly consistent with the precautionary principle. Airborne precautions must be worn by regulated health professionals and other health care workers when providing care to suspected, probable or confirmed residents in long-term care.

Rationale: There is still no scientific certainty on how the COVID-19 virus is transmitted. In July, 239 scientists sent a letter to WHO stating their belief that COVID-19 could be transmitted by air. Most recently, the CDC and Canada's Chief Medical Officer of Health, Dr. Tam, have recognized that the virus could be airborne. Without an acknowledgement in Directive 5 that COVID might be airborne, Employers continue to insist that N95s are not necessary outside of an AMGPs, and employees are provided with misleading information.

71. At a minimum, all health care workers use NIOSH approved fit-tested N95 respirators (or equivalent or greater protection) when providing care or when within six feet of suspected, presumed or confirmed COVID-19 residents.

Rationale: ONA sent a letter to the Commission on December 22, urging the Commission to issue an interim recommendation requiring all health care workers to use NIOSH approved fit-tested N95 respirators (or equivalent or better protection) when providing care or when within six feet of suspected, presumed or confirmed COVID-19 residents. As set out in the letter, there is an ever-increasing body of research establishing that COVID-19 may be transmitted through aerosols suspended in air, created when individuals talk, cough and sneeze. This is a risk particularly in crowded environments with poor ventilation, such as long-term care homes. The CDC, WHO and PHAC have recognized that the virus can be airborne. This is becoming more urgent given the new variants which are much more transmissible.

Anecdotally, we have heard from multiple members that those staff wearing N95s in homes with outbreaks did not become ill. As just one example, one nurse reported to us that she insisted that all workers on the night shift with her wear N95s. None of them became sick.

Health care workers should not have to wait for scientific certainty to be protected. The precautionary principle should be applied and all health care workers should be using airborne

protection when providing care or when within six feet of suspected, presumed or confirmed COVID-19 residents.

72. PPE must be readily accessible to all regulated health professionals and other health care workers in the Home.

Rationale: If workers cannot access the PPE they need, they are not safe, and neither are residents. Resident care needs can change at any time, meaning workers need access at all times. Access is a separate issue from supply. Maintaining an adequate supply of PPE in long-term care homes is a meaningless protection if workers are denied access.

73. Immediately ensure that all employees in LTC homes have been fit-tested for NIOSH approved N95s. As new models are received by LTC homes, ongoing fit-testing must occur.

Rationale: Fit testing of NIOSH approved N95s is a necessary step to ensure that this critical item of PPE is available to protect workers. If workers are not wearing the correct size, the respirator will not form a seal and does not function as a respirator providing airborne protection. ONA is very concerned that Employers do not seem to understand the importance of fit testing. On-going fit-testing will ensure that workers can use the appropriate size NIOSH approved N95 in the event of future epidemics or pandemics.

#### <u>Inspections</u>

#### Ministry of Labour Inspections

- 74. Immediately, Ministry of Labour inspectors must:
  - a. Conduct all inspections in-person, on-site.
  - b. Inspectors must speak to the workers, including the worker, if any, who made the call to the MOL identifying concerns.
  - c. Exercise independent judgment and decision-making during the inspection process.
  - d. Explain their rationale for not issuing an order in the Field Visit Report.
  - e. Complete their investigations in a timely manner, particularly those being conducted in response to notice under s.51(1) of OHSA (critical injury or death.)
  - f. Trade unions must have the right to participate in inspections.

Rationale: The SARS Report spoke about the pivotal role of the Ministry of Labour ("MOL"). Throughout this pandemic, the MOL has again failed to fulfilled their statutory responsibility to ensure workers' health and safety. This, in part, was caused by the failure of MOL inspectors to properly investigate allegations of *Occupational Health and Safety Act* violations and unsafe workplaces. ONA has filed 20 Occupational Health and Safety Act appeals and numerous grievances as a result of inspectors abrogating their responsibility to take appropriate, timely action.

75. Inspectors must inspect so as to fully enforce the Act, the precautionary principle, and the standards set in the Directives.

Rationale: The Standards set out in CMOH Directives under the HPPA are minimum standards that must be consistent with the *Occupational Health and Safety Act*. Inspectors cannot fetter their discretion by simply requiring compliance with Directives; they must independently assess whether the requirements of the *Occupational Health and Safety Act* have been met. Whether the employer has taken every precaution reasonable in the circumstances cannot be limited to a consideration of whether the employer has met the minimum requirements established in the Directive.

76. At the outset of a pandemic, the Ministry of Labour must deploy inspectors into long-term care homes to ensure that they are prepared, from a health and safety perspective, to respond to an outbreak. In the inspection, the factors to be considered include, but are not limited to, whether the Joint Health and Safety Committee is meeting regularly in accordance with the Occupational Health and Safety Act, that all measures and controls required under OHSA are in place, that an organizational risk assessment is conducted, and that homes have implemented administrative and engineering controls and have sufficient personal protective equipment to protect workers.

Rationale: Lack of preparation was a significant factor in many of the Long-Term Care Homes that were not able to contain an outbreak. This remains an on-going problem. Providing guidance documents to long-term care employers is not sufficient. Proactive inspections are an important tool in ensuring preparedness. It is not too late to carry out inspections to assess the preparedness for COVID-19 outbreaks in all homes. In any future epidemic or pandemic, proactive inspections must be initiated early, before outbreaks hit vulnerable long-term care homes.

77. On an ongoing basis, the MOL should conduct a proactive inspection blitz in long-term care homes, which would include unannounced inspections. As part of the blitz, inspectors will inspect to ensure the internal responsibility system including the Joint Health and Safety Committee ("JHSC") is functioning with regular meetings, that all policies, measures and procedures required under the Act are in place, that they have a sufficient supply of PPE, all staff are trained in the use of PPE and the Homes are acting in accordance with the precautionary principle.

Rationale: Proactive, preventative action is required to prevent future harm to workers. In many cases, MOL inspectors are called after an outbreak has been declared and our members have already become sick from workplace transmission. As we enter a Second Wave of COVID-19 in Ontario, it is important that the MOL ensure that every long-term care workplace is in full compliance with the *Occupational Health and Safety Act*, and has all the necessary equipment and procedures in place to keep workers safe in a Second Wave. A functioning JHSC is an essential component of workplace safety.

The SARS Commission recommended "that in any future infectious disease outbreak, the Ministry of Labour take a proactive approach throughout the outbreak to ensure that health workers are protected in a manner that is consistent with worker safety laws..." It is time we implement this long overdue recommendation immediately.

78. Inspectors must be truly independent from political interference and be protected from reprisal from their Employer.

Rationale: ONA heard from multiple inspectors that they were required to consult with a committee before they could issue any orders. The Toronto Star reported that an internal committee, the

COVID-19 Advisory Committee, was vetting reports and orders before they were issued. It is imperative that inspectors have the freedom and independence to make any orders that they see fit based on their inspection findings.

79. Inspectors should receive training in infection prevention and control and how IPAC measures relate to health and safety in the workplace.

Rationale: Occupational disease is a significant workplace hazard in the health care sector. MOL inspectors cannot fulfill their duty to fully enforce the act and the precautionary principle without an understanding of infection prevention and control and its relationship to occupational health and safety.

80. To ensure transparency, Ministry of Labour inspections should be posted in a prominent place in the worksite, on the MOL website and on the MOH/MLTC website profiling individual long term care homes <a href="http://www.health.gov.on.ca/en/public/programs/ltc/home-finder.aspx.">http://www.health.gov.on.ca/en/public/programs/ltc/home-finder.aspx.</a>

Rationale: MOL inspection reports are not readily available to the public. While the reports are provided to employers and to Joint Health and Safety committees, during the pandemic, ONA struggled to access inspections reports as so many long-term care staff were off sick and not actively in the workplace to receive copies of reports. MOL inspection reports are public documents and should be as easy to access at MLTC inspection reports.

#### Ministry of Long-Term Care Inspections

81. The MLTC inspection focus should not be on strict regulatory compliance but must look more broadly at whether the Home promotes resident dignity, security, safety and comfort and ensures that residents' physical, psychological, social, spiritual and cultural needs are adequately met.

This will require an amendment to s.142 of the *Long-Term Care Homes Act* which provides that inspectors may conduct inspections for the purpose of ensuring compliance with requirements under the Act.

82. The Ministry of Long-Term Care must reinstate annual inspections ("RQIs") If a full "intensive risk focused" RQI cannot be completed every year, then the shorter "risk focused" inspection must be done, with a full intensive risk focused inspection every two years. RQI inspections must include interviews with union representatives.

Rationale: The policy change to discontinue annual inspections on every home was a grave mistake. Complaint and critical incident inspections are unlikely to uncover the range of issues addressed in RQIs. Issues with IPAC preparedness is a prime and pressing example of the type of issue unlikely to be the subject of a complaint or critical incident.

83. The inspection process must include a focus on infection prevention and control practices, pandemic planning and health and safety. The sufficiency of the IPAC program must look not only at whether there is an IPAC program and training, but should inspect to assess the sufficiency of the program and training, which must include in person donning and doffing training, the location and quantity of PPE and whether fit-testing for N95 respirators has been performed.

Rationale: It is clear that for merely having an IPAC policy is not sufficient. To ensure long-term care homes are, and remain, prepared for future epidemics or pandemics, the inspection process must be more rigorous and must consider the sufficient of all aspects of the IPAC program, from policy and procedure, to education and training, to supplies.

84. The MLTC inspectors should attend the LTC homes on evening and night shifts, in addition to day shifts.

Rationale: long-term care homes operate 24/7, 365 days a year. Staff who work evenings, nights and weekends work in a very different environment, with far less support than those who work day shifts. To ensure compliance with all aspects of the Act, it is important that inspectors are able to observe the operation of the home on all shifts, including interviews with staff who do not work day shifts.

85. In targeted inspections (inspections in response to critical incidents and complaints), Inspectors should ensure that staff are provided the opportunity to review relevant documentation (charts, care plans, or other) prior being interviewed.

Rationale: It is matter of fairness and natural justice that any employee being interviewed as part of an investigation have the opportunity to review relevant documents in advance.

86. Inspectors shall provide a copy of the inspection report to the trade unions representing employees in the Home.

Rationale: Section 149 already provides that a copy of the report goes to the licensee, family and resident councils. This section can be amended to provide that a copy also goes to the unions.

87. MLTC inspectors should receive both infection prevention and control training and health and safety training.

Rationale: This recommendation was made in the SARS Commission Report, and remains as relevant today as it was then. MTLC inspectors cannot fulfill their duty to fully enforce the Act without an understanding of occupational health and safety and its relationship to IPAC.

88. MLTC inspections must be conducted without warning to the home, in-person and on-site. Inspectors can attend on-site with appropriate PPE.

Rationale: The MLTC cannot fulfil its mandate under the *Long-Term Care Homes Act* without attending Homes for inspections.

#### **Legislative Changes**

#### **Long-Term Care Homes Act**

89. Amend the Long-Term Care Homes Act to specify that abuse and neglect can include the failure to comply with Directives under the Health Protection and Promotion Act and with Infection Protection and Control practices, policies and measures. The Ministry of Long-Term Care should create a policy directive to ensure that this amendment is clear to licensees and management in the Homes.

Rationale: The failure to comply with directives and IPAC measures can negatively impact residents who are vulnerable. ONA is aware that some RNs contacted the MLTC to report that the Home's decision to not isolate residents was abusive or neglectful. The MLTC did not treat this as either abuse or neglect, despite the fact that it caused physical harm to residents who became ill by the failure to take basic infection control measures to contain the outbreak.

90. Amend the Long-Term Care Homes Act to require that licensees, DONs, Administrators and all home managers undergo mandatory training on infection prevention and control, pandemic planning and health and safety. This training is in addition to that which must be provided to all persons pursuant to s.76 of the Act. The MOH will create a provincial curriculum for this training instead of leaving it to individual homes to create and provide.

Rationale: IPAC, pandemic planning and health and safety are of fundamental importance to long-term care residents and staff. The pandemic demonstrated that there was an insufficient knowledge base amongst licensees and management on those topics. This knowledge gap must be immediately remedied. All long-term care management and licensees must undergo mandatory training that has been provincially developed to ensure that they understand IPAC, health and safety and how to plan for a pandemic.

91. Amend the Long-Term Care Homes Act to require that all managers in long-term care homes receive leadership training (such as LEADs in a Caring Environment Capability Framework). This training must include courses, onboarding, opportunities for leadership skill practice, individual development planning, mentoring/coaching and a formal and objective annual performance review process.

Rationale: There was a failure of leadership in many long-term care homes during the pandemic. Scarborough Health Network identified this issue in their interim and final reports regarding Altamont and Extendicare Guildwood, recommending that managers in long-term care should receive leadership training. ONA agrees and adopts their recommendation.

## 92. The DON, Administrator and IPAC lead must be certified under OHSA, pursuant to s.7.6.1 of OHSA.

Rationale: Leadership in long-term care homes must be aware of their obligations under OHSA. They have great influence over the workplace and must understand their accountabilities as employers and supervisors under the Act. ONA heard repeatedly that attempts to make the workplace safer for staff and residents was stymied by the DON and Administrator who failed to implement engineering and administrative controls in the workplace and restricted access to PPE.

#### Occupational Health and Safety Act

## 93. The Precautionary Principle must be enshrined as an employer duty under the OHSA.

Rationale: The COVID-19 pandemic, like the SARS crisis before it, illustrated that employers do not act in accordance with the precautionary principle of their own volition. It is imperative that a clear expectation about the precautionary principle be enshrined in the OHSA as an enforceable employer duty.

94. Section 9 of OHSA should be amended to require that the Joint Health and Safety Committee, including worker members, must be involved in performing risk assessments.

Rationale: It is insufficient for the JHSC to simply be advised of the results of risk assessments. Similarto their role in physical inspections of the workplace, the JHSC should be involved in performing risk assessments.

95. The Act must require all Employers to prepare and regularly review a pandemic plan on an annual basis or more frequently if needed including when a novel respiratory virus is circulating in the province. This plan must be reviewed by the Joint Health and Safety Committee annually.

Rationale: Many employers did not have an updated pandemic plan. ONA received numerous reports that even when employers did have a plan, they did not want to provide it to the JHSC and the union, in some cases being told that it was "proprietary." The JHSC should be consulted about the plan as the committee representatives know the workplace best and will have valuable insight into what will and will not be effective. Sometimes these plans are created by the chain and need to be individualized for the specific workplace. Workers must also be aware of the contents of a pandemic plan so that they can act in accordance with it in a timely manner.

96. The Act must require the Employer to provide the Joint Health and Safety Committee with monthly reports on the supply of PPE and where there is less than adequate supply report how they will make best efforts to acquire further supplies. The JHSC must inspect the supply of PPE as part of their regular inspection regime.

Rationale: It is imperative that the JHSC be aware of PPE supply given how critical PPE is to overall safety in the workplace. Worker representatives on the JHSC in both the Hospital and long-term care sector reported to ONA that they were not being provided with information about PPE supply when requested. In some cases, worker representatives sought out this information in January and February, in advance of widespread COVID-19 cases and were denied access to that information. ONA continued to have difficulty obtaining PPE supply information in the fall 2020, despite Arbitrator Stout's award that such information should be provided to us.

- 97. The OHSA should create a section specific to infectious diseases. These provisions would require:
  - a. That an employer advise workers, affected trade unions and the Joint Health and Safety Committee of exposures to infectious diseases. Notice of an exposure would need to be provided immediately upon learning of the exposure.
  - b. That an employer notify an inspector, the JHSC and union immediately when a person is killed or critically injured from an infectious disease suspected to be acquired in the workplace and the employer shall, within 48 hours, after the occurrence, send to the Director a written report of the circumstances of the occurrence containing such information and particulars as the regulations prescribe.
  - c. That an employer provide notice containing prescribed information within four days if a person is disabled from performing his or her usual work or requires medical attention because of an illness caused by an infectious disease suspected to be acquired in the workplace. The notice must be

- provided to the JHSC, and the trade union and the Director, if an inspector requires notification of the Director.
- d. That if an employer is advised by or on behalf of a worker that the worker believes he or she has an occupational illness or that a claim in respect of an occupational illness has been filed with the WSIB by or on behalf of the worker, the employer shall provide notice in writing within four days of being so advised, to a Director, to the JHSC and to the trade union, if any, containing such information and particulars as are prescribed.
- e. That during any infectious diseases resulting in exposure or occupational illness the Joint Health and Safety Committee must conduct a workplace investigation to determine the potential source and cause of the infection, containment measures, and measures to prevent recurrence. This should be included in the report under paragraphs a-d and in a report to public health.
- f. That during an infectious disease outbreak, workers must be provided with fit-tested NIOSH approved N95 respirators or equivalent or better protection.
- 98. In the alternative, amend the current notice requirements found in s.51 and 52 to ensure that illness caused by infectious diseases acquired in the workplace are included.

Rationale for 97 and 98: These important sections of OHSA more clearly apply to industrial settings such as mines and factories where the concept of an "accident" readily applies. While "accidents" can and do happen in the health care sector, these sections of OHSA need to be broadened so that reporting of other significant hazards and safety events are captured, in particular, infectious diseases.

Section 51(1) of the OHSA currently provides that where a person is killed or critically injured from any cause at a workplace, the employer is required to notify the inspector, the JHSC, and union immediately and to send within 48 hours a report to the Director. Throughout the pandemic, employers have refused to provide this notification, arguing that employees who are hospitalized and on a ventilator in the ICU after contracting COVID-19 in the workplace are not critically injured and that notice is not required.

Section 52(1) provides that an employer must provide notice within four days if a person is disabled from performing his or her usual work or requires medical attention because of an accident, explosion fire or incident of workplace violence.

Section 52(2) provides that if an employer is advised by or on behalf of a worker that the worker has an occupational illness or that a claim in respect of an occupational illness has been filed with the WSIB, the employer shall provide notice in writing within four days.

The MOL has taken the position during this pandemic that the only notice that an employer is required to provide when an employee contracts COVID-19 is the notice of occupational illness under s.52(2).

We need to broaden this to ensure that notice is provided when an employee is exposed to the virus. We also need clarification that a person who contracts COVID-19 (or other dangerous virus) and is ventilated is critically injured. The notice sections of the Act are key sections that allow Joint Health and Safety Committees and the Internal Responsibility System to function.

99. Amend section 25 of the Act to create a duty on the Employer to provide personal protective equipment upon request by a worker including a fit-tested NIOSH approved N95 or equivalent or better protection for any novel respiratory illness.

Rationale: Section 25 is one of the most important provisions of OHSA, as it sets out the duties of Employers with respect to occupational health and safety. Of the nineteen enumerated duties currently contained in the section, none address PPE in general or fit-tested NIOSH approved N95s or equivalent of better protection.

After the experience of health care workers endured during the First Wave, there was the expectation that employers would act quickly to minimize the risks in their home by fit-testing staff and obtaining PPE over the summer months. This did not happen and consequently RNs continued to experience the same barriers to obtaining N95s. At least one Home had not even fit-tested their staff by December, 2020. There must be specific requirements in the OHSA to provide PPE based on the assessment of the worker, not a manager who is not in the same vulnerable position.

100. Amend section 43 of the Act (work refusal provisions) to clarify that if a worker requests personal protective equipment and is denied that PPE by the Employer, they have the right to refuse work.

Rationale: As of January 22, 2021, the number of health care worker infections in Ontario has increased to 16,204. Health care workers have been infected disproportionally to the rest of the population. A direct cause of these infection rates access to N95s since the start of the pandemic. The legislation must be changed to eliminate the discretion inspectors have to grant a work refusal. Throughout the pandemic, MOL inspectors were determining workplaces were safe, yet were telling workers that it was not safe for them to do an in-person inspection in the workplace.

Section 43 currently permits a worker to engage in a work refusal where "any equipment, machine, device or thing the worker is to use or operate", "he physical condition of the workplace or the part thereof", or "workplace violence" is likely to endanger the work, or where there is a contravention of the Act that is likely to engager the worker. None of the enumerated reasons specifically address the absence of PPE.

101. Define "biological agent" to include a pathogen or virus that comes into the workplace.

Rationale: The Ministry of Labour currently takes the position that COVID-19 is not a biological agent under the *Occupational Health and Safety Act*. This has implications for whether Reg 833: Control of Exposure to Biological or Chemical Agents would apply to circumstances of a COVID-19 outbreak.

#### Health Protection and Promotion Act

102. Amend s.77.7(2) of the Act to require that the Chief Medical Officer of Health and health care facilities shall apply the precautionary principle where, in the opinion of the CMOH there exists or may exist an outbreak of an infectious or communicable disease; and the proposed directive relates to worker health and safety in the use of any protective clothing, equipment or device. Health Care Institutions shall also be required to apply the precautionary principle when implementing the directives.

## Currently the legislation only requires the CMOH to consider the precautionary principle.

Rationale: The HPPA does not require the CMOH to follow the precautionary principle. There is no justifiable reason to give the CMOH discretion to circumvent the precautionary principle. The word "consider" has a specific legal interpretation which is associated with simply having canvassed various options to come to a decision. The SARS Commission Report is clear that the precautionary principle is central to infectious disease response for the health and safety of workers.

#### 103. The precautionary principle must be defined in the HPPA.

Rationale: The Commission heard from counsel for the Ministry of Health Liam Scott in a presentation on the CMOH and the HPPA that that the precautionary principle is "not well known" in health law. Eighteen years after SARS, this is not acceptable. Clearly defining the principle in the HPPA will assist in remedying this problem.

There must be more transparency and accountability from the CMOH. In an emergency when time is of the essence, it does not make sense for parties to have to dispute the definition of the precautionary principle. The important issue is what decisions need to be made flowing from the precautionary principle. Having a clear definition of the precautionary principle is adds accountability and transparency to decision-making should a dispute arise.

#### **Mental Health Support**

104. Mental health supports must be provided to employees who worked throughout the pandemic, including counseling to be made available to employees for a period of up to 2 years at no cost.

Rationale: Nurses working in long-term care have experienced significant trauma and require support. Our recommendation is that this be done through the WSIB. Any long-term care worker who worked during the pandemic should have a claim for health care benefits presumptively approved by WSIB. Providing the benefits through WSIB is appropriate, as the mental injuries incurred by workers clearly fall within the scope of a workplace injury under the WSIA. This also ensures that all workers in long-term care would have access to benefits, which are generally not provided to part-time and casual employees, and limited even for full-time employees.

#### Compensation to Nurses Who Worked an Outbreak

105. Nurses who worked in a long-term care home that experienced an outbreak should be entitled to be compensated a set amount of damages for mental distress/post traumatic stress disorder. The amount of damages would be higher for those who acquired COVID-19 in the workplace, and higher still for those who were hospitalized.

Rationale: The Commission heard evidence about the trauma and grief experienced by long-term care staff, including RNs, as a result of working in homes during serious outbreaks. This trauma is immeasurable. While the current WSIB system provides non-economic loss awards for ongoing impairments, it does not provide compensation for pain and suffering. In order to restore trust and accountability of registered nurses in long-term care, they should provide compensation to those that deserve it.